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📞 (0905)

[*English*]

**The Chair (Ms. Bonnie Brown (Oakville, Lib.)):**

Good morning, ladies and gentlemen. It's my pleasure to welcome you to the Winnipeg section of our travelling consultations on prescription drugs. We're anxious to hear your comments on the subject matter that we're studying.

This morning we have representatives from the Manitoba Centre for Health Policy, the Department of Family Medicine, the National Steering Committee on Patient Safety and the Addictions Foundation of Manitoba.

We'll begin with the Manitoba Centre for Health Policy with Dr. Noralou Roos and Dr. Anita Kozyrskyj, one the director, the second is the assistant professor with that organization.

Ms. Roos, would you like to begin?

**Mr. Noralou Roos (Director and Senior Researcher, Manitoba Centre for Health Policy):** Thank you very much. I would certainly like to commend those of you involved in this effort for focusing on what I believe to be absolutely critical questions facing Canadian medicare over the next decade.

To get to my bottom line first, there are four areas that I would urge you to focus on in your deliberations. One, and from my perspective, extraordinarily important, to create the capability for reviewing and funding research on the cost effectiveness of drugs, and here's the kicker, at arm's length from the pharmaceutical industry, both generic and patent.

Secondly, I think it's extraordinarily important for you to come up with mechanisms for aggressively prohibiting the direct advertisement to consumers. The legislation's in place, the enforcement of it is somewhat problematic.

Thirdly, I think it's very important that the nascent efforts to develop means of collaboration across the country among the provinces on both listing of drugs and purchasing of drugs is a very important effort to support.

Fourthly, I would urge you to look very critically and skeptically at proposals. We really don't need to be that concerned about rising pharmaceutical costs, but it's really another form of industrial development, economic spending, which might be seen as an engine of economic growth. This is an argument which we're hearing more frequently and it's something which needs to be examined very critically.

First of all, to focus on the arm's length research. This is an extraordinarily important thing, which really is not happening. Without having research into drug effectiveness, into public interest research questions about the use of drugs and the compliance with the recommended use patterns, the right questions just don't get asked. The evidence that is produced, we have several studies showing, it tends to be very optimistic of that drug effectiveness. The research ends up in some sense often having critical biases.

My colleague, Anita Kozyrskyj, who is a pharmacist and appointed in both the Faculty of Medicine and the Faculty of Pharmacy will speak to some research that we've done at the centre focusing on why it's critical to introduce this public interest perspective on cost effectiveness into drug research with some research that we've done at the centre.

The critical question always comes up, it may be important, but how do we fund it? What I would point out is the part of the patent legislation, companies are required to devote 10% of sales into research and development in the country. They've achieved this target.

While some of this goes into basic research, only the latest report that I read from the Patent Medicine Review Board, only about 16% was going into basic research. The big

bulk of these funds are going into clinical trials and into post-clinical marketing, post-trial marketing.

If only one-quarter of this 10% of sales, which is their commitment, went into arm's length research, this would basically transform our ability to assess the cost effectiveness of drugs in this country.

So what's the problem with the existing approach to research? I think the most compelling evidence of how serious these problems are is represented by the statements that the editors of the leading medical journals made a couple of years ago, when they came out with recommendations based on their experience of the problems that they were having with the manuscripts that they were receiving: asking for full disclosure of the sponsor's role in research, assurances that the investigators were independent of the sponsor, ensuring that they were fully accountable for the design and conduct of the trial, ensuring that they had independent access to the data

⊕ (0910)

And importantly, assurances that they had control over all editorial and publication decisions. So it's concerning that they felt they had to make these requirements but what's even more concerning is they did a study in the U.S which found the vast majority of contracts and contract research done in the U.S didn't even come close to meeting these requirements.

Canadian institutes health research is taking a similar kind of study in Canada, which will be starting, I believe in the winter or early spring, we have no reason to expect that the situation in Canada is any better than this, so the situation is very serious.

I mentioned the importance of cross-provincial collaboration, I think if you haven't done it already, looking at what's going on in New Zealand and Australia around mass purchasing, around coordinated review of what gets listed is very important.

Prohibition of direct consumer advertising, again the evidence suggests...what happens is you drive up physician visits and drug costs through direct advertising consumers and the results are very interesting. Physicians are very likely to prescribe drugs when asked by a patient.

However when physicians are asked, do they think this was a good idea that such a drug be prescribed, in more than half the cases they said, had they made the decision independently and not been asked by the patient, they would not have prescribed this drug to the patient. So this again is a very problematic situation.

Finally the area of drug costs as an engine of economic growth. The health economists who have worked in this area are very concerned that unless there's this strong commitment to arm's-length assessment of drug research that expansion of the pharmaceutical industry in Canada will lead directly to a marked escalation in drug costs.

The big concern is that the way this initiative is being pushed is to ask for quid pro quo, i.e., the public policy forum document, which was one of the first places, this is a meeting which was held in Montreal, not this last summer, the previous summer made the statement that Canada's research based pharmaceutical industry is ready to entertain significant investment commitment under certain conditions.

The conditions which they're looking for would essentially make even some of the somewhat effective policies in place, which include the referenced based pricing initiative in B.C or the mass purchasing or the extended use of generic drugs, which one finds both in B.C and Saskatchewan much more difficult if this quid pro quo approach to increased investment was accepted.

In summary of my work and my look at this, I would urge you to look very carefully particularly this arm's-length funding of research. I think some of the work which we've done at the Manitoba Centre--which Anita will speak to shortly--reinforces the importance of this policy. Thank you.

⊕ (0915)

**The Chair:** Dr. Kozyrskyj.

**Anita Kozyrskyj (Assistant Professor, University of Manitoba, Manitoba Centre for Health Policy):** We had provided you with an example of the research done at the Manitoba Centre for Health Policy in the area of appropriateness of use of pharmaceutical, effectiveness of use, cost effectiveness . The example we've provided is in the area of use of anti-hypertensive drugs. We released a report last year which compared two kinds of drugs, the ACE inhibitors and the A2RAs which are considered therapeutically equivalent, and at the time that we evaluated their use, there was a recommendation that the A2RAs only after a trial of the ACE inhibitor. The A2RAs are a newer class of drug and they're more expensive.

We conducted our evaluation and we found that actually 60% of individuals who use this new class of drug had not received a previous course of the ACE inhibitor. And so this was a test of evidence based on the literature and also of clinical practice guidelines at the time. This was in 1999.

Since the release of the report, of course, the time has passed and the clinical practice guidelines has been changed, such that in this year, this new class of drug now has appeared as a first line alternative to the older class of drug. And this is of interest because when actually read the clinical practice guidelines, there are statements that appear relating the background material that was used in the production in the clinical practice guidelines and, i.e. that the evidence is based on clinical trials, and it does not include any consideration of public health considerations or cost effectiveness.

So the clinical practice guidelines is based on evidence, but it's not based on cost-effective evidence. And our research shows that it's important to consider the

appropriateness of use and the effectiveness of use. And I guess this evidence compliments the efficacy or the clinical trials evidence. And since our earlier report, we will be releasing a report which shows cost savings, if you actually do follow the practice of using one drug before the other as a step-wise approach to prescribing.

And so in terms of the interpretation of the clinical practice guidelines, I think I just wanted to bring to your attention that there are various influences involved in the creation of these guidelines and cost-effectiveness and public health considerations may not be one of these influences.

**The Chair:** Thank you, Dr. Koryrskyj.

We'll move onto the Department of Family Medicine and the Manitoba Centre for Health Policy at the University of Manitoba, and the representative is Dr. Alan Katz from the Department of Family Medicine.

Dr. Katz.

⊕ (0920)

**Dr Alan Katz (Professeur associé et directeur associé, Département de médecine familiale et Manitoba Centre for Health Policy, Université du Manitoba):** Thank you.

I have three major messages that I'd like to address. The first one is with regard to the approval of new drugs and the mechanism therewith. The second is with regard to funding for clinical trials and the third is with regard to accountability for prescribing of drugs.

I think there's currently significant problems with the system that Health Canada uses in the approval of new drugs at the moment. This is because there are two very strong conflicting interests at stake here. The one is the safety of the public who are to use these drugs and the other is the pressure from both interest groups, disease groups such as HIV AIDS where we saw a significant change in the amount of drugs that went through rapid approval process because of the activism of that group and also from industry who frequently comment on the millions of drugs that are lost on a daily basis as the approval for drugs are delayed.

I think the solution lies in a differentiation in the process of approval. I think that there's potential to recognize that very few of the drugs that come before the approval process actually lead to dramatic improvements in either quality of life or in survival. It's a small fraction of the drugs that are approved that actually make a dramatic difference. And for those drugs, we need to be a process that recognizes that, that allows a much more rapid approval process but part of that needs to be compulsory surveillance. So a drug can be approved for use much more quickly with a much more ... less rigorous

approval process but built into this is it's not a complete approval. It's an approval with caveats that surveillance of all use of this drug should be compulsory.

I mention this both in terms of addressing the safety but I think there's an added spinoff value for this in that our current system does not support physicians or even encourage physicians to be involved in surveillance of safety of drugs. Currently the adverse effects reporting system is dramatically underutilized. It may even be compulsory. I think it's voluntary, maybe it's compulsory. But I'm a practising physician and I can tell you that none of my colleagues fill in those forms. None of my colleagues see this as part of their responsibilities in a busy day of seeing multiple patients to go and fill out a form that a patient has a reaction to a drug. We need to change that.

One of the ways of changing that is instituting a system with a small select few group of drugs that are high impact drugs and that you know if you prescribe that drug, you have a responsibility for surveillance. And surveillance in that context doesn't just mean adverse effects. It means good effects too. So it becomes part of the process.

So I see a system that's a differential system based on the potential impact of the drug. The vast majority of drugs will go through an extremely rigorous process with a few drugs going through the more rapid process.

The second issue that I wanted to relate to is the funding of clinical trials primarily but really other research as well. There was a recent paper that was published in the British Journal of Ethics by in Manitoba who made a very argument that all clinical trials should not be funded by industry at all based on a number of ethical arguments and some examples of places where things have gone wrong.

I don't believe that's realistic. I don't believe you will accept that as being realistic but I do think that there is a potential for a middle of the road situation. I want to draw your attention to some of the work that we've been doing in the department of family medicine through our primary health care research unit in combination with industry. I think there's place for partnership between industry and academia.

One study in particular which I want to tell you about some of the results of. It's called the Manitoba Appropriate Anti-inflammatory Utilization Intervention study. We found a neat acronym, MAAUI for the study and we've got some interesting findings.

⊕ (0925)

But if they study where there's a partnership between industry, academia and government, local provincial government--and I think it is an example of a potential model for collaboration and partnership--that certainly, in my view, is a great improvement on the current situation where the vast majority of research is funded by

industry with no input from academia or governments. And I think that's a sad situation and it doesn't serve us well.

I must tell you that our experience in this kind of model has not been universally positive. There is a tendency from industry, depending on your industry partner, to want to dominate the process. So we have learned that some partners are better partners to work with. But I think we have found, certainly in the MAAUI project, partners who understand where we're coming from and it works extremely. So it can be done.

The third comment that I wanted to make was around accountability for drug prescribing and the monitoring of prescribing practices. There is, in my view, currently no current accountability for those who write a prescription. Errors are made, pharmacists unfortunately work in an environments where the more prescriptions you fill the more you earn. Just like the majority physicians who work in an environment where the more patients you see the more you earn. The errors slip through. There is no current incentive, to either the physician or the pharmacists, to really pick up those errors, to monitor prescribing practices in terms of interaction of drugs.

In Manitoba, for instance, we have an electronic system which actually sends an immediate message to the pharmacist whenever there's a potential interaction of two drugs that the patient is on as part of the dispensing process. Since that's been in place, for I think 10 years now, I have not once received a phone call from a pharmacist telling me of a potential interaction. Not once. I know that I've prescribed drugs where there have been potential interactions, but the current system allows an immediate override. You hit the button and it just goes away.

The assumption on the part of the pharmacist is that I know that. I can tell you that that's a false assumption. Most physicians do not use information technology to its potential and are not aware of those interactions, which is the way to find out things. So there currently is no accountability in the system.

**Mr. Svend Robinson (Burnaby—Douglas, NDP):** Does that warning go to the pharmacist or does it go to physician?

**Dr Alan Katz:** It goes to the pharmacist. When the pharmacist enters the drug into the current system, the provincial system, that system automatically looks through the drugs that patient is already on and a little of the compulsory system that all pharmacies in Manitoba have. The same does not apply to family physicians offices. Probably 10% of family physicians have electronic health records and have a system that has that potential.

One of the things we need to do is support information technology that allows the point of prescribing, the physicians office, to have this potential. I would suggest we need to go a step further. When I spoke about surveillance for high risk drugs we need to build a culture of accountability where physicians have a sense of accountability not only to themselves and the individual patient, but to the system.

I think there've been a number of initiatives in the UK and this regard where primary care reform over the last 10 years in the UK has recognized the need for accountability, has put money into the system to build a system of accountability and to build research into that, that allows accountability to be measured. In Australia as well, there's been significant resources put into primary care research specifically recognizing the high percentage of health care that happens at the primary care level and the fact that if you look at the distribution of research dollars currently, primary care is dramatically under researched and accountability is one area where I think research is necessary.

An example of the work that we've done in this regard is with regard to anti-inflammatory medications where the development of COX-2 or NSAIDS are a group of drugs that are recommended. In Manitoba reimbursement is only provided if these drugs are prescribed to high risk patients. So what I presented in my written submission is the result of some of the work we've done in the Maui Project that shows that out of high risk patients, the majority of them, 53%, received the old anti-inflammatory drugs, which they should not be receiving, so there was under prescribing in that group; 47% receive appropriate prescribing. In low risk patients, a much smaller group as you can see, there is over prescribing in about 3,000 patients. So some low risk patients are receiving drugs they don't need, but the majority of high risk patients are not receiving the protection they need. So there's a lot of potential for improvement there as the study shows.

The conventional wisdom is that the pharmaceutical industry are dramatically successful in their marketing and that everybody is getting the most expensive drug. I think they are successful and I think there needs to be balance in that marketing process, but I think there are as well a number of patients not receiving the potential good that they can receive.

In my written submission I also mention the work that I did at the Centre of Health Policy with regard to beta-blockers, drugs that have been shown to have a 14% reduction in mortality after myocardial infarction. Only 59% of Manitobans are on beta-blockers after myocardial infarction. A fairly dramatic potential saviour in mortality if there was an increase in beta-blocker usage, but to be honest the pharmaceutical industry does not promote beta-blocker usage because there's no money in it.

These are drugs that have been on the market for 10-20 years and I, in the last 10 years, can't remember having seen anything from industry supporting the use of beta-blockers after myocardial infarction because they are certainly on the market and these are not expensive drugs. So we have potential here for dramatically improving outcomes with a very simple use of a drug that's freely available on the market and relatively cheap.

⊕ (0930)

**The Chair:** Thank you, Dr. Katz.

Our next witness is the former chair of the National Steering Committee on Patient Safety, Dr. John Wade.

Dr. Wade.

**Dr. John Wade (Former Chair, National Steering Committee on Patient Safety):**

Good morning and thank you for inviting me. You probably don't know me, but I've been described as a paleoanesthesiologist, a has-been and in recovery from being a deputy minister of health for a few years, but I want to speak about patient safety which I think will be a really major issue in this nation over the next couple of months, never mind years.

My background in this goes back to the days in anesthesia in the late sixties when we were concerned that the death rate from anesthesia in Canada was probably one in 500. We pursued some outcome studies with the assistance of the Centre for Health Policy and others documenting the problems and then we wrote the guidelines to practice for the Canadian Anesthesia Society. Those are now in place. They are upgraded every year and the outcome from anesthesia now, the death rate is only one in 250,000. I'd say only even that isn't good enough. We've gone from the highest CMA medical legal fees. We were there with obstetricians, neurosurgeons in the seventies. Our rates have actually gone down to a very low level as a result of paying attention and documenting and doing research and acting on patient safety and outcomes.

I think the Patient Safety Institute, I've provided you--I don't know whether you've read this, have you, our study--I've given a copy to you, but it arose out of a meeting of the Royal College of Physicians and Surgeons in 2001 in Ottawa. Out of that the Americans and others spoke "to err is human" where there were something in the neighbourhood of 80,000, 90,000, 100,000 deaths in hospitals in America every year and at least 50% were preventable.

That alerted many people in this country. We had no study. There was no coordination, so that group which was composed of lay people, physicians, nurses, pharmacists. Two ministers of health from Alberta and Nova Scotia and Health Canada formed the steering committee which I chaired and our message was to bring back a plan within a year. We did that.

The other thing we insisted on was this would be government hands off, okay. Let us do it because we did not think with the current state of federal-provincial, whatever you want to call it, that it could be done through the political process. So that's what we did.

We formed five working groups. Those working groups were in the areas of measurement and evaluation, education, systems. We now know that most adverse events are not caused by individuals, but by systemic failure. Legal and regulatory--if we're ever going to have reporting, we need to look at the provincial regulations and the legislation in terms of privacy, confidentiality and privileged communications.

That's exemplified by the tragic death of the young child in British Columbia at the Children's Hospital who had an injection of chemotherapeutic cancer agent into her spinal chord. It was only supposed to be administered intravenously. She died, but when

that was looked at, there had been three other incidents in Canada that had gone through coroners juries and inquests and that information was not shared across the nation and as a result we had the fourth preventable death.

So the legal regulatory is critical. We need to have a new form of educating, multidisciplinary, our nurses, pharmacists, others, systemic reviews, the accreditation process--things like wrong limb surgery, etc. can be handled that way--measurement and evaluation and we know from what's going on in the United States that the public needs to be informed, physicians need to be informed. The public says that's low on our list because we're more concerned about getting our hip done or getting our MRI or whatever. Physicians say "well that may be true and some doctors, but not me and not in my hospital" and we know that that's not right.

Medications are an important part of adverse outcomes and deaths, probably amounting to 40%, but they are also part of the systemic problem in that when you see adverse events with medication, certainly in the institutions, there are also a failure and breakdown of other people within the system as well as the medication itself.

⊕ (0935)

They are part of a greater problem and they need to be addressed in that manner.

Our report has gone in. We had 19 recommendations. We presented to Mr. Romanoff and to the ministers of health in the latest federal budget. There is \$50 million allocated to patient safety, \$10 million a year for five years.

There's an interim group looking at setting up a Canadian patient safety institute which I think needs to proceed very quickly. I think the pressure is going to come from what's called the "Baker Norton" study. CIHI and CIHR have funded a study to look at adverse events and outcomes in Canadian hospitals. That study will be published late this year in peer-review journals. It's coming down the track. I would be very surprised if there are not 10,000 deaths in Canadian hospitals annually, 50% of which are preventable.

As politicians, if you're not ready for this, I think the Canadian public is going to be very concerned about what's going on in our health care system.

That publication is going to be out. I'm not sure when, probably later this year. It will be published in the peer-review journal, something like the *Canadian Medical Association Journal*.

There is some urgency for the Canadian patient safety institute to be set up, organized, and get busy. I think that is in the best interest of the health of all Canadians.

I should say, too, there's a tremendous economic spinoff. If you increase through adverse events the length of stay in hospitals or legal fees or any of those things, we're talking about millions, if not billions, of cost to the system. Although that shouldn't be the primary driver, there is a strong economic driver to it as well.

I would urge you to have a look at our document, and to do whatever you can to help to facilitate the establishment of a permanent Canadian patient safety institute that would coordinate, facilitate, and stimulate patient safety in our country.

Thank you.

⊕ (0940)

**The Chair:** Thank you, Dr. Wade.

Our next witness is from the Addictions Foundation of Manitoba. We have today Deb Kostyk, seniors and addictions prevention education consultant.

Ms. Kostyk.

**Mrs. Deb Kostyk (Seniors and Addictions Prevention Education Consultant, Addictions Foundation of Manitoba):**

⊕ (0945)

And it's actually quite alarming when we look at the numbers of older adults using those particular kinds of drugs. What I can tell you is that in Winnipeg a number of years ago--I guess that dates me a bit--we had done a study in a Winnipeg hospital in emergency looking at possible drug dependency with opiates and benzodiazepines. What we found was 17% of people over the age of 65 were possibly drug-dependent on benzodiazepines or opiates. And when you look at the population of older adults, that's quite an alarming number that had just been taking medications for, again, too long, in appropriately, beyond the therapeutic use, beyond its usefulness.

We're also looking at the older a person gets the more likely they're to be prescribed benzodiazepines particularly. In my language what I hear older adults referring benzodiazepines to is sleeping pills or nerve pills, but the older you get the more likely you are to be prescribed these particular drugs and they're known to be...because of the aging sensitivity, the aging body changes in many ways, there's increased fat content, decreased muscle content, decreased water content, all of those kinds of things that happen, which leaves greater sensitivity for these particular kinds of drugs, or any drug, for that matter.

But, from my perspective, looking at benzodiazepines and opiates, what you get from this, from using these particular drugs inappropriately is unsteadiness, fatigue, increasing cognitive impairment, difficulty concentrating, which can, in many ways, create a lot of

difficulty for an older adult, who may possibly be compromised physically and mentally in some ways anyway.

Some of the things, also, that we'll see, in terms of prescription drug use, that make this a bit complex with anyone, but also for older adults, is not only the prescription drug use, but also what they're mixing that prescription drug use with. There's an alarming piece of information that I have: alcohol has a negative effect on over 150 medications. The other thing is--this information also really blew me away--that 20% of people over the age of 65 that use multiple medications are also daily drinkers. So again, the therapeutic effect and the possibility for adverse drug reactions becomes quite high for this particular population.

If we also add "over the counter" drugs, some of them also have opiates, codeine in them, they have alcohol in them, and you add an older adult is also taking a or an opiate, you increase the sedating effect without older adults even being aware of it. Herbal remedies can also have a definite dramatic impact on prescription medication, and older adults are using a lot of herbal remedies.

So it complicates the whole issue about use of prescription drugs, in terms of what they're mixing this with, which then can increase the incidence of adverse drug reaction, and adverse drug reaction is definitely the worst possible consequence of prescription drug use for older adults.

The other alarming factor about prescription drug use, particular use, among older adults is that falls are the sixth leading cause of death among older adults and consistently in the literature benzodiazepines have been mentioned as one of the factors in creating the incidence of falls.

⊕ (0950)

The thing about using benzodiazepenes and opiates is that it is about the relationship. It's about patient-doctor relationship. It's about older adults becoming quite...looking for a quick remedy for symptoms, usually sleeplessness, anxiety and chronic pain. We all like to have relief of symptoms and also then physicians feeling compelled to provide some answer to those remedies.

For some of the factors in terms of relating to substance misuse among older adults, when we look at the system per se is I would agree with the panel. It's about a fragmented health care system, particularly when we have family physicians, pharmacists and other service providers to older adults that tend not to communicate with each other and also you have an older adult that may or may not know what to say, what to report to their health care providers and the time to do it.

What we found out also, I was involved with elders health program and we had gotten a three-year national funding again a few years ago and we found that when we identified an older adult who had been on benzodiazepenes and commonly for us to find someone

on benzodiazepenes for 10 to 30 years regularly using them interested in tapering off those kind of medications, a phone call to the physician, physicians were actually given the support, were ready and willing to collaborate in whatever way was going to be effective for the patient and also in many ways increase health benefits for that patient if they were tapered off appropriately.

We found quite often is that it's support. If you can provide support to physicians, to pharmacists and provide intersectoral cross system support and connect. In some ways it's kind of a case management way, there can be definite health benefits that can rarely assist not only the older adult, but the system at large.

Another of the factors about substance misuse that relate to that is also the training: training in geriatric care; training in addictions; training in brief intervention, what to say, what to do. Also some of the factors in terms of this system is the lack of prevention initiatives, what kind of message is getting out? We've also talked about marketing, not only messages getting out to physicians and pharmacists, but also to the public.

**The Chair:** You are well over your time. Can you just wrap up, please.

**Mrs. Deb Kostyk:** Some of the solutions we would be looking at in Manitoba that we see is we look at a medication information line to older adults and that's a toll free number that people can use. It's a well accessed program. There's intersectoral community collaboration, partners seeking solutions with seniors going on right now. We're also really needing aids specific substance misuse programming. Older adults are not going to traditional addiction services. They're not speaking to physicians. They need a specific programming that can work between systems.

Thank you.

**The Chair:** Thank you very much.

We'll move on to the second part of our meeting and begin with Mr. Merrifield.

**Mr. Rob Merrifield (Yellowhead, Canadian Alliance):** Thank you for coming in and sharing with us what you've seen and what you recommend. It's kind of interesting, but it's so broad and we have very little time to ask the questions. First you have to discern how big a problem we have out there and I appreciate Deb's remarks and John, I think you've done quite a bit of work on this.

There's no question from the research that I've done personally on it that I would concur with everything you're saying. We have a serious problem out there and some of the numbers we heard even in witnesses the other day were 50% of our patients within our facilities have the potential or being misprescribed or having addictions and adverse reactions.

I'm wondering is there anything that...maybe I'll ask the doctor this one is would you say that number is perhaps false or would you confirm it?

🕒 (0955)

**Dr Alan Katz:**

I don't know of any evidence either way yet. I know the study Dr. Wade referred to will answer that question in terms of the actual numbers, but in terms of experience it doesn't surprise me.

**Mr. Rob Merrifield:** Okay, that's what I'm asking. You have personal, hands-on experience and you get a sense as to whether that is practically true or not, but you're saying to us that it's probably true.

**Dr Alan Katz:** One of the issues you face in seniors, in particular, is the issue of drugs being prescribed for some traumatic reasons. Many times we know the drug is not going to cure a disease but as you get older you develop multiple disease that interact with each other and as a result, patients come in with multiple complaints and the natural response is to want to help your patient, which means you're prescribing a drug for (a), (b), and each time it's a different drug and the more drugs you prescribe, the more potential there is for interactions. In fact, that's how people end up in hospital with those problems.

**Dr. John Wade:** I think the data is pretty clear from other countries and I doubt that Canada is any different. Those numbers are probably right.

I would also say that Canada has an amazing opportunity to change that in Health Infoway. You funded that to \$3 billion. They're looking to create electronic health records for all Canadians within the next five years. That will do two things: one, it will give us a database we've never had before to pursue further, drill down on some of the data we need, but also combined with the PharmaCare systems that are in Manitoba, the PHIN system here and others, you will have electronic subscribing--probably interactive, and tracked--and that's an amazing opportunity. No other country could do that because no other country has a single pair and--

**Mr. Rob Merrifield:** It seems like each province is doing their own on this one. I know Alberta has the Alberta Wellnet program. They're looking at their electronic records falling within the next 12 months. There will be an interesting pilot in that province to see if that can be applied, but there's no question we have a unique opportunity in Canada to make...

Hopefully Infoway will allow all provinces to talk together nationally and work its way through. I would agree with you.

I'll really be looking forward to your report and being able to read it and your 19 recommendations and some of the work you've done because I think you're ahead of the

curve because when we talked to the department we hear that very little work has been done in this area, so thank you for your work and what you're doing with it.

I just have one question before we get on to some of the other solutions. With the benzodiazepine you talked a lot about the problem that's there. Can you tell me, how difficult is it when you find that an individual has been addicted to benzodiazepine, to get them off of that?

**Mrs. Deb Kostyk:** It's quite possible. The Elders Health Program successfully tapered older adults off of benzodiazepines with support and with promoting other behavioural therapeutic alternatives, which is really key. There are tangible behavioural alternatives to offer that allow people options in terms of managing their symptoms.

**Mr. Rob Merrifield:** How long does it take to get them off?

**Mrs. Deb Kostyk:** It varies. With brief intervention, I have seen some older adults--in some ways it's a bit scary but they're doing it--tapering themselves off in a matter of a few weeks to a few months. Others I've seen require about one to two years.

**Mr. Rob Merrifield:** So it's a long process.

Getting back to the Doctor--because I know my time is limited here--you're suggesting, as far as some of the solutions that you're recommending, you're saying academia and industry are not working in a collaborative way for some of the studies on drugs right now and you're recommending that should be taking place.

**Dr Alan Katz:** The vast majority of studies that are currently taking place are funded by industry through research organizations, but some academic people will be participating in but the studies are controlled by industry.

**Mr. Rob Merrifield:** So you're talking about the control of it, not necessarily that you're working together collaboratively.

**Dr Alan Katz:** Yes, the model I'm talking about is a steering committee model where the actual data is kept within the academic environment and the publication is not controlled by industry.

🕒 (1000)

**Mr. Rob Merrifield:** Yes, I would concur. I don't have a problem with that.

Right at the beginning we were talking about the recommendations of research direct to the consumer advertising listing of purchasing drugs and using it as an engine of growth but I'm wondering if you recognize or what your thoughts are to faster approvals being safer and cheaper and how important is moving to that on the faster approval of drugs when you relate that to your comments on the economic engine and growth driver?

**Mr. Noralou Roos:** I think that Alan's comments are pertinent here. When they reviewed the 1,000 drugs which had been approved in the last, I believe, 10 years what they found was 85% of these drugs were really marginal improvements on what had been available before. So the argument about the need for faster approval only if you're going to focus on identifying where there's this promise for the very small minority.

**Mr. Rob Merrifield:** Do we know that all the time before?

**Dr. Alan Katz:** We should because part of the process is that people have to make submissions with evidence and when they file other drugs in the same category....

**Mr. Rob Merrifield:** Isn't that happening to some degree now? You're saying no?

**Mr. Noralou Roos:** No.

**Mr. Rob Merrifield:** Okay, fair enough.

**The Chair:** Mr. Thompson.

**Mr. Greg Thompson (New Brunswick Southwest, PC):** Thank you, Madame Chair.

I want to pick up on what Dr. Katz and Ms. Roos had to say in terms of the approval of drugs and some of these marginal drugs that are approved.

It goes back to testimony that we have heard, in part of that testimony we've heard from Dr. J. Bury, who, in one of his publications on reducing drug prices, he talks about irresponsible prescribing. It fits in with what you people are saying about some of these new drugs that come on the market. He's talking about drugs that cost 100 times as much as some of the first line drugs that are doing exactly the same thing. One of the examples he draws is the area of high blood pressure hypertension where some of those new drugs costing 100 times as much doing virtually the same thing.

Yesterday in our talks one of the things I suggested to him, that we've heard actually from the Minister of Health for the province of Saskatchewan, was the idea of a clinical trials registry where.... I guess one of the things a clinical trials registry, I just want to hear your comments on that, what identifies some of those marginal drugs so that I guess we wouldn't be in such a rush to push some of these on to the market.

Because what happens with this, we're talking about the high cost of prescription drugs, which a lot of that could be avoided by bringing on these wonderful cures that do absolutely nothing new, if you will, only to find out that it's costing either the government or individuals much more than it should. I'd just like to hear you speak on that, , specifically in regards to a clinical trials registry, whether or not that could work, would it in fact help. Ms. Roos, maybe you could pick up on what has to say.

**Dr. Alan Katz:** I don't believe that the answer lies in a clinical trials registry necessarily because the results of clinical trials are generally published anyways. They may be a little bit more difficult to find, but they're out there.

The issue of not approving the more expensive drugs is a complex one because ultimately the problem isn't that the more expensive drugs are used at all, the problem is they're used unnecessarily in a majority of patients. There is a place for the more expensive hypertension drug but it's not in the majority of patients. Maybe 60% or 70% of patients should be taking cheap diuretics that cost pennies a day rather than the drugs which cost \$2 a day, but there's still a need for the more expensive drugs in patients.

I don't think it's wise to suggest that those more expensive drugs should never be approved, I think it's how they're used that we need to look at and how they're used by physicians. Clinical trials will not address that issue, that's a marketing issue, that's an issue of balancing the influence on prescribing patents.

🕒 (1005)

**Mr. Greg Thompson:** In regards to clinical trials, you can compare quickly, I guess, the results of one drug over another in terms of how the process unfolded. Would that be helpful? Would it be helpful?

**Dr. Alan Katz:** The problem is that the clinical trials comparing diuretics which cost pennies a day and the drugs that to refer to are not done because the people who fund clinical trials are the pharmaceutical industry and there's no advantage in doing that comparison, comparing pennies to dollars. It's not so much a registry of what's being done, it's influencing the process initially. Rather than keeping a registry of what's being done it's influencing it and developing partnerships with industry that actually help make the decisions about how these trials are done.

**Mr. Greg Thompson:**

So you're saying that some of the evidence in clinical trials was skewed from the get-go because the person who's conducting the trials is in fact the person who's going to benefit.

**Mr. Noralou Roos:**

They design the trials very deliberately to ensure that they pick a drug for comparison that they anticipate they're going to show advantageous results.

**Mr. Greg Thompson:** Ms. Roos, is there an area that we can go to beyond the clinical trials in terms of practical evidence that is provided by, for example, the medical profession on the success rate of a particular drug or the ability to cure an ailment, if you will?

**Mr. Noralou Roos:** This is really why I'm a very strong believer that setting up very significant investment in arm's length evaluation, a public-interest driven question as you've just posed. There needs to be funding out there to ensure that there is broad distribution and one figures out how you counter the marketing, which the drug companies are very effective at, in ensuring that one potentially reviews how physicians are prescribing in a very public way and ensures that this gets communicated broadly to the public around the cost effectiveness kinds of issues that Anita was describing.

**Mr. Greg Thompson:**

And that fits in well with your position on advertising as well--

**Mr. Noralou Roos:** --Absolutely--

**Mr. Greg Thompson:** --Because that was just another opportunity to exaggerate the claims of drugs, whether they're effective or not, and we've had many examples of that.

**Anita Kozyrskyj:** If I may add, the issue of the clinical trial evidence and choices that I made in terms of which drugs are compared is that this evidence is then incorporated into clinical practice guidelines and we don't have additional evidence in terms of the effectiveness of these drugs once they're released onto the market and the example that we gave of the population-based studies that we do at the Manitoba Centre for Health Policy would give the opportunity to make comparisons of drugs that are more expensive, less expensive, as effective, and to contribute to this evidence. So this is evidence in addition to clinical trial evidence, if it was available then would have the opportunity to be incorporated into clinical practice guidelines.

The clinical practice guideline is the guideline by which the physician practices, so once this evidence is incorporated into the guideline it's very difficult to make substantial changes.

**Mr. Greg Thompson:** Then being able to share that information quickly and world-wide, if you will, because a lot of that evidence...I guess what I'm saying is that it's okay for Canada to adopt that system, it would be fine, but that type of system would have to be international, if you will. Is that correct?

**Dr. John Wade:** No, I don't think so. I think you have a wonderful opportunity in Canada with the new Infoway on drugs to put that in every doctor's office, so one of the reasons clinical practice guidelines haven't worked is it's too complicated for the person. I was a GP. I've been on the firing line. You don't have time to be going and looking up clinical practice guidelines, etc., but if you had that on your computer in your office where you could see it, interact with it, etc., and prescribe that way, which is entirely possible in this age and should be...I mean you see it at McDonald's every day, it would really go forward.

I'd just like to comment on clinical trials. They're number one the biggest marketing that drug companies have. What they do is go out and recruit, me being one of them, people, in terms of anesthesia in the United States and Canada and then you go and talk about it on some platform and that's the best advertising a drug company can have, so that's...clinical trials you have to look at as marketing for drug companies.

Secondly, Canada has not funded good clinical research so many clinicians have had to resort to clinical trials to get some money to do research or often for other things and you know as they said in my first profession, you always skate to open ice. Well, the only open ice that clinical investigators have had has been from the clinical trials and funding that way because government provincial funding hasn't supported that.

So you've got this problem. I agree completely with Noralou that if you took a certain percentage of money that is now being used in clinical trials and put that towards a stand alone evaluation and communication strategy, we'd be miles ahead and the drug companies, the good ones that have good products, would benefit from strong peer reviewed research that showed benefit from their drugs, but they have to be convinced.

🕒 (1010)

**Mr. Greg Thompson:** Thank you, Madam Chair.

**The Chair:** Thank you, Mr. Thompson. Mr. Dromisky.

**Mr. Stan Dromisky (Thunder Bay—Atikokan, Lib.):** Thank you very much. You know, through all these hearings and so forth, and the more we read and the more we listen to the kind of problems that are related to this area, I could draw an analogy. It's much like a symphony orchestra. We have a large number of very, very talented people, well-educated, very bright, even creative, but they're all playing a different piece of music at the same time and that's the way I see it.

Now here we have a doctor who says he's too busy, you know. We have a huge problem regarding adverse effects of drugs in our population, not just seniors, but doctors are too busy. Well, how are we going to find out when the vast majority of people who are affected maybe don't know what they should be doing. They turn to the doctor. After all, the doctor prescribed it. They don't go running to the radio stations. They don't go running to the press. They don't go running to Health Canada. Where do they go? How are we going to find out? That's the big problem, so what suggestions would you have as professionals to make that system work so that we get the information pertaining to adverse effects.

You know, I talked to a doctor the other day. He's fading out of the system, out of his practice. He's only working half-time now so I asked him how many patients he sees in a day. He says well, I try to keep it to forty. You know. So I can appreciate and understand what he's going through and what all the doctors are going through in this country on the

pay system and everything else. So any comments pertaining to what I just finished saying?

**Dr. John Wade:** Instead of working harder we have to play smarter and I don't you'll ever change and do it right until you change the funding system for physicians.

You know people have talked about multidisciplinary reform etc. I've heard it for 25 years, why hasn't it worked, well because most Canadian physicians are still on fee for service. If you're really interested in primary care, change the funding system, allow the payment of other providers and what I'll call health access centres, pharmacists, physiotherapists etc. give people the technology they need that's now out there.

It takes fundamental guts to change the system and to do the things that are necessary but you know we'll be talking about this for another 25 years unless you make the fundamental decision to change the funding system and provide physicians and other healthcare providers with the support that they deserve and the technology that's now present.

We just have to get on with it, otherwise we'll, as I said, we'll still be talking 25 years from now.

**Mr. Stan Dromisky:** Because we're directly related to the work ethic. The harder you work, the more money you should get, that's what we've been teaching our children for years and years and for centuries maybe, I don't know. But it definitely is in our society.

The more people you see in a day is a good indicator to me that you are working harder than the doctor who sees fewer patients in a day. Therefore, you should get more money than he does. But the care you're giving is lousy, we know that, all right then.

I'm really interested in this part of the country in Alberta and Saskatchewan and Manitoba you have large collections of certain ethnic groups. Can you tell me from your experiences that as far as herbal medicines are concerned maybe or other kind of "treatment" that's the word I'm going to use, are more prominent with certain ethnic groups than others? Do you find certain ethnic groups are more adverse...in other words, they stay away from pills as much as possible than others.

🕒 (1015)

**Mr. Noralou Roos:** I know I haven't...

**Mr. Stan Dromisky:** Is there evidence whatsoever, I just think you have certain ethnic groups in the city of Thunder Bay and I know what they believe and what they preach to each other pertaining to hospital services. As an example, hey if you're going to the hospital you're never going to come out. So stay away from the doctors and stay away from those kinds of places because once they put you in there you're finished. We still have people who think that way.

**Dr Alan Katz:** It's unfortunately true for some people.

**Anita Kozyrskyj:** We really haven't done very much research in that area but one bit of research we have done relates to variations in prescription youth, according to neighbourhoods in Winnipeg for example.

There is some very interesting patterns, one that I recall whereby a certain neighbourhood that had a large proportion of new immigrant families had the lowest rates of use of anti-depressants for example. This is probably as close as we can get in terms of evidence relating to certain cultural groups in differential use of the healthcare system. And it is an interesting question.

**Mrs. Deb Kostyk:** I mean it's definitely anecdotal, we hear...I hear...

**Mr. Stan Dromisky:** Yes, that's what I'm referring to.

**Mrs. Deb Kostyk:** You know stories about...I had just met with a man who is from the Philipino community is a senior and he talked about how there are certain beliefs about medications, certain beliefs about alternative healthcare practices that that particular community...and finds them quite effective thank you very much.

**Mr. Stan Dromisky:** Could I have one more question? This is switching the topic.

It's marketing we're talking about. The drug companies want to make big bucks, but when I take a look at the whole system, it seems to me that we're all players, but there's somebody controlling the whole industry, and that, of course, is the pharmaceutical companies. They seem to be able to get away with anything they want.

I would be very suspicious of any kind of results that they publish pertaining to a new kind of trial or research that they're doing on a new drug. I'd be very, very cautious, there's no doubt about it. But they've gone through the experience, they've spent millions of dollars. I've visited pharmaceutical factories--I call them factories--in Montreal. I went to every one of them. In one of them, they had 170-some professional people with Ph.D.'s, and involved in post-graduate studies, doing all kind of research costing millions and millions and millions of dollars. We know that story.

But how do I get my drugs out? I would like you to be very honest and tell me how you are enticed to pass on their drugs over someone else's drugs, to give the more expensive drug instead of the cheaper drug? What are the kinds of things that the drug companies do to you people to entice you, encourage you to market their product, or to sell their product, or to pass on the recommendation that their product should be used, not using your common sense, or your own intelligence, your own judgment? There must be things being done for that to happen because I hear all kinds of stories. I would like to gather more information before this committee.

**Dr Alan Katz:** As a practising physician, let me speak first and tell you about an experience I had ten years ago when I took my rental car back which I had rented to Avis or Hertz, or whoever. The fellow came out into the parking lot with a handheld device and recorded my mileage immediately and gave me a receipt on the spot within 15 seconds. That kind of technology still does not exist in the medical system. It existed in private industry years ago. So my point is that we're dealing with private industry that had access to millions of dollars and incredibly sophisticated marketing procedures.

A simple colour ad in the premier medical journals are the tip of the iceberg. I probably am not aware of some of the ways that I'm being influenced by the industry, and that's their right. They have sophisticated marketers and they're doing that because this is a free enterprise society, and I think that's fine. Part of what I wanted to say was that we need to try and balance that. In my written submission I said that we need to try and support good evidence-based information given to physicians through other alternative means that are currently available. It doesn't come through industry. Yes, there are dinners, and there are gifts, and there are trips, and there are academic lectures that are sponsored by industry. There are all these things that are out there, and there are other more subtle things.

When someone from industry comes into a physician's office in the morning and gives details about a drug, that person has as their information often the amount of that drug that this physician has prescribed. There's a system out there where they buy from the pharmacies information around your prescribing habits. They know that after they've been to your office, a few weeks later they get the data back and they see that you're prescribing more. So there's an enormous sophisticated system out there that currently is not balanced by evidence by academia. It's purely driven by industry.

🕒 (1020)

**Mr. Stan Dromisky:** For the future, do you think that the profession can really govern itself without the interference of government or other agencies regulating your life in the use of drugs? Will you ever reach that point?

**Mr. Noralou Roos:** The pharmaceutical industry governing itself?

**Mr. Stan Dromisky:** No, no, I'm talking about the medical profession and all allied personnel who are involved in the prescribing of drugs.

**Dr. John Wade:** I think if you want to kill the health provider professions, then have government regulate them. I mean, nobody would tolerate that, I wouldn't tolerate that. I think the professions by and large are doing an increasingly better job of regulation themselves. I've been in the bureaucracy, and no way would that work, if they tried to regulate the professions. They can support regulation and help with that, provide tools, etc., but if you put that into the bureaucracy, forget it. I guess I'd feel very strongly about that, and most of my colleagues would, not to say that we're doing a good job as the health providers, we could do a lot better. Why support us in getting the technology and

funding and things necessary to do it because I think the professions would do it. I'm saying "professions", not "medicine" alone.

**The Chair:**

Thank you, Mr. Dromisky.

Mr. Robinson.

**Mr. Svend Robinson:** Thanks very much, and thanks to all of our witnesses for your evidence this morning. It's been very helpful.

I must say that the more I listen to and the more I read in this area, the more convinced I become that a system which is based, fundamentally, on maximizing corporate profit in this area is one that leads to all sorts of outcomes that are just fundamentally at odds with the public interest and certainly with maximizing the prevention of illness and the treatment of illness. That's the overall perspective that I come at this from.

I was interested, Dr. Katz, in your reference to the article by, I'm not sure if it was one of your colleagues...with respect to clinical trials and taking corporate inference out entirely. It makes a lot of sense to me. What's the name of that particular clinician?

**Dr Alan Katz:**

Arthur Schafer wrote the article.

**Mr. Svend Robinson:** I wonder if our researcher could get the information on that article so it could be circulated to members of the committee.

I just have a couple of follow-up questions. You're at the University of Manitoba. I gather the Centre for Health Policy is associated with the university as well. Does the University of Manitoba have any particular policy or guidelines with respect to confidentiality agreements for clinical trial outcomes or research that is being done?

Frankly I think it's outrageous that, in too many instances, researchers who are conducting research which is paid for by corporations sign agreements that effectively muzzle them and silence them. I think Nancy Olivieri and a number of other examples you're well aware of. What about the University of Manitoba?

🕒 (1025)

**Mr. Noralou Roos:**

This is a very good question. Dr. Katz and I were smiling at each other because several of us, and he was formally the Chair of the ethics committee, have been very concerned precisely about this issue. We have been working with the administration to try to

develop a series of guidelines, actually much is based on the recommendations of the medical editors, to ensure that research is reviewed in a systematic way, to ensure the contracts are not signed, which are contrary to publication rights, etc.

However it's recognized it's a very uphill battle. The universities across the country are faced with exactly the same issues. There's no expectation it's going to be solved quickly.

**Mr. Svend Robinson:** I'm not sure if Dr. Katz wants to add anything, but basically the University of Manitoba, then, has not changed its policy in this area.

**Mr. Noralou Roos:** It's in the process of developing a policy which fundamentally protects patients' safety issues and publication issues. How this gets implemented.... Most of the contracts with pharmaceutical companies are, in fact, not signed at the university. University researchers don't drive the design of this research. They're signed by the hospital research foundation. There, the contract officers are basically charged, because they get an overhead from these contracts, with bringing in as many contracts as is feasible because it supports much of what goes on in these organizations.

**Mr. Svend Robinson:**

**Mr. Noralou Roos:** Exactly.

**Mr. Svend Robinson:** This is clearly an area that, as a committee, we're going to be wanting to look at carefully. Universities are publicly-funded institutions. Frankly I think it's outrageous that a publicly-funded institution should be prepared to be a party to this kind of agreement.

**Dr. John Wade:** Can I comment? I used to be a dean.

**Mr. Svend Robinson:** I caught that in your introduction.

**Dr. John Wade:** What happened with Ms. Olivieri I don't think would have happened at the University of Manitoba. There you had a hospital-based research institution that was primarily with a contract. It didn't necessarily go through the University of Toronto. Here, hopefully, that would have gone through the faculty and out to the central university. That should....

**Mr. Noralou Roos:** No, it wouldn't.

**Dr. John Wade:** It would have when I was there.

I want to make a different point, though. I don't think the problem so much.... The universities are one problem, but what you're seeing now is a bunch of clinical trials coming up in the community that do not have the scrutiny of research ethics committees or whatever. I think that's a far greater problem than universities. What you're seeing out there are people in private practice doing clinical trials for drug companies and getting

paid for it without training and research, education and research, and without the scrutiny of an ethics committee.

**Mr. Svend Robinson:** That's another problem.

**Dr. John Wade:** That's a far greater problem.

**Mr. Svend Robinson:** I'm not sure it's a greater problem but it certainly is a serious problem.

You made reference, Dr. Wade to a study which is going to be coming out later this fall which is really quite shocking. I think Canadians should be deeply concerned about that and to the extent that we as a committee are able to make recommendation in the pharmaceutical area at least because not all these 10,000 are related to pharmaceuticals, of course, but--

**Dr. John Wade:** That's just in the hospitals. That doesn't include the deaths in the communities.

**Mr. Svend Robinson:** No. I understand.

**Dr. John Wade:** So that's a far bigger problem, more difficult to study and not easy to compare with the studies that have been done in other countries. That's why this is simply only hospital data.

**Mr. Svend Robinson:** I appreciate that, but I'm saying I very much appreciate your reference to that and certainly as a committee I'm sure we're going to be looking very carefully at the results of that study and also what recommendations we might make hopefully that flow from that study.

Just one other question and that is with respect to the issue of patent protection. I read a study recently. I think it was in the New England Journal of Medicine but I can't remember where it was which was pretty radical. It suggested that in fact maybe as a society we should be asking the most fundamental and basic question. Why is it that we have to basically bribe big pharmaceutical companies to do research in splendid isolation trying to make money? Of course they only do research on stuff that makes money-- sleeping sickness that affects millions of poor Africans and don't want to go there--what about--and I don't know whether any of you want to take this on--what about the suggestion that instead of funding research through corporate bribery and patents that we publicly fund it?

🕒 (1030)

**Dr. John Wade:** We've underfunded research, including clinical research and we're even with what has happened at MRC and CIHR. We're probably one-third of what the Americans are per capita. We're really low, but don't forget, some of this research is the

creation of new chemicals, etc., and I'm not sure if that's funded through NIH even in the United States.

So you have to have some mechanism of funding early, early research, and right now, it's the drug companies and that's fair--they get some profit from it. We just underfund research, especially clinical research, in this country.

**Mr. Svend Robinson:** Nothing at all that would prevent some of our fine young researchers from dedicating themselves with public support to doing the kind of research that you're talking about as well. They would do it.

**Dr Alan Katz:** Well, they would do it but the problem is much bigger than that because currently the tendency is for our public institutions, our universities, to patent everything they do. So you can criticize industry who are openly in it for the money, but the current trend is for any significant findings in universities to be patented. The SARS virus genome has been patented by the University of British Columbia, etc.

And so the extent of the underfunding of public research in universities has reached the stage that for their survival, universities have industry liaison officers and patent offices whereby they need to survive to promote research. They're patenting all these things which I think is not necessarily in the best of the public interest.

**Mr. Svend Robinson:** Thank you.

**The Chair:** Thank you.

On behalf of committee members I want to once again thank our witnesses for coming forward. I think it's been a very valuable morning and we've had a look at some of this from a different angle than we've had up to now. Thank you very much. We look forward to anything you have to send us from the point of view of publications or new information or something you think might follow up some of the questions you've heard today.

We'll take a 10--minute break.



Called back to order and welcome to our next group of witnesses to our hearings on prescription drugs.

This morning we have representatives from the Coalition for Manitoba Pharmacy, the Manitoba Pharmaceutical Association and the Manitoba Society of Pharmacists.

From the Coalition we have three witnesses. I'm not sure which one is going to present, Mr. Dueck, Mr. Skura and Ms. Fontaine. One of you I think is going to lead off.

🕒 (1050)

**Mrs Michelle Fontaine (Coalition for Manitoba Pharmacy):**

Good morning. My name is Michelle Fontaine. I am currently a community pharmacist in Winnipeg and vice-president of the Coalition for Manitoba Pharmacy. On behalf of my colleagues with the coalition, I would like to thank the committee for the opportunity to address you today.

As the committee gathers evidence from Canadians regarding prescription drug prices, availability, prescribing practices and adverse events, it is critical closely examine a new and dangerous trend that is growing across Canada that is currently most serious in Manitoba.

The primary concern of the Coalition for Manitoba Pharmacy is the rapidly growing cross-border Internet pharmacy export business. The coalition believes this trade is illegitimate, unethical and causing significant harm to our health care system.

I would like to begin by speaking to a frightening development I have seen in my pharmacy and that has been reported community pharmacists from one end of Manitoba to the other, increasing shortages of urgently needed prescription drugs. By their own reckoning Internet pharmacy companies are diverting at least \$1 billion worth of Canadian drugs to the United States. This is against U.S. federal law. In order to fill orders south of the border, Internet pharmacies have shown no regard for Canadians who need prescriptions, but rather have created an illegitimate, underground network to buy Canadian medication at Canadian controlled prices, then turn around and resell those drugs at significant profit to Americans who can pay more.

My pharmacy is located adjacent to the Winnipeg Health Sciences Centre and we process a significant percentage of the outpatient cancer prescriptions in Manitoba. In my practice I have recently seen more shortages than in my entire professional career and some of the drugs that have been short are life-saving cancer drugs. On several occasions drugs for conditions such as brain tumours and adult and childhood leukemia have been simply unavailable through legitimate distribution networks in Manitoba. On the same day I have found the same cancer drug listed as available to U.S. customers through Manitoba Internet pharmacy website. It is not acceptable for Americans with money to pay more for our drugs, to have access to medication that I can supply to my patients only

through literally days of frantic sourcing and sometimes receiving only a single bottle of emergency drug supplied from the manufacturer.

Internet pharmacy companies are claiming that increasing widespread shortages reported by community pharmacists are not their fault. They blame wholesalers, they blame manufacturers, they claim it's a coincidence. It is no coincidence. When you make it your business to divert to the U.S. as much of Canada's drug supply as you can possibly sell, you create shortages for Canadians.

**Mr. Greg Skura (Coalition for Manitoba Pharmacy):** Good morning. My name is Greg Skura and I'm a pharmacist and partner at Super Thrifty Drugs Canada, the only pharmacy chain based in Manitoba. I'm also the secretary for the Coalition for Manitoba Pharmacy.

One of the most serious concerns regarding Internet pharmacy is how this commerce is creating a severe shortage of pharmacists in our province. Recently my company was forced to close the doors of our profitable pharmacy in Winnipegosis. This was the only drug store within a radius of 70 kilometres and also served the hospital and nursing home. This was the first time in 35 years that I've had to shut down a pharmacy. The reason-- there is simply pharmacists available to work at our Winnipegosis store.

Why? Cross-border Internet pharmacy through the huge profits they make by selling Canadian drugs to the U.S. at higher prices can lure pharmacists from our communities and hospitals with promises of huge salaries, bonuses and a cut of the profit.

The result: approximately 20% of the pharmacists in Manitoba now work in an Internet pharmacy trade shipping Canada's drug supply to the U.S. rather than caring for Manitobans who are less profitable.

Pharmacists have been in short supply before in Canada and Manitoba, but not like this and it is the quality of pharmacy care to Manitobans that is suffering.

My company has three more rural drug stores that are on the edge and are struggling to remain open with no relief pharmacists available and an inability to hire new pharmacists.

Internet pharmacy companies say the severe shortage of pharmacists in Manitoba is not their fault. They blame pharmacy chains. They say it is a coincidence. It is no coincidence. You can't take 20% of the pharmacy professionals out of Manitoba's communities and hospitals to serve the U.S. cash market and not find pharmacy care at home.

How many rural pharmacies will have to be shut down putting the access to medicine and pharmacy care of Manitobans at risk before government takes action to stop the diversion of Canadian drugs and pharmacy care to the U.S.

**Mr. Lothar Dueck (President, Coalition for Manitoba Pharmacy):** Hello. My name is Lothar Dueck. I'm a community pharmacist in Vita, a small rural community, and president of the Coalition for Manitoba Pharmacy.

I'd like to talk about how cross-border Internet pharmacy is driving up the price of prescription drugs and the risks if this continues.

Recently drug manufacturers have begun to raise prices of their products in Canada, for the first time in many years. One manufacturer raised its price by 4%, for the first time in four years. Others also have raised prices by 4%, for the first time in 10 years or more. We believe this is a reaction to the massive volume of drugs, meant for Canadians, that is being now shipped to the U.S. and Canadians are the ones who are forced to pay more so that Internet pharmacies can make money in the U.S. market.

If Canada's governments allow this trade to continue, we believe the result will be an end to Canada's price controlled drug regime that allows us to pay much less than Americans do for their prescription medicines. Canada's drug prices will rise to match those paid in the U.S.

The coalition is not alone in its ethical and professional opposition to cross-border pharmacy. The Canadian Pharmacists Association, the Canadian Medical Association, the Association of Deans of Pharmacy of Canada, the Manitoba Society of Seniors and many other professional and consumer groups have made their concerns very clear.

As we have outlined in our submission to the committee, it is time for the federal government to act. Shortages of medicines, shortages of pharmacists and pharmacy care and rising drug prices for Canadians are no coincidences. These, we believe, are the product of the cross-border Internet pharmacy trade.

Canada's health care professionals are asking for your help. Canadians need more care, more involvement from pharmacists here at home, not less. We appeal to the federal government to take immediate steps to protect Canadians and stop the export of Canada's drug supply and our pharmacy care.

**The Chair:** Thank you very much.

From the Manitoba Pharmaceutical Association, we have the registrar, Mr. Ronald Guse.

**Mr. Ronald Guse (Registrar, Manitoba Pharmaceutical Association):** Thank you, Madam Chair.

I appreciate the opportunity to speak to the committee this morning. My name is Ron Guse, and I am the registrar with the Manitoba Pharmaceutical Association. Just for

clarity, to let you know, the pharmaceutical association neither represents the pharmaceutical industry nor the pharmacist. Our role is primarily protection of the public and I'm sure you're familiar with the College of Physicians and Surgeons throughout the country. Our role would be similar to that except certainly we deal with the practice of pharmacy and of the practice of medicine.

We prepared a brief that's been circulated ahead of time to the standing committee and most of my comments will be directly from that brief for your ease.

Although this committee is stressing many issues, I'd like to focus on a certain number of issues that were listed in your mandate, certainly the rising cost of prescription drugs. With regards to prescription drugs in Canada you really cannot speak about patented medicines without referencing the Patent Medicine Prices Review Board. I won't explain that board to you because I'm sure you're well aware of what the responsibility of that board is.

In the 2002 report from the Patented Medicine Prices Review Board, this is the first year where patented medicines in Canada were 1% higher than the other jurisdictions that they use for comparison. I believe Canada's market introduction of patent medicines price increases being regulated by the PMPRB--Patent Medicines Prices Review Board--do a phenomenal job for the Canadian public in regulating those prices.

One of the areas of prescription medications not regulated by the Patent Medicines Prices Review Board are products that have gone off patent--or some of them were never on patent because they predated that process, and we commonly refer to them as generic products in Canada. Although the overall health care costs in Canada are somewhat lessened by having generic products on the market, the generic products, by and large, set their prices in relation to the patented products on the market and not necessarily anything to do with their cost of development.

What we've seen recently in the last couple of years in the formulary in Manitoba, and the formulary in Manitoba is not unlike formularies in other provinces that indicate what products are interchangeable and the prices of those products. What we've seen recently with some of the products on the formulary with respect to the generic products is there's been a substantial increase over the last two years in where products would cost less than a penny per tablet have now increased to over 6¢ per tablet. It doesn't sound like a lot of money when you say 6¢ per tablet when you look at some of the products costing in excess of \$1, \$2, \$3, or maybe \$10 per tablet. But if you looked at the percentage increase, you're looking at over 750% in price increase.

As mentioned in the previous presentation, there's been phenomenal growth in pharmacies across Canada. They're selling mostly patented medications to patients residing in the United States. Often this term is called Internet pharmacy. The Manitoba Pharmaceutical Association that licences the practice of pharmacists and pharmacies in the province have identified these pharmacies as international prescription service pharmacies--IPS pharmacies. Frankly, as much as it's called Internet pharmacy, it really

is a mail order system and the Internet media is used for advertisement and to gain access to larger numbers of population.

However, this unforeseen and unintended diversion of medication from Canada's price protected system will and has resulted in a more rapid cost increase of our once economically priced drug system. To date, provincial governments have supported the selling off of Canadian preferentially priced products to the American patient. This support has caused the manufacturers to examine their voluntary participation in the Patent Medicines Prices Review Board. The reason I say voluntary is, if they're going to market their product their product in Canada, they have to have it reviewed by the Patented Medicines Prices Review Board, but realize there's no obligation for them to market their product in Canada, so that's why I use the term voluntary.

We've had very recent examples of two of the major international manufacturers have put price increases on the Canadian public; price increases that they haven't put forward for probably about ten years.

🕒 (1100)

There may be many reasons for their responses but I think if you look at the large disparity between the American priced products and the Canadian priced products for the same product, likely what they're leaning towards is more of a North American price. The indication we've seen looking at the prices on both sides of the border that the tendency is for the Canadian prices to increase as opposed to the American prices to decrease.

The Pharmaceutical Association has some grave concerns that increased prices or the lack of the manufacturers to voluntarily participate in the Patent Medicine Price Review Board will cause diminished access to medications in Manitoba.

With regards to mechanism for controlling prices, again the PMPRB does the best job possible within their mandate to review patented medication prices in Canada. But I think there also needs to be a review of what the generic prices are being established in Canada. If you look at our prices compared to other markets, the prices that we charge in Canada or the prices we're subject to in Canada are considerably higher. Really because there's little competition for generic products and once the manufacturer moves their product off the formula, the major manufacturer moves their product off the formula, typically the generic prices increase and I eluded to that earlier.

I'd also like to speak briefly about drug to consumer advertising and I won't go into details. I'm sure you're well aware about the controls on drug to consumer advertising in Canada for prescription products. But the American market at one point in time would not allow drug to consumer advertising. That was changed recently. As we all see, there's many advertisements going on in American television and radio for prescription products.

Typically the advertisements are for patented products trying to encourage a switch from a patient's existing treatment plan to a treatment plan involving the product

advertised. Again typically, the patient might be stabilized on economical, therapeutically effective program and the influence is try to switch them to the product being advertised.

I think Canada can take the opportunity to learn how or whether this form of advertising has advanced patient care and enhanced the treatment of diseased conditions. Because it came from an area, United States prior to this had no advertising. Now it has a large amount of advertising, I think Canada could learn from that and see in fact if this has enhanced patient care then it's something that would be welcome in Canada. But if it hasn't, what components of that enhanced information to the patient would enhance patient care in Canada.

The other thing that has to be considered is Canada has a different social health care system where United States there's more so private payers of the program. The patient is somewhat restricted to certain physicians that they can see because of the payers of the program. In Canada under our social health care system, the patient is really unrestricted to the amount of physicians that they could see. Now certainly there isn't an abundance of physicians and there's some restrictions on access. But if a patient was influenced to the extreme of why a particular product and wouldn't take no for an answer, it's not inconceivable that a patient could attend enough physicians until they found the one that would prescribe the product for them.

I want to also address the issue that you've identified in marketing and lobbying prescribers and pharmacists. Once physicians or health care professionals graduate, it's a challenge for them to maintain current knowledge about recent treatment plans and medications. We've developed a program in Manitoba and it's unique to Manitoba, but there are programs in the country that takes recent information to the prescribers basically dealing with the best practice issues. We believe that's something that has to be welcomed by governments and encourage that practitioners now would be able to understand and have knowledge about the best practice models not necessarily what's being advertised most often.

Consumer access to health professionals and access to drugs. There's three issues that I've addressed in my brief and I won't go over them in detail. I think we have some major challenges in northern or remote communities in Canada that presently are not being addressed in a universal and wide application.

Secondly, as I mentioned earlier access will be diminished by the issue of sending medications to the United States, Canadian medications to the United States.

🕒 (1105)

Secondly, as I mentioned earlier, access will be diminished by the issue of sending Canadian medications to the United States.

Thirdly, I think we need to involve the pharmacists more in their role to enhance patient's access to medications. We recently presented a four point proposal to the Manitoba Government showing how enhancing the pharmacist's role in patient care would enhance the patient's care and also their access to medications. Further details on that four point proposal can be made available to the chair if she wishes.

The second last thing I'd like to address is misuse and abuse and addiction within the general population. And I saw previously that you had a presentation by the Addictions Foundation of Manitoba. My suggestion or proposal for addiction or misuse is not necessarily related to addiction and when there's an unintentional misuse by the patient. And that's typically because of them not knowing how to use their medication properly or other medications that they might be using.

Approximately 15% to 25%, depending on which report you follow, admissions to the hospitals are as a result of medication mishap. I think that's a serious issue about medication access. In other words, the problem not being that they don't have access to the medication, but the problem being that the access to the medication has lead them to drug interactions and medication mishap. Those problems, by in large, could be addressed by enhancing the role of pharmacists and bringing the pharmacists into the health care team for the patient care.

I also want to address an issue to the committee that although it's not a prescription item in Canada it's a prescription item in many other countries. And I think, if I'm not mistaken, Canada is probably the only country that has codeine available without a prescription. Codeine is a narcotic. Under Section 36 of the regulations of The Controlled Drugs and Substance Act a patient can purchase small amounts of codeine from a pharmacist without a prescription. And although there may be some therapeutic value for codeine as a cough suppressant, 8 mg of codeine is very much sub-potent as an analgesic.

The problem being is that in Section 36, in order for codeine to be available without a prescription, it has to have other products in that dosage form. Typically, an example would be codeine with acetaminophen and caffeine. And those individuals who are using or misusing the product for the codeine content are causing themselves some irreparable damage caused by the acetaminophen. The product comes with the codeine.

So I'd like to raise this issue with the committee. I know you're speaking on prescription medications only. This is a non-prescription item in Canada. The registrars from across the country challenged Health Canada a number of years ago to review this product and if it had therapeutic value, work with us to develop some issues around proper access. If it doesn't have any therapeutic value, and I think that's more so the case, then the product should be removed.

The last thing I'd like to leave the committee with--and I apologize for the length of this--is the international comparisons you've asked about. And through the National Drug Scheduling Advisory Committee, set up the National Association of Pharmacy Regulatory Authorities, which this committee is participated on by Health Canada,

they've identified some 35 prescription medications that are now moving to non-prescription in other countries and likely it will be moving to non-prescription in Canada.

I know your mandate is prescription medications, but it's very difficult to speak about that issue in isolation of the non-prescription market. And I think the committee ought to look at where international movement of medications are going; that being prescription to non-prescription and be cognizant of some issues around patient access and patient care in that regard.

Thank you very much.

🕒 (1110)

**The Chair:** Thank you, Mr. Guse.

Our next witnesses are from the Manitoba Society of Pharmacists in the persons of Marian Kremers, the president; and Scott Ransome, the executive director.

Ms. Kremers.

**Mrs. Marian Kremers (President, Manitoba Society of Pharmacists):** Thank you, Madam Chair, and thank you to the standing committee for this opportunity to present the focus that the Manitoba Society of Pharmacists has, which is the interest of our working colleagues, their conditions, and the negotiations for remuneration with the government agencies.

As I can see today, this certainly recognizes the fact that the standing committee knows you cannot effectively study prescription drugs without involving pharmacists in that aspect. We are the drug experts. We have more training in drug therapy than any other health professional. Pharmacists are trained to understand the chemical makeup of prescription drugs and their effects, and how medications interact with one another and also within the patient themselves.

The rising costs of prescription drugs is a topic that, as we see today, garners significant debate, they're a multi-faceted cost required by a lot of different factors. Rising costs are a product of pricing and increased utilization, to put it simply. The pricing of drugs is clearly important, however, greater attention must be given to the utilization, specifically inappropriate utilization of prescription drugs.

The three most typical examples of utilization error are: underuse, therapies that could make a difference and maybe are not applied; overuse, therapies that do not work are used or misused, therapies that could make a difference but are misapplied either by dosing or the wrong format, wrong dosage route, etc.

Antibiotics are a really good example of this. One of my colleagues said, "Where have all the prescriptions for Amoxicillin and Cetra gone, formerly the mainstay of therapy?"

The norm is now Ciprofloxacin, Viromax. These are highly potent, broad spectrum antibiotics that I would venture to guess 50% of the time are misused and used inappropriately.

Effective medication management must become a reality. By more fully involving pharmacists, improvements can be made to the efficiency and effectiveness of drug therapy, therefore reduce costs and enhance patient care. Reducing costs and improving patient care are two of the most important goals of health care reform.

In order to provide the standing committee with a tangible example of just one of the real opportunities that exists for reducing costs and improving the health of the population, I'd like to take the opportunity to highlight the findings of one recent study which brings into perspective the practical solutions that pharmacists can bring to an improved health care system.

The high-risk patient intervention program done by the Institute of Health Promotion Research in October 2001 is a study that involved a randomized, controlled trial to test whether a pharmacist and nurse home care team could reduce hospital re-admissions of seniors discharged from hospital who were taking six or more medications.

The study involved 255 seniors and the outcome measures included the number of emergency visits to general practitioner or specialists, the number of non-emergency visits to general practitioners or specialists, the number of pharma-care prescriptions written, the number of times the person was hospitalized via emergency departments, the number of times the patient was hospitalized for a 24-hour period when admitted via the emergency department, and whether the senior received long-term care service. So there were a lot of factors that measured whether this was going to be successful or not.

Between September 1999 to October 2000, the intervention teams made home visits to seniors in the experimental group. They conducted a thorough needs assessment and went through patient medicine cabinets. What they found was lots of outdated medication, drugs that didn't go together, the medication was prescribed in too high or too low a dosage--speaking to aforementioned inappropriate use. In these cases the pharmacist would contact the patient's physician, get things straightened out--in other words, make needed dosage adjustments and/or increase or decrease the medication.

The intervention team also developed plans, each with a monitoring component to ensure that every senior in the experimental group received optimal medication therapy. In all, the intervention team contacted the seniors' physicians 136 times and made 255 medication-related recommendations of which 206, or 81%, were accepted by the treating physician.

🕒 (1115)

And among the recommendations were changing medication, discontinuing a medication, adding a treatment or increasing or decreasing the dose.

The team also made changes in how the medication was delivered, they removed outdated or unused medication, contacted community services, provided a booklet where seniors recorded their medication, changed the ways the medication was packaged, furnished a list of medications and supplied the written information to various people who were concerned with their therapy, provided medication schedules, changed the times the drugs were administered and, all in all, simplified the total drug regimen. This is what pharmacists refer to as “pharmaceutical care”; non-pharmacists often call it “appropriate medication management”.

Today, in the pharmacy care field--and Michelle Fontaine could probably back me up on this--the value-added care provided by pharmacists is given at the moment with no remuneration. This quality tax to professionals cannot continue and, as representative of our pharmacists negotiating for appropriate remuneration, I make the committee aware of this problem.

The study that I was referring to showed that seniors experienced significantly fewer hospitalizations and used other costly medical services less often. After the cost of running the program and all the other costs were deducted, there was an average net saving of \$680 per person in this experimental group. So not only did it save the government money, but we were looking at extremely much better treatment of the patient. And is that not ultimately our goal in the healthcare system?

The study is hardly unique. A multitude of studies exist that support the proposition that pharmacists can improve health outcomes by achieving optimal patient medication use. The Manitoba Pharmaceutical Care Project demonstrated similar findings. An expansion of this service could encompass positionings of pharmacists at sites of prescribing. We have a few pilot projects going on right now where pharmacists are actually in family physicians' offices.

This could also include employing pharmacists to develop evidence-based prescribing guidelines, which provide feedback for prescribers. Unfortunately, pharmacists really are underutilized members of the healthcare team and the underutilization is one of the largest barriers to achieving optimal pharmaceutical care for our citizens in Manitoba.

Do I have time to just do the ABCS?

🕒 (1120)

**The Chair:** Yes.

**Mrs. Marian Kremers:** We have a report from Dr. Colleen Metge, the associate professor at the Faculty of Pharmacy, University of Manitoba. In her submission to the Romanow Commission, which she did co-jointly with the students of fourth year in pharmacy, and presented the ABCs of pharmaceutical use: the role of pharmacists in the provision of primary health services, A for assessment: is the drug chosen for an individual most appropriate and the cost-effective one at the moment? B, bottling: is the

right drug given to the right person at the right time in the right dosage for the right duration? Now, we refer to this as “traditional dispensing”. This a role that we can delegate to other people. C, counselling or consultation, our role: does the individual understand how to take their medication? Do they know why, what and what they should expect? Does the pharmacists have the time to consult with the individual's physician about what are the desired outcomes? Will the physician consult with the pharmacist about the desired outcomes? And S, surveillance or follow-up: is the drug actually doing what it's supposed to do? Pharmacists are the ones who see the patient the most often and is somebody looking to find out whether the individual has the desired outcomes and are having minimal side effects?

Dr. Metge points out that the while pharmacists do a good job of the B, the bottling, they've been overtrained for this, to utilize that as their full service to society, and to improve the health of Canadians and achieve cost savings in the healthcare system pharmacists need this expanded role.

The Commission on Future Health in Canada reach a consistent conclusion about the role of pharmacists and I'd like to ask committee to carefully consider recommendation 39 of the Romanow report, which states:

A new program on medication management should be established to assist Canadians with chronic and some life-threatening illnesses. The program should be integrated with primary healthcare approaches across the country.

In support of this recommendation, Romanow notes the following:

Part of the management that would be effective use of prescription drugs and other medications, it also means that pharmacists can play an increasingly important role as part of a primary healthcare team, working with patients to ensure they are using medications appropriately, providing information to both physicians and patients and monitoring the use of drugs to provide better information and communication on prescription drugs and thus affecting the type of savings that we can see over and over again in studies that involve a comprehensive treatment of our patients in Manitoba and across the country.

Thank you to the committee for hearing.

**The Chair:**

Thank you very much, Ms. Kremers.

We'll begin the questioning with Mr. Merrifield.

**Mr. Rob Merrifield:** Well, again, we have quite a panel. Thank you for coming in, and it goes right from Internet to pharmacy and everything in between.

Let's start with the Internet pharmacists, and this is what I understand, two years ago it was about a \$400 million a year business, last year it was \$1.2 billion I believe. Therein lies your concern, and probably the stress that it has put on you as far as 20% reduction in available pharmacists. That's really what you're saying, a shortage of pharmacists.

I'm concerned also with what you're saying about the shortage of drugs. I'm a little puzzled as to why that would be in a sense that, do you not have any kind of a priority to them, or is it because they buy them more bulk that they're able to get the drugs ahead of you? Can you explain what's actually happening at the manufacturer side of it to describe what's going on there.

**Mrs Michelle Fontaine:** What we believe to be true is that the manufacturers are aware that they are exporting a lot of the medications to the United States. They have stopped allowing purchase by these companies directly from the manufacturers. They try to limit distribution through the wholesalers as well. They're watching for irregularities in large bulk buying that haven't occurred, so they know that's being drawn out.

We believe there's a large illegitimate underground supply. We believe that and we do have some evidence that the Internet companies are also contacting other community pharmacies asking them to purchase drugs for them, paying them extra for that drug, and then taking it and exporting the drug to the U.S.

🕒 (1125)

**Mr. Rob Merrifield:** So they're actually using some of the pharmacists.

**Mrs Michelle Fontaine:** Yes.

**Mr. Rob Merrifield:** And that's how they're getting the product.

**Mrs Michelle Fontaine:** They're illegitimately bypassing the .

**Mr. Rob Merrifield:** And that's what you mean by the underground illegitimate supply.

**Mr. Greg Skura:** Let me add to that. When a drug is introduced to Canada or Canada is only 2% of say the drug utilization, U.S. takes up 40%. The companies determine how much drug is going to be released to Canada, how much is going to be released to Manitoba.

In a lot of these cases of the Internet pharmacy are using this drug, there's only so much available right now because the companies have said that's all that's going to be released on a monthly basis. This is where they're having a problem. Because they're expanding their business, they can't get enough drug, so they're looking for other alternative ways to achieve the drug. And because we have to buy it through the wholesaler, now we're having a shortage of drugs that we have to service our Manitobans.

**Mr. Rob Merrifield:** It just seems odd to me. I've had pharmaceutical companies in my office talk to me about this problem. The brand name guys are saying they don't like this any more than you do and they're having a problem with this.

They even know which doctors are prescribing how much of the product. I can't believe they can't trace and find out where it's being bought. It just doesn't make sense to me. So this underground trade, are they looking the other way when it's happening? Can you tell me how you feel they are able to get away with that and honestly, legitimately say they don't know who's doing it?

**Mr. Lothar Dueck:** The issue of shortage just means the demand exceeds the supply. As a pharmacist looking after Manitobans and Canadians we feel that is a serious challenge to put to our health care system that these drugs are being diverted.

We don't have the answer for that as well. We see the problem. We get solicitations. And because of the nature of the business, we have to pay a lot higher salaries for our pharmacists, some pharmacies are getting into that business to supplement their expenses so they can afford to keep on serving the same Canadians, Manitobans in particular.

**Mrs Michelle Fontaine:** I'd like to add something if I could please.

The coalition is an ad hoc committee. We have no budget. The burden of proof should be on our provincial government and perhaps our federal government.

We don't have the resources to investigate how the shortages come about. All we can tell you is that when I need Purinethol for my pediatric leukemia patient and I have to spend five hours on the phone sourcing enough drug until it's released again, and I go home and it's listed as available on Internet sites, it poses a question. I don't have the resources to answer that. But I would like somebody to. And I believe the burden of proof should be on the government.

**Mr. Rob Merrifield:** That was my second question as to what kind of lobbying needs to be done with regard to the provincial government here in the province and where are you going on that front?

Maybe Greg Skura would be the person to talk about that.

**Mr. Ronald Guse:** I'll let Greg speak first, and then if I can provide some additional clarity, I'll do that.

**Mr. Greg Skura:** We have tried to get an appointment with the health minister of the Manitoba Government and we haven't been able to achieve that.

From what we understand, Internet pharmacy is supplying a lot of jobs and that's the major benefit that they can see. They're not looking at increased drug cost, the shortage of pharmacists, the quality of care that the pharmacist can give.

Because the Internet pharmacy, they're not concerned about Canadian health at all. They're not giving the free clinics. They're not available for consulting on a rash on a child with a croupy cough or whatever. I think everybody's had occasion to go into a drug

store and ask a pharmacist for advice. And advice is always there. There's no charge. The pharmacist is always available. One of the things that Internet says is that "Well chains are always opening up". Yes, Shoppers are open until 12 o'clock. Isn't that convenient, I can see my pharmacist until 12 o'clock midnight about a health problem. Internet is not available for those type of problems.

**Mr. Lothar Dueck:**

On the federal level we have met with Health Canada to discuss our concerns about Internet pharmacy. We've talked to Mr. Rock, we've talked to Pierre Pettigrew's office as well. It doesn't seem to be an issue at this time.

🕒 (1130)

**Mr. Rob Merrifield:** You're not getting support from the provincial government, is what you're saying.

**Mr. Lothar Dueck:** Not provincial, not either, no.

**The Chair:** We're going to have the provincial health minister here this afternoon, so perhaps we can ask him.

**Mr. Rob Merrifield:** We may ask him on your behalf.

**Mrs Michelle Fontaine:** Pardon me for interrupting. I'm sorry. The response that we have received from the minister and I from believe MaryAnn Mihychuk as well is that no Manitoban, it's an issue that perhaps we have throughout of in our heads, I suppose, because no Manitoban has been denied drugs.

I don't know how they can say that. Tapazole's not available. We can't get any, but we don't pone the minister to tell him everyday that we weren't able to supply that drug. We'll go to great lengths to buy it. I've bought drugs from an Ontario hospital for a brain tumour patient because that was the only place I could get it, from the doctor. We find an alternative. We make sure that the patient, the bottom line is looked after.

So maybe no one has been denied drugs exactly where they're out in the cold. We would never do that to a patient. We will go to great lengths to ensure their safety and their health is looked after. I'm at an inappropriate response and that's the only significant response I can say.

**The Chair:** Mr. Guse would like to comment on that question as well.

**Mr. Ronald Guse:** We could spend a good amount of your time discussing this issue because there are questions still to be answered about the legality of it, the patient safety. There are certainly a lot of political issues that need to be addressed on both sides of the

border. The state board and provincial governments, and also to the federal governments on both sides. It's a very interesting topic, to say the least.

With respect to the provincial government, the direction that we've seen from the government seems to be that taken by the Minister of Industry, Trade and Mines, Minister Mihychuk. It is disconcerting that we haven't heard directly from our minister. We're working on that, certainly. I guess others are working on that as well.

What we're hoping to get from the minister and from the government is some big-picture analysis, because as much as it might be a boom for industry in Manitoba and jobs, you can't have such a phenomenal increase in something without having something else suffer. The concern is clearly that the something else that might suffer is the Canadian access to medications.

The Manitoba Pharmaceutical Association, from a regulatory authority has said if this is done safely, it's done legally and Manitobans are placed first, it's something that the pharmaceutical association could certainly endorse. I don't think any one of those subjects have been addressed.

**Mr. Rob Merrifield:** The degree to how hard you're having to look for new drugs. You've mentioned a couple, two or three of them. I'm trying to get a handle on the scope of... Is it chronic? Is it periodic? Is it increasing? Is it stabilizing? Tell me where....

**Mrs Michelle Fontaine:** The number of shortages are increasing. As far as "Is it chronic?", there are some that are chronically short. Chronovera, 240 mg, the manufacturer has said will not be available till January 2004. That is listed as available on at least 15 Websites.

Other ones are short-term. Sinemet CR was short for a while. It comes in, there are a few bottles, and they're gone again. It is both.

**Mr. Rob Merrifield:** Maybe you don't know the answer to this, but are you having shortages right across Canada from pharmacists and your colleagues in other provinces? It's not just a problem in Manitoba, this is happening in other provinces as well. The supplies could come from other provinces, for sure.

**Mr. Ronald Guse:** If I can just speak to that briefly. It is a national problem. I believe, and I can't speak on behalf of the coalition, but I know that's why we touched on it. I know why the coalition has spoken on that clearly this morning. It is a national problem. It might be centred, by some people's perceptions, in Manitoba. There are other reasons for that, I could go into that in detail, but it is a national problem.

International prescription service pharmacies are located in Manitoba, Saskatchewan, Alberta, British Columbia, Ontario and east. Do each of the provinces, have they all experienced the shortages that are being reported here? Because some of the

manufacturers can't quite handle on it in other provinces, just by the way the pharmacies are licensed, they are having more difficulties in addressing this situation.

Not to speak on behalf of the manufacturers, but there are some liability issues that they have. Their product is marketed for Canada, let's face it. They have some experience of their product being shipped to the U.S. market.

Overall, what we see or what we hear from the licensing body is that typically the drug supply chain in Canada was, and for the most part still is phenomenal. A pharmacist in Manitoba can sell their last bottle of a product on their shelf to their patient and have that bottle replaced by later that day, if not the next morning. That's the way things were.

I can tell you that the general uneasiness with pharmacists, not only in Manitoba but across the country, is that they sell that last bottle from their shelf, they don't know when it's going to be replaced.

🕒 (1135)

**Mr. Rob Merrifield:** Is it generic and brand or is it just...

**Mr. Ronald Guse:** Typically the products going to a U.S. market are patented brand name medications not generic. If you look at the generic prices, one of life's ironies...

**Mr. Rob Merrifield:** Oh yes.

**Mr. Ronald Guse:** The generic prices down in the United States are considerably cheaper than they are in Canada. Our markets, their market...

**Mr. Rob Merrifield:** No shortage is there then.

**Mr. Ronald Guse:** It appears not.

**The Chair:** Thank you Mr. Merrifield.

Mr. Thompson.

**Mr. Greg Thompson:** Thank you Madam Chair.

I want to again talk about the Internet pharmacy or as Mr. Guse called it, the mail order pharmacy. Mr. Guse I'm looking at your presentation representing the Manitoba Pharmaceuticals Association in your mission statement, I'll just put it in those terms.

Talking about, and of course you identified it as being similar to the Canadian College of Physicians and so on, you're saying that the MPHA is for protection of the public, this provides wide scope of responsibilities, I'm reading from your presentation that includes

licence establishing auditing compliance of standards, complaint investigations and so on and so on.

You know it seems to me that your pharmacists are being rewarded for bad behaviour. Because you have a group of pharmacists over here talking about a problem, you're sitting on the other end of the table and it appears as if you've got some powers over that group of pharmacists that are creating the problem that these people have identified but doing nothing.

Then we're hearing about getting the provincial government to do something, maybe the federal but don't you have responsibility of yourself to shut down those types of operations when you know the public is being endangered.

**Mr. Ronald Guse:** The authority of the Manitoba Pharmaceutical Association does come from government. I have to operate under a provincial act, Pharmaceutical Act of Manitoba and the regulations that are supportive of that act.

**Mr. Greg Thompson:** But you're saying protection for the public in your statement here. That's not accurate, other words, you don't have any power, no teeth.

**Mr. Ronald Guse:** I would probably agree with that when it comes to this issue, frankly. Because we need additional investigative powers to not only discover the information but to share the information with those that need it.

**Mr. Greg Thompson:** Okay now, I hear these types that is code language, often when I get talking to certain groups but you know the problem is there and then you try to codify it in a sense that we don't really know what it is and then if we try to do something about it, you get into this kind of fuzzy language but it's not very strong, it's not very authoritative. It seems like the problem just goes on and on and on.

Maybe some of the other members can pick up on it but I don't want to dwell on that totally but I think we're on to something here. I'm sure Mr. Robinson and others will want to pick up on it as well.

Just one of the things that you mentioned that I want some clarification on, you're talking about codeine being--and this is very specific--being able to be off the counter, no prescription necessary. For example, Tylenol 3 has codeine in it, correct? That's one of the reasons Tylenol 3 has to only be purchased through a prescription, is that correct?

**Mr. Ronald Guse:** That's correct.

**Mr. Greg Thompson:** But how much codeine would be in Tylenol 3 versus that which you can buy off the counter if you will, off the shelf. In other words I'm wondering if that amount is excessive in Tylenol 3.

**Mr. Ronald Guse:** Tylenol 3 has 30 mg of codeine. The product you can buy without a prescription has maximum 8 mg of codeine.

**Mr. Greg Thompson:** Okay and that's just a specific one. Time is the problem here and I'd like to talk more with you on that one but the other one when Marian was talking, again Marian I think you're talking in code, speaking in code. Because you're talking about the expanded role of pharmacists and to me when I hear what you're saying because I understand the team approach and how involved, more involved that pharmacists could be.

In other words I do have a problem when I'm standing there watching someone as highly educated as yourself or the other pharmacists counting out pills one and two and three and four and five at a time, thinking well Greg Thompson could count out pills with no training at all, if you will.

I understand that need for an expanded role and I understand the team approach, we've heard some evidence to suggest that that approach does work. When I'm coming in codified language it appears to me that some groups, other than the pharmaceutical industry business if you will, are suggesting that the person that sells the pill should be prescribing the pill.

In other words, I want to sell the pill and prescribe it in one fell swoop. In other words, let's move into that area of prescribing the pill as well as selling it. I feel that and I sense that and I just want your comments on that, whether or not pharmacists shouldn't actually be writing prescriptions as well as selling it. Do you see a problem with that?

🕒 (1140)

**Mrs. Marian Kremers:** At first glance it would seem there's a conflict of interest there, but actually the system that we have right now creates more conflict of interest because the pharmacist is rewarded monetarily by selling a product and whether or not we choose to not fill that prescription. If we choose not to fill that prescription that means that our monetary reward is not there under the current system.

Should we be practising pharmaceutical as I mentioned. Being a professional, we would be able to recommend that a specific medication be discontinued, without it being monetarily punitive to us, in order to make for the best care for the patient. So the prescribing of the medication would not necessarily take place by what you're traditionally seeing as a pharmacist in a community pharmacy setting. But it make take place by a pharmacist paid for through a government agency or however it is chosen to pay that pharmacist for their expertise and prescribing expertise. And that pharmacist, perhaps, would not even end up filling that prescription at all, they would have no connection with a commercial pharmacy.

**Mr. Greg Thompson:** Well, we see all kinds of bad behaviour being rewarded in the industry. I'm just....

**Mrs. Marian Kremers:** I take exception to you calling it an industry, it is a profession, Mr. Thompson. The industry we typically think of as the drug manufacturers, if I could clarify that.

**Mr. Greg Thompson:** We're getting into semantics, but I think the sense of bad behaviour being rewarded is pretty evident within, let's say, the business of pharmacy or the profession of pharmacy itself.

**Mrs. Marian Kremers:** As president of the Manitoba Society of Pharmacists, I see that happening all the time, the frustration of our members that are not being rewarded adequately for the services that they do supply to the residents of Manitoba versus the ones who seem to be being rewarded by the Ministry of Industry, trade and mines.

**Mr. Greg Thompson:** I'm being shut off, but thank you. Maybe we'll have another chance to continue in another round.

**The Chair:** Thank you, Mr. Thompson.

Mr. Dromisky.

**Mr. Stan Dromisky:** Thank you very much.

On a positive note, my own personal experience with pharmacists is absolutely outstanding. I stand and watch while they serve other customers, there's a lot of counselling going on, information passed and shared and so forth and manners. I'm talking about the manner in which the relationship has been enhanced between the druggist and the customer over a period of years. They are truly professional in my community where I have been dealing for years. All right?

**Mrs. Marian Kremers:**

**Mr. Stan Dromisky:** That's very positive.

In light of the fact that I just finished saying that a customer will share. Because in this relationship that this person has developed with the pharmacist, they begin to tell things that you might call family secrets, in other words become very personal, and they'll pass on information pertaining to the drug that they have been using, prescribed by some doctor and often you will hear things that are just not going well. In other words, the pharmacist picks up information about adverse effects of a certain chemical, a certain drug and my question is related to that.

Do you, in Manitoba, have some network or some way of sharing that information that you pick up, even though it's anecdotal, with the doctor that prescribed it or with other pharmacists throughout the network, your associations? Do you have some network to share it with the manufacturers or even with other patients that have come to you and are receiving the very same drugs? Is there some follow-through?

🕒 (1145)

**Mrs. Marian Kremers:** Yes, there are many mechanisms. One of them, of course, is the long route, and that's the Canadian Adverse Drug Reaction Reporting.

**Mr. Stan Dromisky:** Through Canada Health.

**Mrs. Marian Kremers:** Through Canada Health.

**Mr. Stan Dromisky:** Yes, they the list that was set out deliberately because I know they don't do anything with that.

**Mrs. Marian Kremers:** I would tend to agree with you. And only just recently have they accepted submissions from pharmacists, by the way, it's always had to come through medical practitioners up until.... Perhaps Mr. Guse can help me with the dates, but I don't know exactly when that was but you can see that there is a considerable lapse.

The aspect of sharing the information with the physician, of course, is always there, and it is the pharmacists duty to do that when we uncover adverse effects and that's how we can contribute to improved care for patients is to make the physicians aware that there is potentially a problem.

**Mr. Stan Dromisky:** When you're not too busy to do it.

**Mrs. Marian Kremers:** Pardon?

**Mr. Stan Dromisky:** When you're not too busy to do it, in other words, contacting the doctor.

**Mrs. Marian Kremers:** No, that is part of the problem, sometimes getting the reply. However, that's not part of this discussion. So that part is definitely there.

We anecdotally share information with colleagues, of course. It does not become part of an official notation so that it is available across the network. I don't know how you address that and still keep some confidentiality in the system.

**Mr. Stan Dromisky:** My next question pertains to something that Mr. Thompson has already introduced and the committee has sort of been introduced to them exploring such a possibility. You know we have nurse practitioners? Now, nobody knows as much about chemicals and the drugs than you people do. Doctors know very little, to be very honest about it, and they rely very heavily upon your information, your guidance, and so forth.

**Mrs. Marian Kremers:** I wish they relied a little more.

**Mr. Stan Dromisky:** Yes, possibly.

We have a problem in many of the isolated communities and many of the smaller communities. The problem is being aggravated here by this cross-border trade. You're losing a lot of pharmacists. I don't know if there's any thought about integrating a program, some type of harmony between a medical program and a pharmacists' program at university campuses where a pharmacist will pick up additional credits and courses in order to become a pharmacist practitioner in a community where there is a great need for someone to do some of the preliminary work in initial stages for customers in that community where there might not be a doctor, but there may be a pharmacist. Or, a pharmacist who visits, because we do have pharmacists visiting various centres throughout northwestern Ontario and other parts of the country. Has any thought in your profession been given to that enhancement of your role, if you want to use that term?

I see it that way. I think you could enrich the quality of life by more than just giving out drugs, but more counselling and more guidance. I know that's happening already in my riding. The pharmacists are taking a very, very active role in counselling customers. But I would love to see something more professionally done.

**Mrs. Marian Kremers:** On a national basis, the Canadian Pharmacists Association has approached government on many areas, one of them being pharmacist prescribers, and being a practitioner as you're defining it, as a nurse practitioner, a pharmacy practitioner, a pharmacist prescriber, who would take extra training. The students that we are graduating out of the university right now, however, probably could handle that role quite effectively.

**Mr. Stan Dromisky:** Graduating who, the pharmacists?

**Mrs. Marian Kremers:** The recent pharmacy graduates are more than capable of taking on that role.

**Mr. Stan Dromisky:** Why more today than they were 10 or 15 or 20 years ago?

🕒 (1150)

**Mrs. Marian Kremers:** Twenty years ago?

**Mr. Stan Dromisky:** Is there something new in the program?

**Mrs. Marian Kremers:** Twenty years ago, quite frankly, I could never have done that.

**Mr. Stan Dromisky:** Is there something new in the program?

**Mrs. Marian Kremers:** Absolutely.

**Mr. Stan Dromisky:** Okay, programs have changed.

**Mrs. Marian Kremers:** Absolutely, the programs have changed drastically in the last ten years.

**Mr. Ronald Guse:** If I could just speak to that for a moment. The program is now a five-year program. In the past when Marian and I graduated, it was four years. In that additional year there's a lot more critical involvement of the pharmacist. The medications are phenomenally more complex. There are different areas of study regarding pharmacokinetics which was sort of just starting when we graduated. So there is more complexity and the pharmacists have been trained phenomenally to do that.

We would echo the thoughts of Marian and yours that the pharmacist could be challenged and charged to do the tasks you described. It's one of those interesting issues--and there's many, many of those issues--about where the federal government leaves off and the provincial government takes on. As much as prescription drugs are established federally by the government, who can prescribe those products for the most part is established by the province.

As mentioned earlier, we have a proposal in front of the provincial government now to show how pharmacists can enhance the patient access to prescription medications. I don't think that we're here to say that a pharmacist is an expert, or will be an expert as a diagnostician and say what exactly is wrong with the patient, but with some of the minor ailments the pharmacist could do that. It still requires, obviously, the role of the physician to diagnose. When it gets into the area of which medication is the best for treating that illness, that's when I think the pharmacist can work along with the physician, and as the treatment goals identified by the physician--they have a patient and they want to get that patient to this area for their wellbeing--involve medications, and often it does, the pharmacist can do that.

**The Chair:** Thank you, Mr. Dromisky.

Mr. Robinson.

**Mr. Svend Robinson:** Thanks very much to all the witnesses for your evidence this morning.

I have questions just in two areas.

We heard evidence earlier this morning in the first panel from a practising physician, Dr. Katz with respect to a computerized program here in Manitoba that basically indicates when an individual receives a prescription for a particular drug it gives you the history of other drugs that they have been prescribed and if there is a potential for a conflict or a problem with the interaction between those drugs a red light goes on. There is a warning. What we also heard was that this isn't working. According to Dr. Katz at least, pharmacists are not communicating to the physicians when there is a warning received about a potential adverse effect from an interaction of drugs. He said that in the

10 years he's practised he's never had one, and yet there have been circumstances in which there clearly was a potential for an adverse result from the interaction of drugs.

I want to give you the opportunity to just explain why we're hearing that and why the system doesn't seem to be working.

**Mrs. Marian Kremers:** Perhaps Dr. Katz isn't very available to receive his calls.

**Mr. Svend Robinson:** He said he hasn't gotten any calls.

**Mrs. Marian Kremers:** Okay.

I have absolute faith in pharmacists solving the problem. Perhaps they could solve the problem without contacting the physician. I find it very peculiar in that position Dr. Katz would not have received any calls. As a former practising pharmacist, I was on the phone many times to physicians. I don't understand why Dr. Katz would not have been contacted. Maybe Michelle or some of our more recently practising pharmacists can answer the question.

**Mrs Michelle Fontaine:** Some of the time the interactions show up as codes. There's ME1, ME2, ME3. There is a series of MY, MZ, MW, and I think perhaps sometimes they're missed just because of the abundance of codes that are presented. It is very good that you have to look, but it could be missed. If it's ME1 that means the highest level of an interaction. That's where you should contact the physician. Sometimes it's a short period. You may have resolved it so that they don't take their Lipitor while they're taking their Erythromycin for that period of time.

Initially, when it first started, it was pretty overwhelming for the pharmacists to see all of the codes and to identify them and be able to act on them. I believe that process is improving. The newer graduates who are coming out are more trained to use the system. The codes have been simplified. It is probably improving. I don't know if it is ideal, but I'm sure it helps.

🕒 (1155)

**Mr. Ronald Guse:** I don't know if Dr. Katz' example might be the exception as opposed to the rule. I think if you spoke with a number of physicians they would be complaining on the other end saying the pharmacists are always bothering them—in a kind way, I hope—with this type of information because it's ongoing.

**Mr. Svend Robinson:** I would hope if that ever came up you would be the first people—and you are professionals. I would assume that would be happening, but you will understand that when we hear this information it gives rise to concern.

My other area of questioning is on the Internet pharmacies. I want to try to understand this.

First, why is there a Coalition for Manitoba Pharmacy that was created in June of this year? There is the Manitoba Society of Pharmacists and I would have thought that if the Manitoba Society of Pharmacists was concerned about this you wouldn't have to create a separate body. I have so far heard silence from the representatives from Manitoba Society of Pharmacists on this issue. I guess I would ask the Manitoba Society of Pharmacists directly, have you taken a strong stand on this issue? Why is it necessary for there to be an ad hoc coalition?

You mentioned that you have no budget. Do you receive any funding at all from the pharmaceutical industry for your coalition?

**Mr. Lothar Dueck:** We have no funding right now.

**Mr. Svend Robinson:** You have no funding at all.

**Mr. Lothar Dueck:** We have no funding. We're working as volunteers.

**Mr. Svend Robinson:** Then over to the society...

**Mr. Scott Ransome:** The Manitoba Society of Pharmacists represents all pharmacists. That includes, as referenced earlier today, that there could be as much as 20% of practising pharmacists currently in Manitoba who are practising in international pharmacy. We represent them as well pharmacists who work in hospitals and pharmacists who work in community pharmacies. We're an organization that represents all pharmacists and, clearly, a good piece of our membership works in international pharmacy.

**Mr. Svend Robinson:** Are you not also concerned about some of the ethical questions that have been raised with respect to those people that you do represent and the prescriptions that are going out without direct contact between physician and patient?

**Mr. Scott Ransome:** Clearly we're concerned with that. We have a formal position with respect to this matter. I described the position as being quite balanced, but one of the things we point out to all practising pharmacists is that they have to comply with all provincial legislation, all federal legislation, all international legislation and the code of ethics—code of conduct here in Manitoba. We are not in any way advocating that anyone ignore their professional responsibilities.

**Mr. Svend Robinson:** Well let me deal with the issue of the relationship between physician and patient.

According to the brief of the coalition here in Manitoba doctors can't sign-off on these prescriptions. So in order to get the prescription they've got to find a doctor from another province as I understand it. The obvious question is, what on earth are doctors in other provinces doing signing off on a prescription for a patient that they've never seen? Are

there not similar codes of conduct in place in those other provinces that would say, look you do that and you lose your licence to practice medicine?

**Mr. Ronald Guse:** I would love to answer that question for you if I may. I'll try not to speak in codified language.

When we have that information in our possession, our provincial act, the Pharmaceutical Act of Manitoba set up by the Government of Manitoba, prevents me from sharing that information with licensing medical authorities in other provinces. So I can't sit here and say to you that is occurring, because even if I told you that it was raised by the coalition, I couldn't even confirm that in fact is occurring. I can't even confirm to you that pharmacies that ship medications to the United States are in fact using physicians from other provinces.

**Mr. Svend Robinson:** You can't confirm that?

**Mr. Ronald Guse:** I can not confirm that to you because if I confirm that, it might be information that I've discovered by doing on-site audits and that information is private.

We just went through a process of having a prosecution against me personally—against the Manitoba Pharmaceutical Association as a whole, but it was directed at me personally—because I didn't break the act, but by their interpretation it was perceived that I broke the act, but I did not. It started a long legal process to silence the Manitoba Pharmaceutical Association and me as Registrar.

🕒 (1200)

**Mr. Svend Robinson:** I think it's outrageous. If you people are able to identify physicians from other provinces or territories that are signing off on these prescriptions in breach of their ethical responsibility, you're on the front lines, why shouldn't you be in a position to report this directly so that there can be follow-up action in those jurisdictions so that those doctors aren't allowed to get away with it?

I don't know if you want to comment on that, but to me that seems like a no-brainer.

**Mr. Ronald Guse:** In plain language, welcome to my nightmare.

**Mrs Michelle Fontaine:** If I can speak. It partially answers one of the questions that Mr. Thompson asked. The coalition was formed in response to the MIPA, the Manitoba International Pharmaceutical Association and the MPhA's mediated agreement. Now you had asked why the MPhA has no teeth.

The MPhA, in my understanding and in my opinion, was doing their inspections and they were trying to come up with some sort of—they are a regulatory body—regulations. The Manitoba government allowed MIPhA, or the Internet guides or whatever you want to call them, to come in and speak to them. All of a sudden our regulatory bodies had to

go into a mediation process to find a way that Internet pharmacy...my understanding is made to come up with an agreement that would allow Internet pharmacy to exist thereby taking away any teeth that they had.

The agreement was reached—and these guys can help me with the dates—but it came up with was they were told not to tell the pharmacists body for about a month. It was released days before the election and the pharmacists had one week of this information to go to the vote, to vote on whether or not we agreed with this mediated agreement.

We had 300 pharmacists in a week sign a petition asking for it to be delayed so all the pharmacists could actually read the agreement and see what it said and see if we could come up with an understanding. That wasn't granted. Then we had 307 members out of 1,000 roughly vote against the agreement.

Why did the MPhA have no teeth? Maybe ask Mr. Chomiak.

**Mr. Svend Robinson:**

**Mr. Greg Skura:** If I can just add into this, as Ron said, there's a lawsuit against him. There were several lawsuits and the governor was promoting international pharmacy and they said to our association-- Ron is the registrar--make this work. Ron had no choice. He had a personal lawsuit, other lawsuits. They have a war chest of \$1 million for just legal matters.

**Mr. Svend Robinson:** Can I just ask one very brief final question. I'm sorry to take your time, but this is an important issue, I think for us to flesh out.

Just to understand how it works, when your members, when the Internet and your 20% members who you're also representing, which is why you're a little cautious about this stuff, when those members receive a prescription signed by a physician in Alberta or Saskatchewan, for example and they see it comes from a person who they recognize is an Internet pharmacist maybe making repeat purchases, for example, right, there's nothing at all can be done? Well, I guess they don't want to do anything, because this helps their business, but is there nothing at all that can be done I guess by your body in these circumstances?

You're saying your hands are completely tied, that even if you really know what's going on here, because you know who the people are presumably, who are your Internet pharmacist people, you well know who they are, they come in and they have a prescription signed by a doctor in Saskatchewan, you know what's going on. You have to know what's going on. You're saying there's nothing you can do.

**Mrs. Marian Kremers:** No, there's nothing that MSP can do because we are not a regulatory board, but--

**Mr. Svend Robinson:** I was questioning more about--

**Ms. Marion Kremers:** Okay.

**Mr. Ronald Guse:** According to the legislation, I have the ability to share information with my colleagues, the pharmacy licensing boards, colleges, associations across the country. I have the ability to share information with the medical licensing body in the Province of Manitoba and that's it.

**Mr. Svend Robinson:** But if you shared it with the medical licensing body, which is the college of physicians and surgeons, do they not have the authority then to raise concerns with their counterparts in other jurisdictions?

**Mr. Ronald Guse:** Our legal advice and I can tell you that our legal budget in 2001 was \$6,000. We're now at \$91,000 and we're not quite done this year yet. But our legal advice is and he's used these terms so I can understand it, you can't do something through the back door you're not allowed to do through the front door. So if I share it with someone who....I can't share it from point A to point C. They won't allow it to be point A to B and B to C. That just won't be allowed.

🕒 (1205)

**Mr. Greg Skura:** May I just answer that briefly.

I know the medical association of physicians of Manitoba have sent letters to all the physicians saying that no, this is not a good practice. You're not meeting the person face to face. It's up to the physician whether they want to sign these prescriptions. They're getting paid \$10 to \$15 for every prescription, so all of a sudden here is another revenue for physicians.

If Internet pharmacy isn't stopped, we're going to start doctors--

**Mr. Svend Robinson:** You say in your brief it's been banned: they can't do that. In Manitoba now.

**Mr. Greg Skura:** No, there's...Manitoba. Whether they can do it without anybody knowing they still can do it.

**Mr. Svend Robinson:** A Manitoba doctor?

**Mr. Greg Skura:** Yes.

**Mr. Svend Robinson:** So they'd be breaking the law?

**Mr. Greg Skura:** They'd be breaking the law. But they're not going to be....But this is a part that we can't notify anybody if...and we're not Internet, so I don't see any of the doctors who sign it. Internet has signed their own agreement among themselves, because this is such a cash cow that they're not going to give this information to anybody.

Most of the doctors, now I shouldn't say most, but because I'm not part of MPhA, a lot of doctors are coming from the maritimes, New Brunswick, some B.C. or whatever, because there are some doctors there who have their own Internet set up and they just do Internet. I think there are three of them. It was written in the *Globe and Mail* about four months ago. But everybody's making money off it.

I know of one physician in northern Manitoba who was offered \$15,000 a week just to sign Internet prescriptions and this was just three months ago. So this is even though it's against....There's money to be made--

**Mr. Svend Robinson:** It's pretty tempting.

**Mr. Greg Skura:** It's tempting, that's it, yes.

**Mrs. Marian Kremers:** Well, the real flaw is the Manitoba Pharmaceutical Act and the fact that the practitioner is defined as any registered practitioner in Canada, whereas most other provinces it is restricted to their own province.

**The Chair:** But a minor change could eliminate these out of province practitioners from signing?

**Mrs. Marian Kremers:** I wouldn't go so far as to say that. It could go a long way to helping to regulate it though.

**Mr. Greg Thompson:** Madam Chair, could I just have one word before...and this is just a comment. I think the code's been broken. I really appreciate your testimony here today and I know the chairperson will probably want to say that as well, but this has really been helpful and I do thank you very much.

**The Chair:** It's interesting because at the coffee break, Mr. Dromisky and I were talking and saying, the one thing we've learned today is that Manitobans are so honest, and we didn't have as much code as we've had other places. So thank you very much for your frank appraisal of the situation and alerting us to these problems which have been highlighted more in Manitoba than anyplace else but you've given us somewhat of an understanding of it at least to the best of your knowledge. So thank you very much, and ladies and gentlemen, we will now break till 1:00 p.m.



CANADA

**Standing Committee on Health**

**Comité permanent de la santé**

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**Thursday October 2, 2003**

**WINNIPEG, MB**

🕒 (1315)

*[English]*

**The Chair (Ms. Bonnie Brown (Oakville, Lib.)):** Good afternoon, ladies and gentlemen. It's my pleasure to welcome you to the Winnipeg hearings of the Standing Committee on Health on the subject of prescription drugs.

We're very happy to have with us in this first hour, from Manitoba Health, the minister, the Hon. Dave Chomiak and the deputy minister, Mr. Milton Sussman and Marcia Thomson from health programs and Jack Rosentreter, executive director of the pharmaceutical drug programs and Ulrich Wendt, the federal-provincial advisor.

I would imagine we're going to hear from the minister first. Minister, the floor is yours.

**Honourable Dave Chomiak (Minister of Health, Manitoba Health):** Thank you very much and thank you for the pleasure and the honour of being here, madame la présidente.

I have a presentation I will make and I believe copies have been handed out or will shortly be handed out to members of the committee.

**The Chair:** The clerk is saying he doesn't have them.

**Hon. Dave Chomiak:**

Having been on the other side of the microphone on numerous occasions, I appreciate the fact that we should get it to you.

I'd like to begin by congratulating the Standing Committee on Health for focusing on this issue. This presentation will deal with several of the questions that your committee has raised, and in particular will be focusing on the issue of drug costs and drug prices as cost drivers of the system, mechanisms and opportunities for reviewing and controlling prices and costs, the marketing and lobbying of prescribers and dispensers, direct-to-consumer advertising.

I should indicate that most of these topics that I'll be presenting have been the subject of federal-provincial conferences over the past four years for which I've been involved and I think have been worked on by various federal and provincial agencies.

We'll focus on these questions, because from the perspective of Manitoba health, they are key areas where the federal government can plan an important role in helping to keep the health care system sustainable. Our system is highly valued and envied throughout the world. As you know, medicare is only one component of the system.

In Manitoba, our system includes such components as a comprehensive home care program, a comprehensive long-term care program, a strengthened public health system and five separate pharmaceutical programs. Provincial drug programs include hospital-based services, a palliative care drug access program, drugs provided through personal care homes and drugs provided through the mantra of the Department of Family Services and Housing for low-income Manitobans, and a pharmacare program.

Provincial drug programs represent a relatively small portion of total health care costs, which in Manitoba are now around \$3 billion. In 2001, two provincial drug programs represented only 6.7% of total health care spending, but drugs are a far more important component of our sustainable health care system than this ratio implies. There are two reasons for this--rising drug costs and rising drug prices.

Pharmaceuticals are the fastest growing component of the health care system in most provinces and territories. I'm sure members of the committee are familiar with some of the statistics, such as between 1998-1999, 2001-2002, provincial drug program expenditures outside of hospitals increased by over 80%.

Provincial drug programs are also subject to the effects of a complex interrelationship between the industry, health research, service providers and consumers. The interaction

among these factors is leading to positive outcomes in the form of research results, new effective treatments and new ways of keeping people healthy or reducing their dependence on the rest of the health care system. It may also lead to negative outcomes in the form of artificial industry-driven demand, rising costs and prices, inappropriate and redundant treatments, and pressures on the sustainability of the overall system.

One important innovation to provincial drug programs has been the introduction of the Palliative Care Drug Access Program, which was implemented December 2002. This program provides a deductible free coverage for patients who are assessed to be palliative. It's anticipated the demand will rise for this access program as palliative care patients and families become more familiar with it. The biggest cost drivers, however, will continue to be the approval of new and more costly drugs, and the rise in demand.

Like most provinces, Manitoba has experienced a varying degree of success with attempts to control both costs and prices. For example, before a drug is listed in Manitoba's drug formulary, it is subject to rigorous cost-benefit analysis. A national common drug review process, which will be implemented shortly by the provinces, territories and the federal government, has the same philosophy. Where possible and appropriate, generic drugs are substituted for higher-priced patented drugs in Manitoba.

🕒 (1320)

We continue to explore a common tendering process for bulk purchasing. These initiatives help to mitigate the rise in costs, but many factors remain outside of the province's control.

The federal government also has an important role to play in mitigating costs and prices. Some of the key areas that the federal government could explore or revisit include, firstly, patent issues. When Bill C-91 was passed in 1993, it extended the period of time during which new drugs are protected from competition from lower priced generic substitutes. We appreciate that the standing committee does not focus on industry related issues so we will confine ourselves to the impact on the health system and some of the key provisions of this act.

One of the things the Patent Act did was to eliminate the practice of compulsory licensing. Compulsory licences permitted a generic firm to apply for a license to manufacture and sell a patented drug subject to a fixed royalty fee. The act also extended patent protection for brand names to at least 20 years. It also provided technical means for patent holders to block or hinder rapid entry into the market of generic products, even after the patents expired.

Without getting into the technical details, the result has been, from our perspective, a much slower ability for lower priced generics to come onto the market. The federal

government could revisit the Patent Act to make it easier for generic companies without effecting our international trade obligations.

For example, a greater onus could be placed on the patent holder to demonstrate that a new generic indeed fringes on patent rights. It could also make it more difficult for a patent holder to make a minor change or produce near identical products in order to extend the patent beyond the 20 year life plan. This is practice is sometimes known as “evergreening”.

Secondly, we could streamline approvals for generic drugs. Health Canada has the regulatory responsibility for pharmaceuticals. This also includes the reviewing and approval of generic drugs. We are aware that Health Canada is considering mechanisms for streamlining the process of approving generic drugs. This initiative should be accelerated in order to bring generics on the market more quickly and to allow provinces to list generics more quickly.

Thirdly, non-patented single source product. There are a number of important pharmaceutical products which are not patented, but for which there is a single manufacturer. In 1998-99, Canadian prices for top selling, non-patented, single pharmaceutical products averages 28% above median foreign prices; that is in those countries used by the Patent Medicine Prices Review Board to review prices of patented drug. The average prices of these non-patented single source drugs were highest in the U.S., followed by Canada; Germany; Switzerland; Sweden; the U.K.; France; and Italy. Price levels in Italy and France were 53% and 44% lower than Canadian prices respectively.

The federal government could expand the role of the Patent Medicine Prices Review Board. Since 1987, when the board was established, the price increased of patented drugs have stabilized and now are more comparable to prices in Europe. We are aware that a good deal of work has been done to examine the feasibility to extending Canada's price review mechanism in non-patent drugs, especially single source non-patented. We are not aware of any reasonable barriers. We therefore urge the federal government to expand the role of the Patent Medicine Prices Review Board in this area as soon as possible.

Fourth, reviewing and tracking prices and costs. We are aware that work is continuing on a national prescription drug utilization information system. This system will provide a critical analysis of price, utilization and cost trends so that Canada's health system has more comprehensive and accurate information on how prescription drugs are being used. It will help us also to better understand the sources of the cost increases. This work is being conducted in collaboration with the Canadian Institute for Health Information and the Patent Medicine Prices Review Board. We urge that this work be continued and, in fact, accelerated. From the point of Manitoba Health, we would be willing to share the data produced by our drug programs information network to facilitate this initiative.

The inherent logic behind pharmaceuticals is that they are needed to treat illnesses and keep people well. They are different from other consumer products because the decision

about their use ought to be made on medical grounds rather than on a basis of consumer choice. That's aside from recreational drugs. That is why regulation is appropriate and why marking and advertising practices need to be carefully examined.

In the pharmaceutical industry the emphasis on the marketing has been increasing. The proportion of total sales revenues allocated to marketing has been rising continually. A 1997 article in *Scrip* magazine estimated that pharmaceutical companies spent approximately 35% of sales revenues on marketing. I'm advised that's about twice what they spent on research and development.

🕒 (1325)

Moreover even some of the research and development could be called “marketing by other means”. We will come back to direct-to-consumer advertising in a moment.

Our focus here is the promotion of marketing activities of the industry that are self-regulated by a code of marketing practices. As we understand it, in 1997 a semi-autonomous organization called the Pharmaceutical Advertising Advisory Board was established as an alternative to direct government regulation of promotion.

This board is responsible for pre-clearing published advertising. The board consists of representation from the pharmaceutical industry, the advertising industry, the Canadian Medical Association, the Canadian Pharmaceutical Association, and the Consumers' Association of Canada. It was set up in a pluralistic model, but the majority of the members are representatives from particular industries.

A review done in 1990 showed that a significant proportion of advertisements do not comply with guidelines established by the board. I'm advised that in 1991 nearly half of the advertisements included no-risk information although it is clear requirement of the board.

However this structure does provide some positive features for our system. There is probably less information than in some other regulatory systems. Manitoba would like to see these positive features enhanced. Health Canada, through the enforcement of the Food and Drugs Act, could do a more aggressive job of monitoring the function of this board.

Clinical drug trials and the Health Canada Special Access Programme are also sometimes used as a means of enhancing consumer demand. I make that statement quite clearly understanding that it has implications in both directions.

Clinical drug trials are intended to ascertain the efficacy and effectiveness of new drugs prior to licensing. The Health Canada Special Access Programme provides

unapproved drugs on an emergency basis to treat patients with a serious or life-threatening illness when conventional therapies have not been successful.

The program sometimes employed use of clinical trials and the Special Access Programme as a means of building consumer demand for the drug that needs to be regulated.

The federal government could play a stronger role in ensuring ethical practices in the use of the Special Access Programme and clinical drug trials including the requirement to disclose all of the risks of the drug study, and by making transparent any potential conflict of interest between the researchers and sponsors.

Stronger federal regulation would have been helpful, as an example, in 2001 when a patient using the drug Remicade under the Special Access Programme...who were asked by the Canadian Advisory Reimbursement Exchange on behalf of a drug company to write to the provincial governments to request that Remicade be placed on the provincial drug formulary.

Direct-to-consumer advertising is not permitted in Canada; nevertheless, there are issues around advertising to the public that should be noted. A study published in the *British Medical Journal* in 2002 showed that doctors were more likely to prescribe a drug that a patient has seen advertised, even when the doctor was uncertain about its appropriateness for the patient.

There are three essential ways in which the pharmaceutical industry manages to directly influence Canadian consumers through advertising. The first is due to proximity of the United States, which is only one of two industrialized countries which allows this type of advertising. There is a significant spillover effect from the U.S. advertising in magazines and on U.S. television pertaining to and penetrating the Canadian market.

The argument is often raised that nothing can be done about U.S. television advertising, but the parallel example of tobacco and alcohol advertising shows that Canada can effectively block unwanted advertising signals from the Canadian market except in, now, instances of illegal satellite signals. We urge the Government of Canada to more aggressively block direct-to-consumer advertising by upholding and enforcing existing Canadian law.

Pharmaceutical companies are permitted limited advertising provided that it is confined to the drug's name, price, and quantity. Marketers are finding ways around these constraints as the example of Viagra advertising so eloquently illustrates. Frequently they will use sophisticated advertising to entice consumers to visit websites where further product information is provided including a sales pitch.

Other forms of prescription drug promotion are becoming increasingly common. These fall outside of Canada's regulatory codes. Sponsorship of patient-advocacy groups, public meetings, public relations activities, video news releases, and upbeat releases to the

media all contribute to increased product sales regardless of actual medical need. There is room for federal regulatory enhancements to prevent or, at least, mitigate some of these activities.

In conclusion, we'd like to emphasize that the purpose of our prior presentation is not industry or drug bashing. The pharmaceutical industry is an extremely important and integral part of keeping Canadians healthy and treating disease.

🕒 (1330)

We are cognizant of the very important economic role and research contribution that the industry makes. Our goal is to enhance the relationship between industry and our health system. Stronger federal regulation and advertising practices, faster approval of generic drugs and other mechanisms for containing costs and the other recommendations we have made in this presentation are all intended to sustain our health system and the role pharmaceuticals play in it. We think that everyone, especially the Canadian consumer, can win with this approach.

Thank you very much. I'm prepared to answer questions.

**The Chair:** Thank you, Minister.

We'll begin questioning with Mr. Merrifield.

**Mr. Rob Merrifield (Yellowhead, Canadian Alliance):** Thank you, Mr. Minister, for coming in to share your ideas with the committee.

We've really had an interesting time this week getting a bit of a handle on this whole area of drug pricing, as far as the amount of addiction that we have within our senior population, as well as the problem that we have within our own hospitals.

We've had testimony that up to 50% of individuals who are hospitalized have a bad reaction to medication within the hospital setting. A lot of doctors and nurses are not trained or are not knowledgeable enough or don't have the time. I'm not here to judge motives or capabilities on those reactions. It becomes a pretty serious problem when you really look at it and yet very little study has been done on it.

My question to you is really that 50% of your presentation to us was on the pricing of drugs. We had testimony this morning from individuals who had a difficult time—from the pharmacy group—and had serious concerns about the rising cost of drugs in Canada, particularly in this province, with regard to brand name pharmaceuticals because of Internet sales. That is within your jurisdiction and within your mandate, and I'd like your response on how you can come and say we should be changing patent law and looking after all the proposals that you have here and yet, on the other side, are sitting there while it is directly in your mandate to deal with the Internet pharmacy group and how that is,

right now, impacting drug prices in Canada and potentially could impact in a very significant way.

**Hon. Dave Chomiak:** Thank you.

I'll answer both questions that you raised.

The first question is on drug utilization within the province and the issue of over use, perhaps inappropriate use, etc. We have an electronic information system with information for all prescriptions in the province which tracks that. It is an automatic system. It red flags, though it's not perfect and there are obviously more areas to be brought in, but we have a system that tracks drug utilization of prescriptions, cross-references etc. and allows pharmacists to understand dispensing and when drugs might have inappropriate interaction.

Second, we also have programs with the College of Physicians and Surgeons, which is our regulatory body, that track particular drugs with particular system they have in place. That is essentially for narcotic based drugs and other drugs for over use or inappropriate use. That deals with one of the issues.

I'm also quite cognizant of two other issues in that area. First, we are working on processes with our College of Physician and Surgeons and our medical association to do a better job of drug utilization within our borders by physicians and others for more appropriate use of drugs. I also raise the issue of antibiotic use. That's the first part of the question.

The second part of the question deals with the Internet pharmacies per se. The fact is we have been able, in this country, to maintain, relative to the United States, a lower cost for our drugs, which has had the effect of creating an industry that provides cross-border utilization of drugs. I'm not cognizant of direct drug price increases as a result of that in Manitoba per se. I am aware that the industry has considerable impact on the Manitoba economy. I'm also aware that the FDA has expressed concern. I'm also aware that there is a bill in Congress to, in fact, permit it, so I think there is a divergence of opinion.

What I do know is that for decades consumers have been coming to Manitoba to purchase drugs, and continue to do so and, in fact, are now doing it on the Internet. Whether that industry will continue in the future and survive in the future is still a question that's up in the air.

In terms of Manitoba's response, we've put together a very aggressive mediation process with the industry, with the pharmaceutical association and others, to try to reconcile something that is relatively new and, I suggest, will only expand in the future and is just not confined to pharmaceuticals and the cross-border utilization of medical services is something that is going to grow. In Manitoba now we are involved in a process in conjunction with France to do surgery via telecommunications from international locations. It's an issue we're going to have to face.

🕒 (1335)

**Mr. Rob Merrifield:** Yes, we certainly are. The point is really we can't determine what the United States is doing--it's not our jurisdiction--nor should we. Although, from a federal perspective, we may want to enter into some dialogue with regard to the problem.

But what is our mandate? It's making sure that Canadians receive and have the ability to receive pharmaceuticals at the lowest price possible. As we move forward into these next number of years, as pharmaceuticals come even more in demand, what we heard this morning is that they're compromised in two areas. First, availability, and also the price because of Internet sales. Internet sales have gone from \$400 million to \$1.2 billion in one year. That's tremendous growth. Not only that, you're lacking the ability to have enough pharmacists to be able to dispense in the province.

My question is, if you don't realize that it's a serious problem, that is a problem. I'm sort of bringing it to your awareness and hopefully looking for a response to see how you plan to deal with it.

**Hon. Dave Chomiak:** I don't think the lack and shortage of pharmacists is confined, or has occurred, directly as a result of the Internet pharmacy. We were short in this country of pharmacists for perhaps the last decade.

**Mr. Rob Merrifield:** So it's not impacting ...?

**Hon. Dave Chomiak:** It's an impact, but I think it would be inappropriate to suggest that the shortage of pharmacists is solely attributed to Internet pharmacies. The fact is, U.S. companies were offering major signing bonuses to Canadian-trained pharmacists before the Internet became an up and growing business. So we may or may not have faced that same difficulty whether or not Internet pharmacies were online.

I do recognize that it has put pressure on the ability--and we face that in the public sector--to purchase the services, through contract or otherwise, pharmacist, and we've had to increase dramatically the price that we pay for pharmacists in our public system. I recognize that this has been a pressure, and we continue to grapple with that.

We monitored very closely and we were in touch with pharmacists and associations and individual pharmacies across the province to ensure that supply is not affected. The long term is not just a Manitoba issue. It's a Canadian issue. Manitoba is not the only province that is engaging in this particular enterprise. I think it's something that has to be addressed, but I also suggest that there is a difference of opinion with respect to the U.S. and how they're going to apply their regulations in law in relation to this.

🕒 (1340)

**Mr. Rob Merrifield:** So you'd dispute the numbers we heard this morning about it causing a 20% reduction in pharmacists, the availability of pharmacists, in your province?

**Hon. Dave Chomiak:** I don't see how you could apply a particular shortage because of this. The fact is I was Minister of Health before the Internet pharmacies became a major issue in Manitoba and I was grappling with pharmaceutical shortages prior to that.

**Mr. Rob Merrifield:** So you had the shortages prior to, plus you had the shortage of pharmacists prior to ... ? That's your comment.

**Hon. Dave Chomiak:** There's a national/international shortage of pharmacists.

**Mr. Rob Merrifield:** And health care workers from beginning to end. So that's not news to anyone.

That's interesting. Let's get back to the price of the pharmaceuticals then. If you think that it's not affecting the shortage of either the drug or the pharmacists, then how about the pricing? The testimony this morning is that the pricing of brand name pharmaceuticals is moving up this last year in relation to the degree of the amount of Internet sales. Whether there's a direct correlation there or not, I suppose we need more witnesses. The testimony this morning certainly indicated that was the case, so can you comment on the pricing side of it. That would be pricing not only for Manitoba, but for all of Canada.

**Hon. Dave Chomiak:** Thank you. The price has been increasing dramatically over the past decade, I suggest. I didn't hear this morning's discussion, but we are not aware of any particular shortages that are driving up the prices here.

**Mr. Rob Merrifield:** And you're not having any more availability problems now than you were before?

**Hon. Dave Chomiak:** Monitored very closely and while there have been anecdotal incidents that have been reported, we follow-up and we have not found those to be substantiated.

**Mr. Rob Merrifield:** It's interesting when you sit in our chair and you have witnesses come forward and tell you one state of facts and then others come refuting those. Somebody is not either understanding the issue or is not being straight up with us. I guess we'll have to determine who that is.

**Hon. Dave Chomiak:** Let me just add to the...I mean part of, I think the issue that one has to understand is "shortages of drugs" has been a factor and a fact of life in certain drugs and in certain areas because of inventory matters and related matters for some time.

The fact that Internet pharmacies are present in Manitoba has been pointed to as the reason for any shortage or continuing shortage or difficulties. We have been tracking this on a regular basis. We have written to pharmaceutical companies, we've been very aggressive and we've indicated to all of our suppliers that Manitoba consumers are supplied first. We have made that very clear and is very clear where we're going on this.

To two issues of "shortages" has been present before, I think the committee should understand that. Second, the issue of pharmacist shortages has been present for some time and has been exasperated. I suggest by the use of fact that more pharmacists are providing Internet pharmacies.

I just want committee members and perhaps you to recognize that we were faced the same issue in perhaps the mid 90s and late 90s when the Mom and Pop drug store was moving to large big box stores and we are in somewhat of the same dilemma in terms of pharmacists etc.

There are factors that play in the free market that have impacted on this for some time and will continue to impact on it.

**The Chair:** Thank you very much. Thank you Mr. Merrifield.

Mr. Thompson.

**Mr. Greg Thompson (New Brunswick Southwest, PC):** Thank you Madam Chair and thank you Mr. Minister for coming in with your staff.

I want to pick up on that same issue of Internet pharmacies or mail order pharmacies. We did hear testimony this morning from various groups. One of them being the Coalition for Manitoba Pharmacy. Then in addition to that we heard from the Manitoba Pharmaceutical Association.

To put it very plainly they don't seem to be very impressed with your aggressive move to stop this Internet pharmacy. They're saying, as been mentioned by my colleague that in fact it's growing expedientially and it is having and it's not anecdotal information, I might suggest, it's very factual.

And for you as minister to suggest that it's anecdotal I think that you'll have to go back to your officials because it's more than anecdotal. They're saying that it's bringing about shortages which they see themselves because they're in the drugstore every single day doing their work. So it's far from being anecdotal I would suggest.

In addition to that, they're saying that you're basically skirting PMPRB, review board voluntary participation. In other words, voluntary from the sense that some of the innovative drug companies eventually will choose not to sell some of their products in Canada. So it's going to have not only an effect in terms of pharmacists being pushed out of either a family practice or some of the bigger drug stores.

I mean we've had evidence here today that some of those stores have actually shut down and where they've actually seen these people move into the Internet pharmacy. I mean again, this is not anecdotal, I mean it's very factual.

I think that's something that has to be addressed, I think openly and by the government, that it goes way beyond anecdotal. Again, an expediential increase in this type of behaviour is only going to make the problem worse not better.

In addition to that, as you would well know, as the former Minister of Health, you know doctors are co-signing or counter-signing on these prescription when they've never in fact have seen the patients.

I'll leave it at that but we've had testimony this morning again from the...I just want to make sure that I have the correct name here for you, I'm looking for the name of the person Madam Chair, that represented the Pharmaceutical Association this morning. Pardon, registrar.

🕒 (1345)

**The Chair:** Registrar.

**Mr. Greg Thompson:** Roger Goose, that's it, Ronald Goose, excuse me. For suggesting that the Pharmaceutical Association that has certain guidelines and they act as much the same way as the Canadian College of Physicians. Their mandate is to protect the public, basically no teeth and in fact I guess suggesting that you've taken some of those teeth away from the pharmaceutical association in terms of their ability to police the industry if you will.

So, minister, I'll leave it at that and I look forward to your response.

**Hon. Dave Chomiak:** Well thank you.

I think it is unfortunate that the fact that the average ingredient costs of the brand pharmaceuticals have gone up in Manitoba by our tracking of \$35 per prescription in 1996, 1997; \$37 in 1997, 1998; \$40 in 1998, 1999; \$44 in 1999, 2000; \$48 in 2000 and 2001; and \$48 per prescription in 2001, 2002 is related to Internet pharmacies. The point I made in my presentation is that prices are a function of a number of factors. The information you provided this morning in fact we have tracked every representation that's been made to us that I call anecdotal that has been provided to us on pharmaceutical shortages and every incidence that's been provided. In each incidence we have found that there hasn't been a difficulty.

So regardless how one characterizes it, the point I want to make is that if one wants to discuss the issue of Internet pharmacies and focus totally on Internet pharmacies as the reason for the cost drivers, I think that's wrong. I think that's inaccurate. I think that focusing totally on that issue misses the larger mandate of this committee of dealing with

an issue that's been a problem for over a decade. So with all due respect, there has been representation. There's been representation on both sides of this issue to myself as Minister of Health. My number one job in this province is to protect the patients and we've taken every step that we can to do that.

🕒 (1350)

**The Chair:** Thank you, Mr. Thompson.

Mr. Dromisky.

**Mr. Stan Dromisky (Thunder Bay—Atikokan, Lib.):** Thank you very much.

Thank you very much for appearing before the committee this afternoon. We truly appreciate it. It's interesting the various presentations we've had across the country and before the House, I mean before the committee in Ottawa. Somehow we have to make sense out of the whole picture.

We have a shortage of pharmacists as you've indicated and we've had them for a long time. I'm talking about the shortage, not just in Manitoba. There have been some thoughts been bandied about regarding a model very similar to nurses that are nursing practitioners. We see some value in something of that nature with the people that are most knowledgeable and have a tremendous amount of expertise in the area of drugs and prescribed drugs I'm talking about.

Communities isolated, we have very few of these professional people north western Ontario and all the northern parts of all the provinces in isolated communities and we have do something. Now the first question I have is related to this area. Is the government of Manitoba encouraging the school of pharmacy to increase the number of places to increase the supply of pharmacists in this province? Is there any thought given in that direction?

**Hon. Dave Chomiak:** In fact we are in discussions with them on that. We've increased the supply in every single health professional school, doctors, we have therapists, nurses, every single health profession and we're in discussion with the Pharmaceutical Association with respect to actually increasing their number of students as well. We're also engaged in discussion with the Manitoba Pharmaceutical Association who appeared this morning about expanding the role of technicians. And in this jurisdiction, we've also allowed midwives and other health care professionals to prescribe drugs.

**Mr. Stan Dromisky:** Is there any thought given into enriching the program? I note the five year program now in Manitoba to become a pharmacist, enriching the program, introducing programs from the medical school harmonized with the program in the pharmacy school so that the pharmacists will be able to prescribe drugs under certain conditions?

**Hon. Dave Chomiak:** That's a really interesting question. I am familiar with one health minister in the country who has indicated to me that why wouldn't we have pharmacists prescribing per se for routine matters right at the pharmacy which would ... that idea has been bandied about. At this point, I don't think we're considering... I think it's an interesting idea and a useful idea. It is one component that I think we're examining. The actual integration between medical and pharmacy hasn't taken place in this province.

**Mr. Stan Dromisky:**

I'm intrigued by the kind of programs you have in this province, and that is in sharing of information between and among the various people who are involved in the health care-giving system.

I may have misinterpreted something by one of the presenters this morning. You have a special act governing the responsibilities and the mandate and job specifications and so forth, regarding the pharmacists in this province. Is there anything in that act that curtails their sharing of information, within the province or beyond the boundaries of this province, with other health givers across the country?

**Hon. Dave Chomiak:** Thank you.

I'm advised that we're in fact attempting to obtain that kind of authority through our legislative office right now and we are in discussions regarding that.

**Mr. Stan Dromisky:** That's good. The reason I ask that question is because you know the people in this country are very migrant, like nomads travelling all over the place. There are a lot of people from Thunder Bay, from my community, who live in Winnipeg right now, and in Brandon and moving back and forth. I think these political and geographical boundaries we have, have to be erased in order to have a more effective health-delivery system in this country.

Thank you.

🕒 (1355)

**Hon. Dave Chomiak:** Thank you, and I should just add that our legislation was drafted prior to some of these issues becoming current, and I do suggest to the committee that we are facing a major technological revolution. In Manitoba we're thinking of how we're going to deal with cross-border issues increasingly across the health care spectrum and the health care field because clearly we are probably not prepared for it at this point.

**Mr. Stan Dromisky:** No.

Thank you very much.

**The Chair:** Thank you, Mr. Dromisky.

Mr. Robinson.

**Mr. Svend Robinson (Burnaby—Douglas, NDP):** Thank you very much, Madam Chair and Minister Chomiak and your officials. We certainly appreciate your taking the time to appear before the committee this afternoon.

If I may say as well, I very much value many of the recommendations you've made to the committee in a number of areas, whether it's direct consumer advertising, the issues of patents and also your leadership in an area that I personally feel very strongly on and that's palliative care. I was delighted to see that you moved ahead with the Palliative Care Drug Access Program.

I think you probably know the first jurisdiction in Canada who pioneered that program of making palliative care drugs available was in fact a New Democrat government in British Columbia. Unfortunately that government is temporarily not in office, but this too will change. A visionary government, Madam Chair.

I did want to come back to the issue of Internet pharmacies because you've said, Mr. Minister, that you're number one job is to protect patients and I respect that. I am very concerned that the Internet pharmacy industry, while it may provide jobs and I recognize it provides jobs, raises many very serious health questions. I guess I've got a couple of questions that I want to put to you on this.

We heard evidence, and I thought it was quite compelling evidence, this morning from witnesses with respect to, for example, the concern around the fundamental health issue. My colleagues have raised issues about prices. I'm not focussing on prices here, I'm talking about health. The fact that this is an industry in which too often drugs are prescribed without a direct link between the physician and the patient and you know that and that's a problem. That is a health problem.

As well, I don't think, certainly hearing the evidence this morning, there's much doubt that there are some serious issues around the movement of pharmacists into the Internet pharmacy industry from the general pharmacy industry. Quite frankly, you say it's anecdotal and I appreciate that, but pretty serious anecdotal evidence around some shortages of drugs. We heard from the coalition this morning about Temadol, Purinethol and some other drugs pharmacists who have had to search for a long time to find drugs that previously were available. Now whether that's directly a result of Internet pharmacies, I'm not sure it may very well be.

My question to you is this, if your number one job is to protect patients and ensure quality health care, why has the government not taken a much tougher stand on this Internet pharmacy industry? In particular, why is it that Manitoba continues to allow prescriptions to be filled if they're signed by doctors outside Manitoba, unlike a number of other jurisdictions in Canada?

**Hon. Dave Chomiak:**

Thank you for your opening words and for the questions.

In terms of your preamble, the two drugs that you mentioned, I wasn't aware that those should come to the committee and we will do follow-up on those two. The previous three drugs raised by that group, we had done follow-up on. So we'll do follow-up on that with respect to the two drugs that you mention in your preamble.

What we undertook in Manitoba is to put in place a mediation process where we brought in probably the most renowned mediator in Manitoba to try to reconcile some of these issues, in order to provide for patient safety, to see if industry can still function within proper guidelines and to protect the interests of the pharmaceutical association. We had agreement between all the parties and the agreement brought together by the mediator was put to the general membership of the Manitoba Pharmaceutical Association and was defeated something like 320 to 270. So it was relatively close, in terms of the licensing body membership. And we're continuing discussions with the industry to try to--and we will, if necessary--amend our regulations and amend our act in order to ensure that the system is protected.

The issue at this point that we monitor on a regular basis, there is now essentially two associations in Manitoba that represent pharmacists. Essentially, it's the traditional Manitoba Pharmaceutical Association and it's the Manitoba Internet Pharmacists. We are advised by them that issues of patient safety have been adequately protected.

It is true that our College of Physicians and Surgeons has directed its membership not to sign prescriptions without direct contact between the physician and the patient. We do have the ability for the industry to function within guidelines that they feel are acceptable. At this point, we are still continuing to try to reconcile these views and achieve a legislative regime that will continue to protect the patient and will still allow for appropriate cross-border use of pharmacists.

⊕ (1400)

**Mr. Svend Robinson:** How do you deal with the issue, though? Your doctors have said, "Look, we will not be a part of signing off on prescriptions, co-signing prescriptions, which are ordered over the Internet". Your doctors have said this is a health problem. You're the health minister and yet your province still allows doctors from other jurisdictions to sign off. You can change that by changing the law. Why won't you?

**Hon. Dave Chomiak:** At this point, we're attempting to reach an accommodation that would protect both those interests. I also have our College of Physicians and Surgeons saying that we should maintain small hospitals in rural Manitoba on a call-road of 2:1 doctors, and we're continuing to do that.

**Mr. Svend Robinson:** No, but we're talking about pharmaceuticals. Are you satisfied that a doctor in Saskatchewan or Ontario should be able to sign off on a prescription that's ordered over the Internet?

**Hon. Dave Chomiak:** If our mediation process exceeds, we will eliminate the co-signing issue and we will have the College of Physicians and Surgeons brought on side, and that continues to be our goal.

**Mr. Svend Robinson:** Sorry, just so--

**Hon. Dave Chomiak:** If we were able to achieve our mediation, we would have the agreement and the acquiescence of our College of Physicians and Surgeons. We'll continue to work on that.

**Mr. Svend Robinson:** But do you need the agreement of the College of Physicians and Surgeons to change Manitoba law to say that doctors from outside Manitoba shouldn't be able to co-sign? You don't need that. You don't need their--

**Hon. Dave Chomiak:** No, I don't need that.

**Mr. Svend Robinson:** So why can't you move ahead on that, then?

**Hon. Dave Chomiak:** Because we're still attempting to reach accommodation to allow both our pharmacists to participate and for Internet pharmacies to continue.

**Mr. Svend Robinson:** And how will that happen? Maybe I'm missing something here, but I assume you accept that it's wrong that patients should be able to order drugs over the Internet without those prescriptions being authorized by a physician with whom they have met.

**Hon. Dave Chomiak:** In some ways, it'll be not dissimilar to the question that was raised by one of your colleagues insofar as the pharmacists would have their relationship with the patient to allow the drugs to be prescribed.

**Mr. Svend Robinson:**

So the patient would, in fact, have to have a personal relationship with the physician in order to order those drugs over the Internet?

**Hon. Dave Chomiak:** With a physician, but not necessarily in Manitoba.

**Mr. Svend Robinson:** Where could that physician be, then?

**Milton Sussman (Deputy Minister, Manitoba Health):** The relationship would be with their own physician. Our pharmacist would--

**Mr. Svend Robinson:** So, an American physician. So you're saying that an American physician, then, could sign a prescription and they could order the drugs from Manitoba, over the Internet, if an American physician okayed it?

⌚ (1405)

**Hon. Dave Chomiak:** That is one of the options.

**The Chair:** Thanks. Do you have another question?

**Mr. Greg Thompson:** I was just wondering. If we do, I do have another question.

**The Chair:** Okay.

I'll have to give Mr. Merrifield the first chance, or we could maybe do one quick question with quick answers.

**Mr. Rob Merrifield:** I just wanted to pick up on what my colleague was saying with regard to Manitoba's Pharmaceutical Act. That's the one I think he was talking about that just needs to be changed. I still am not quite clear whether we got a commitment that you are going to change it or not.

**Hon. Dave Chomiak:** We are changing the act. We're in a mediation process in order to have all parties agree to the act and we're in the process of discussion with all of the groups--including the College--to ensure we can change the act, hopefully with the agreement of all parties concerned.

**Mr. Rob Merrifield:** Is the intent to change the act so that it would not allow prescribing anywhere outside of Manitoba for people within Manitoba? Is that how you're planning to change the act?

**Hon. Dave Chomiak:** No.

**Mr. Rob Merrifield:** So what are you trying to do? What are you changing the act to?

**Hon. Dave Chomiak:** One of the options being considered is that we would have patient, pharmacist and doctor and there would be a relationship between patient, pharmacist and doctor that would allow for pharmacists to dispense the drug with the consent of the doctor, not necessarily a Manitoban doctor.

**The Chair:** Mr. Thompson, a quick one.

**Mr. Greg Thompson:** Still, the idea of the pharmacist dispensing the drug, you're still not addressing that issue of anonymity where patients are being signed off without that close supervision or scrutiny that would normally occur. What you're suggesting now, Mr. Minister, is the pharmacists are going to have the ability to sign off, so the person who sells the drug is now the person who's going to write the prescription. Do you feel that--

**Hon. Dave Chomiak:** No. An American doctor who sees the patient could write a prescription that could be filled by a Manitoba pharmacist, just as a Manitoba physician can write a prescription that can be filled by a Manitoba pharmacist.

**Mr. Greg Thompson:** What stops that from happening today--simply because there is no provincial legislation that allows that to occur?

**Hon. Dave Chomiak:** At present the regulations permit a pharmacist in Manitoba to fill a prescription by a doctor who is licensed in Canada.

**Mr. Greg Thompson:** But that's the co-signing aspect of it.

**The Chair:** Mr. Thompson, I think you're finished.

Mr. Dromisky.

**Mr. Stan Dromisky:** Yes, just a simple question. I'd like to know what your government's position is regarding a national databank pertaining to drugs and a drug review process. I know you're involved in some of that right now but I'm talking about a process and a databank that could be shared between and among all the people who are involved in that critical stage of providing effective care service to a certain individual.

**Hon. Dave Chomiak:** Just 100% support, unequivocal. Anything we could do to assist that process, we've been active and would be active in.

**Mr. Stan Dromisky:** I hear that kind of talk in Ottawa, too, but I'm not too sure what it really means because I know in Ottawa a lot of information flows into the Canada Health Department but it stays there or it's buried and nobody seems to have much use for it, or it is not being put to use. I don't know what the answer really is. All I know is it's a dead end.

**Hon. Dave Chomiak:** Two points. I'm sorry. Part of the difficulty, I think, we find that the black hole of information, there's no question on that.

The second point is our own PHIN system. We can and if we could legitimately make it available, we would, in terms of cross patterns.

I think the third thing is that we have found that the personal information legislation has hindered some of these issues and we have found that with out research ability. In Manitoba we have the largest database of health information, perhaps in the world, and we've managed to work a way around it by specific legislative amendments and I think we're going to have to look at that in terms of drug and other related issues because I think that's probably one of the main factors.

**Mr. Stan Dromisky:** I have one little question related to that and that pertains to your colleagues across the country who have the very same position as you do in the cabinet,

has there at any time in the past year or two or three been discussions pertaining to the sharing of information on a databank of that nature?

🕒 (1410)

**Hon. Dave Chomiak:** The implications are very broad because the larger issues are issues of application, who has access to the information, is that information saleable, etc. It becomes very complicated.

The use of the database and having particular criteria applied to it has been successfully utilized for research and other clinical purposes, but I don't think we've effectively done that in terms of drug information if that's where you're going and I think we are encouraging of that.

**Mr. Stan Dromisky:** Thank you very much.

**The Chair:** Mr. Robinson, a quick point.

**Mr. Svend Robinson:** On the American doctor thing, just to say I think I would proceed with extreme caution on this one. I think the potential for abuse is very grave if you go down that road, but obviously that's something you'll be looking at seriously.

I did mention earlier the evidence we heard this morning from a group of pharmacists, the Coalition for Manitoba Pharmacy, that did raise the concerns about a couple of the drugs that you had said you'd looked into and I very much appreciate that.

I understand they have been seeking a meeting with you and I know it's tough to schedule meetings, but I would just encourage you, if it's at all possible, particularly in following up on this issue, to meet with the folks from this coalition that met with our committee. It'd be very helpful. They did raise some important concerns and I would hope they'd be able to raise those same concerns with you as minister in the near future.

**Hon. Dave Chomiak:** Thank you.

I was under the impression that they presented to our caucus which I attended last week, but...at least some of the members of the group were there as well. So if I haven't met with them recently, I've met with groups of parts of them last week and I will continue to meet with them. My deputy minister met with them as recently as a week ago.

**Mr. Svend Robinson:** Thank you.

**The Chair:** If my colleagues can tolerate it, I have a couple of questions too.

We're not unaware of the pressures in government between health industries and industry ministries. There are many people who've served on the health committee who would like to repeal Bill C-91 and we know it has something to do with the increases in

prices and all these points you made so well in your presentation. Therefore I have to assume that this new mail order or Internet drug industry in your own province is probably adding something to your gross domestic product that is considered favourably by your colleagues in cabinet and I understand that.

But the piece of the puzzle that bothered me was the potential shortage of certain drugs and I'm wondering if from the bully pulpit that the minister of health has whether you'd made any enquiries to the major pharmaceutical companies to increase the amount of product that they would normally and traditionally have allocated to Manitoba?

In other words, if this new industry increases your economy, creates a whole bunch of new jobs, brings money into the province and does not drive up the price, it might get to the point where it would be kind of a wash. The main thing I think we want to be sure of is that Manitobans and therefore Canadians are not denied access to certain drugs because a truckload of them has just flowed over the border to some patients in the United States. So it would seem to me the manufacturers want to make money. They need to be told that they need to increase Manitoba's allocation to cover the increase in business that is coming from here.

**Hon. Dave Chomiak:** Thank you.

I think your comments are well founded.

We are in contact regularly with the industry and I know I've written directly to several of them, and we are in daily if not weekly contact with them concerning supply and any perceived or potential shortages.

The issue of the industry providing additional supplies in order to permit an export industry I think would be delicate to discuss with the industry. I don't think we'd be adverse doing that, but I think we probably wouldn't succeed very effectively. But we have got assurances, and we have made it very clear that Manitobans have first access to all supplies and every follow-up we've made in this regard has suggested that.

I won't go on too much on this, but it does raise broader issues and I am not unaware and we're not unaware of the--there are long-term developments and complications in this matter concerning price and future prices, concerning various factors that might occur in the United States and various pressures that can be brought, given political turn of events, and so we're cognizant of that. We're very carefully trying to encourage an industry without hampering or effecting at all the health of Manitobans; and if there any occasion in which we are of the safety of any Manitoban compromised, then we would not fail that.

🕒 (1415)

**The Chair:** I'm wondering if in your own system whereby pharmacists can report to you on drug utilization whether you might add some space on that for them to report

when they can't get access to a drug because then the formation would not be anecdotal, it could be recorded, and it would give you a clearer picture as to whether or not there are these shortages?

**Hon. Dave Chomiak:** On every occasion, both the coalition and other organizations and pharmacists are aware of the fact we monitored and it is monitored on a regular basis and we do have it--oh I see--you're suggesting that we have in place a flagging system perhaps that--

**The Chair:** Each time a pharmacist cannot get a hold of a drug that he or she needs, that they could alert you so that you could collect the data to find out whether it's just the odd day or whether it's an ever increasing phenomenon which was what was implied to us this morning.

**Hon. Dave Chomiak:** I'll ask Mr. Rosentreter to respond.

**Mr. Jack Rosentreter (Executive Director, Pharmaceutical Drug Programs, Manitoba Health):** We met with the Coalition of Manitoba Pharmacists a number of weeks ago and we actually gave them that direct invitation, that whenever they had any particular problems with shortages, they can contact my office, and I've got four pharmacists that would immediately look into it and find out if there's a particular problem.

In the past while in the newspaper, there was three reported shortages by the Manitoba Coalition of Pharmacists. We investigated them. Two of them basically were global shortages but not only in Manitoba but there were in North America. The third one basically stock available in Manitoba. So we did not understand basically where that came from.

**The Chair:** I see.

On behalf of the committee and I think I can say that in this particular period of the evolution of the pharmaceutical industry in Manitoba, none of us would like to have your job, minister. It looks like your stick handling your way through an evolutionary process and it doesn't seem like it's probably much fun. So we're doubly grateful to you for taking time out of your day and bringing your staff along to share your ideas with us, and I'm going to take very seriously your brief which I think was very thorough and helpful to us. So thank you very much.

For the members of the committee, we were supposed to go from 2:15 - 3:45, but we've had some cancellations. I'm going to suggest that we take a break until 2:30 and go until 3:30, at which time our hearing will end.

We're adjourned for a few minutes.



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⌚ (1430)

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**The Chair:** Welcome to this session of the Standing Committee on Health and its study of prescription drugs. It's my pleasure to welcome representatives from the Indian Council of First Nations of Manitoba and from the Women's Health Clinic.

I will caution you that we just have an hour and we need to hear from you in order that we may get some questions in.

From the Indian Council of First Nations, we have Grand Chief, Andrew Kirkness; the Vice-Chief, Glenn McIvor; and the Secretary Treasurer, Tom Kirkness.

I would assume the Grand Chief is going to begin? You have the floor, sir.

⌚ (1435)

**Grand Chief Andrew Kirkness (Indian Council of First Nations of Manitoba):**  
Thank you.

First of all, I'd like to greet the committee. I'm happy that I'm able to get five minutes in. According to what we were told, we have five minutes, and we'll try to do it.

Just a brief description of Indian Council of First Nations' history and involvement with Health Canada, including diabetes initiative. We're an organization that is 19 years old. We're off-reserve and non-status Indians. We represent off-reserve and non-status Indians in Manitoba, and being that, we're pretty hard on...when you talk about any issue, and you're talking about drugs, I guess, the issue of access to prescription drugs by Manitoba Office of Indians and Non-Status Indians. I guess the non-status Indians...a lot of people wonder what that is. We've included in one of the attachments here how these people became non-status.

Now the access to drugs usually is not too bad in communities where you have doctors and a drug store, but many of the small communities don't have that. It is difficult. As far as the non-status Indians, they can't get drugs like the people who are treaty can get drugs through medical services, the Department of Indian Affairs. Non-status Indians do not have status under DIAND's programming to prescription drugs.

Now, from our point of view, all Indians have treaty rights, including health under section 35 of the Constitution Act. That's also attached here. These treaty rights are the basis of the aboriginal envelope and the Primary Health Care Transition Fund. I believe in the third attachment, the transition fund.

So basically what we are here for is to make some recommendations that this committee look at. One of them is to ensure prescription drugs to Manitoba non-status Indians are always provided under the aboriginal component to the fund; involvement of off-reserve and non-status Indians and their organizations in partnership to ensure access to prescription drug programming of Manitoba off-reserve and non-status Indians; ensure those participating in the aboriginal envelope of the transition fund develop methods by which aboriginal people in Manitoba have access to high-cost prescription drugs for growing incidence in aboriginal communities of diabetes, HIV and AIDS, such access to include prescription drugs for emerging cures to diabetes and AIDS.

Now it is difficult, I guess, in some of these communities, as I said, to get drugs. You can't just go into a drug store when there's none in a lot of the small communities that we represent along the bay line. So it is awkward.

First of all, drugs are costly. The non-status Indians, they won't give them any drugs under the Indian DIAND, because they're not treaty.

🕒 (1440)

Non-status Indian doesn't have a treaty card, that's the thing that you use to get drugs. There are some drugs that we cannot get near that they don't...that we have to pay for, certain drugs.

But as I said, it is fairly easy in a bigger community. I presume it would be...I don't know how it would be like in Winnipeg, I haven't had much experience here but in the community that I live in Neepawa Manitoba, we have a place to go see a doctor and then we have a couple of drug stores, one's on a reserve there.

It's fairly good but for the non-status Indian in the smaller communities, it's almost impossible to pay for the drugs. When the community is actually 90% unemployed, how do you...you can't buy drugs if you don't have a job and it's almost impossible.

That's the basic reason for us appearing here. I guess maybe leave it at that and if there's any questions that the committee wants to ask, we'll try to answer them the best that we know how. Thank you.

**The Chair:** Thank you very much.

Our second witness is from the Women's Health Clinic and it's Miss Madeline Boscoe.

Miss Boscoe we remember your presentations to our hearings on reproductive technology and look forward to what you have to say today.

**Ms. Madeline Boscoe (Women's Health Clinic):** Thank you very much.

I take it maybe tomorrow might be our lucky day on Bill C-13. I hear the gossip circulating, so I assume you're all going to be back in Ottawa for that.

I wanted to thank you very much for creating an opportunity for me to come today. I just wanted to take a minute to introduce to you my daughter, Kay Schwartzman. This is sort of our version of take your daughter to work day because she doesn't get to see what I do very often. You may have questions to ask her later, but not about my mothering I'm hoping.

Before I get into my brief per se, I did want to take the liberty of commenting a little bit on my perspective on the Internet pharmacy piece and perhaps provide you with a bit of information that you may not be aware of. This is primarily driven by the consumer health movement in the United States seeking lower prices because our price review board is better at regulating prices than their open competition program. We should, as Canadians, take great pride in that because there are huge numbers of people in the United States who are not covered who are dying because they can not afford prescriptions. I think we need to kind of put that into the mix.

The other piece is that I think we should be outraged that the pharmaceutical industry would threaten Canadians by withdrawing services in this country because they don't like our practices. This is the same industry that screams about competition, removing barriers and decreasing protectionism in every other jurisdiction. I can't help but think that if we had someone who had been in the Sweato meetings around access to HIV treatment from this very same industry that they would give us a very different kind of perspective on Internet pharmacy regulation.

I can say that as a member of the minister's advisory committee on the health information highway, I feel quite confident that we can develop accreditation and cross border processes that will meet standards for health care that will reinforce what we already have in place.

So I wanted to let you know that you may not get an opportunity to hear from a slightly different perspective, but there are those of us that are quite outraged at this incursion into our sovereignty by the very industry that sits at trade tables and says, free enterprise. The fact that we've been able to deliver a cheaper product to their public says to me they should lower their prices down south. I mean it seems obvious that's what they should do. This is not an industry that is starving to death in any way, shape or form.

So with that little comment, I'm going to talk to you about women's health and why we're here before you yet again.

The Women's Health Clinic has been around as a community health centre for women for over 20 years. Our commitment has always been both to improve the health quality of care for individual women but also to address public policy issues that are relevant to women. Our big project right now is actually reducing poverty for women, so in fact I should be talking to the economic committees of the House rather than health protection, but drugs and devices have been a big, big problem partially because of the lack of good regulatory teeth in drug approval processes at the federal level.

I'm going to just read off a few of them for infamy's sake, diethylstilbestrol, a drug that was given to women to prevent miscarriages. It never prevented miscarriages, but caused all sorts of horrible sacral in the offspring. The Dalcon Shield, DepoPrevara, breast implants, reproductive technologies, the over medicalization of our health.

Currently we've been dealing with things like the impact of direct consumer advertising for Dian 35, which is technically a second line treatment for acute acne, this is a very tough drug. The marketing is it's a contraceptive with this neat side effect of clearing up your complexion, which has been very problematic in the health and safety area.

As well we've been pleading with the department for years and years to take a proactive response to RU-486 and non prescription status for emergency contraceptives.

🕒 (1445)

We think that, as we go forward, it is really critical that we develop a framework for managing pharmaceuticals in Canada. Right now it seems to us that there is a dialectic. Is this about helping an industry develop and thrive or is this about health and health care? You can't have it both ways. You have to come to ground, one way or the other.

We also think it's really important that we have something that talks about our values and beliefs about drugs and what their role is in health care. Too frequently we are able—even for free—to prescribe things like antidepressants, sleeping medication while those of us in the health field know that in fact if we were able to offer people free massages, free access to exercise, for example with child care, those folks would do just as well with those interventions, but we never offered them because we do not think about it as a whole package. I say that not just as providers but as a society as a whole we like to run to treatments when we don't necessarily need them all the time.

It is also important that we need to remind Health Canada that its role is to advance and protect the health of Canadians and that the development and provision of drugs is a contribution to economic growth. It is not its mandate nor, frankly, its mandate to protect the interests of the media, which I'm adding now given the expressed enthusiasm by newspaper editors for direct-to-consumer advertising in our country. I agree that our

media needs support. Our grassroots media needs support, but I do not think it should be on the back of health.

We need to really enshrine much more strongly a gender based analysis in all aspects of drug management. Despite Health Canada's statements on requiring gender equity in drug research of any kind, that is not occurring in any substantive way. Within the CIHR I've even put inquiries in and it is going to get back to me.

We strongly support the implementation of the recommendations from the Romanow Report and the National Forum on Health regarding establishing a national pharmacare program with a cooperative buying program. We need to get past the territoriality and develop consistency and expectations for Canadians.

A national formulary, on which we all need to have non-prescription drugs such as condoms and emergency contraception, I must emphasize, is really important. The term catastrophic means very different things to very different people, and in the practice we have, lack of condoms is a catastrophic event.

We need a much more robust and transparent consultative process in both the approval and review of drugs as they go onto the formulary. Recently, for example, in fertility treatments were removed from some provincial formularies without any consultation or debate and with affects for those Canadians who are dealing with this condition who can't afford them elsewhere, you need to remember that there is a gender bias in participation of Canadians and extended medical benefits. People who are part time do not get access to those benefits and the far majority of those workers are women.

We do support, in a very guarded way, improved timely access to drugs, but we need to unpack this a little bit. There's a very big difference between a new drug when you have an old drug that isn't working for you and you're dying and a new drug that's going to be used for healthy populations to prevent something, hopefully. We need to be much more sophisticated in our analysis and our thinking about what this means.

We also need to tie this into a much more robust post-marketing and adverse reporting process than we have, and we need to fund that. I'm sure that you will hear from other researchers in the community about how frustrated they are with the way in which the pharmaceutical industry has been using its budget, that there is no comparison, that there is very little post-market work and that is by far where we need those investments. Because we do not, as Canadians, have power over where those dollars are, we get very frustrated very quickly.

I think, in fact, that we have lots of evidence to say that we do need to repeal the Patent Act, the protection act for this industry. It has had lots of chances and it has had lots of criticism and it doesn't seem to be able to respond.

We also need to think about a decision making process for how we approve and bring new drugs onto market. There is an assumption by the Canadian public that once we

approve a drug people are going to have access to it, that if we think it's good enough to be marketed, we should think that it's good enough to go onto our formulary and become part of our parcel of care...

🕒 (1450)

Which means that we think about it not as something that needs to be sold but as something we need and does it add value. That's quite a different process.

Norway, for example, has used this system for over 15 years, basically saying there's a need clause in their drug approval process so that the staff are not overwhelmed with same-as or drugs that are being changed slightly to protect their patent, patent protection, but they ask what is it we need and then we'll approve it.

This leads me, briefly, to a couple of other points. You asked about international harmonization and I provided you with a summary of a very detailed paper about this. There are right now ad hoc meetings, which Canada participates on, primarily set up by the industry called the International Conference on Harmonization of Technical Requirements . This is primarily an industry-sponsored group with the participation of Europe, the United States and Japan with the view of trying to blend approval processes for drugs.

On one level this sounds like a very useful process. However this is not a process that's open to public scrutiny, it's not done under the auspices of the WHO or other international organizations that represent the interests of government. We think it would be very useful for this committee to actually explore this in some depth.

We are concerned because of our similar issues. One is that there is no gendered analysis or requirement in these processes right now, it looks like Canada is starting to adapt these recommendations in Canada without any public scrutiny or debate or discussion. I'll leave it to you. I've left you with a small booklet that goes into this in some detail. We actually have one of those big sucker documents if you ever want to read 200 pages on international harmonization of drug approval on the way home to Ottawa or something like that.

My last point is really about consumer health information and direct consumer advertising. We are in the business of trying to provide credible health information to the public and we think it's of critical importance. Our brief to the Romanow commission stressed that it's very frustrating to believe that you want to empower Canadians and you do not give them access to good, intelligent information about it. Canadians are overwhelmed right now with the promotion materials of the United States.

I circulated a little graph coming out of the Canadian Medical Journal this month on the costs of promotional advertising in the United States, it's close to \$21 billion so you can just do the math here. Yet, I would argue that advertising is not information any more than it was five years ago, it's just getting worse. We need to develop a coherent strategy

on providing consumer health information on drugs and devices to the public in the context of managing the disease because it's not just about drugs.

I'd like to observe that in fact, from my perspective, DTCA looks like information in the same way like sand looks like water to a thirsty man, that this is not a panacea to our problem and it's a real one, we've never invested in it and we need to.

My last comment is around a compensation fund. This is a new idea, I suspect. As someone who has worked with people who have been hurt by drugs and devices who tried to use the criminal courts and class action suits to cover compensation for their injuries, whether those were fraudulently experienced or not--that is that the company knew that there is something terribly wrong and did nothing about it or that it's a legitimate error coming from putting something on the market perhaps a little prematurely--Canadians are being put out-of-pocket in many ways as a result of exposure to these things. I think we have a right and a duty to think of a mechanism to address this because these things are happening and will continue to happen.

The last is my own, as an organizer at women's health clinic. The amount of energy I have to put into spending time helping the Canadian public understand some of these issues is enormous.

🕒 (1455)

There are very few of us out there in the public talking to the public about these issues. I think the fact that, for example, there may have not been consumers up here talking about Internet pharmacies and why that's helpful for them is about the lack of an infrastructure in the voluntary sector to address these issues.

I'll leave it at that. Thank you very much.

**The Chair:** Thank you very much, Ms. Boscoe.

We'll move to the second portion of our meeting and Mr. Merrifield will begin the questioning.

**Mr. Rob Merrifield:** Well, thank you for coming in. I wasn't going to comment on it, but you waded into it, so I have to.

Forgive me if we're not all as excited about Bill C-13 as you seem to be. This is a piece of legislation that we worked two years on very, very hard and the piece of legislation that's before the House does not reflect the view of this committee, when it came to the actual recommendations that we felt we put forward in a very non-partisan way. But nonetheless, it's proceeding. Hopefully, we can use some sanity, as we move ahead with that piece of legislation or, hopefully, make a new one that's better.

That's the one thing. The other thing is you also waded into the Internet issue. You're saying that it's there to help those in the United States who cannot afford the more expensive drugs in the United States and your passionate plead for that. I wonder how you square that with: right now we have a challenge in our wheat, with the countervail or duty on our wheat because the claim is that it's subsidized through the Canadian Wheat Board; we have the softwood lumber that has a 27% countervail and tariffs on; we have the threats of steel and other products going into the market, to the United States, that they are saying we are subsidizing.

Now, why would you not think that they look at our drugs through our patent law and price review board as a direct subsidy, in the sense of artificially lowering the price of those pharmaceuticals? Do you not think that that challenge would raise the price of our drugs, rather than force lower ones south of the border?

**Ms. Madeline Boscoe:** Because I believe--I'm going to say "believe" because I'm not an expert in this--that the way our Drug Price Review Board works is it makes some assessment of what it actually costs to produce the drug and develop it. It's not necessarily related to the generics. It's actually the cost of the same drug--literally, the same drug--in Canada and the United States by the same manufacturer, the same stuff, the same materials. The name on the label might be the same, but it comes from the same source. It's just that we have a review board that limits what they can--

⊕ (1500)

**Mr. Rob Merrifield:** And they'll say that you're doing it on a 30%-less-valued dollar, so, in essence, you're buying power and then competition between the two countries is there and then you're flooding that into another market. Our challenge is that it's going to compromise cheaper product for Canadians, under the patent law that you just said we should throw out and review, but that's the one that has given us the cheaper brand name products, but the generics, you say, we should maybe put under the price review board, but generics are not part of patent law and they're much higher than the United States. It's a very difficult thing, and it's not as simple as: we can say, "Just throw it out". It's a very complex issue.

**Ms. Madeline Boscoe:** No, I think Mr. Romanow--and I agree--called for a review of the Patent Act, which I think is about to take place. The issue for the industry was a 20-year patent, on the assumption that this amount of money would be invested into research in Canada. The kind of research we're getting into Canada right now, I would argue, is not quite robust enough. It's very much on the clinical trial. There's very little on actually comparative studies or post-marketing surveillance.

For example, in a review, where one would like at that, it might be useful to put those issues on the table and address that.

**Mr. Rob Merrifield:**

Sure, I understand where you're going with regard to where the research dollars are. Is it going to actual research or is it going to studies? And I think that's what you're saying.

Fair enough, if you want to look at that in our patent law. But to just throw patent law out and say it should be repealed--

**Ms. Madeline Boscoe:** Reviewed, yes.

**Mr. Rob Merrifield:** --without recognizing that that's reason we have the cheap products and actually give us the dilemma of the Internet problem and so on. It's not really a dilemma, it's actually an advantage here that we have in Canada because of that law.

But, at any rate, that's a little off the subject you even came to talk to us about, but I just want to make those comments to you.

**Ms. Madeline Boscoe:** Okay, thanks.

**Mr. Rob Merrifield:** But I do want to go back to the non-status Indians and I would just make these comments. I'm not sure that what you're asking for is under the jurisdiction or really in our jurisdiction at all with regard to whether you should have a card or not. And that's really what you're coming here saying is that you can't afford these drugs because you don't have a treaty card. Really, we're looking at the health and safety and actually more on the addiction to prescription medication that I know the native population is victimized very much so because of that problem. But whether you get drugs under the card or not, it's still a significant problem for you. But I don't think it's in the purview of this committee to really deal with whether you should be part of the drug plan, let's say, of the government as a Treaty Indian.

Maybe I'm missing the mark here some place and you could help me with that?

**Grand Chief Andrew Kirkness:** The status Indian, they get drugs free of charge. A non-status Indian doesn't get any. Now all I'm saying is I'm making a recommendation that they be able to be treated the same as a status Indian. After all, they're all Indian. Okay? The only thing is that one guy has got a card and he's Treaty and the other guy, for some reason or another, doesn't have it because maybe something happened. Like, you have the attachment, the reasons for them being in that situation. There's 18 points. I mean, I was given this, but I could think of a lot more people who have lost their status. But all I'm saying is that we make certain recommendations that these people be treated the same.

⊕ (1505)

**Mr. Rob Merrifield:** Yes, but you have to understand that it will be the same thing with the entire population. They're going to be coming saying why aren't we treated the same? We get that all the time.

I just don't think that it's something that we can deal with, but nonetheless I'll read your recommendations and read your information and find out exactly why you're in that situation and follow through from there. But, that's my comments.

**Grand Chief Andrew Kirkness:** Then if you want to know why we're saying that we have a different...I know that non-Indians is different from the Indian because an Indian, if you look at the Constitution Act it states in there that we have a special status, were special status with the Crown, it's right in the Rights of Aboriginal Peoples of Canada.

That's all we're saying is that we'd like to see some kind of a recommendation or something said on that. Maybe the battle is over here where...a lot of these people are trying to their status, they're Indians but they can't seem to get the proper information to make that connection so that...I mean they're ancestry for some reason, there's no documents to say well, this was my father, he's a full Indian, why can't I get that same status.

That's where the problem is in a sense but all we're saying is, okay make these recommendations. I mean the committee, from my understanding is going around saying, what are some of the problems. I presume that's what you're hear for, I don't think you're here just for the fun of it.

We're just making that recommendation. If you choose to say something on it when you make your report that would be up to you. But if you don't then I guess...

**The Chair:** Thank you Mr. Kirkness. Thank you Mr. Merrifield. Next we'll have Mr. Thompson.

**Mr. Greg Thompson:** Thank you very much, Madam Chair. I'm just looking through, sorting through all this paper here, trying to figure out all these names. I think I'm overloaded here today with paper.

Ms. Boscoe, I was interested in your reference to Americans buying drugs over the Internet. Just for clarification, the cost of drugs in Canada as compared to the United States has nothing to do with the price, the Patented Medicines Prices Review Board, has nothing to do with the cost of manufacturing drugs. What it is it's basically we have established a model where the average price in seven industrialized countries most of them in Europe drives our price and then it's limited to inflation factors in terms of future increases in the price. It has nothing to do with the cost of the production of that medication either in Canada or United States.

What I would suggest that some of the people that you represent, your constituency if you will women and particularly disadvantaged women and I presume rural women are included in your mandate, are not being well served by that. They're not being well served by that because we heard testimony today that we have a shortage of skilled pharmacists that are dedicating themselves to the American market. I understand the empathy and I understand your concern because I have relatives in the United States and

I know they're held hostage by their system of regulated or unregulated drug prices. I agree totally with you.

But unfortunately, Canada has only a tenth of the population of the United States and we've got 300 million people scrambling for cheaper drugs. Unfortunately some of our citizens are suffering because of that not only in terms of shortages of pharmacists but doctors writing prescriptions in absenteeism if you will which is wrong, completely wrong. There's some evidence that it's in fact starting to drive up the price of drugs in Canada. But we're losing that critical element that is the pharmacists that provide very factual and detailed information to people that you and I both represent. I want to make that point.

I know that you are sort of freelancing beyond your for a little bit when you introduced that. But we really appreciate you coming and the work that you do with your people. I just want to put that on the record which might be helpful to you in all of this. And it's particularly nice to see your young daughter with you because it's a real treat to have people younger than we here at the table. They're the future and it's such a learning experience. I'm always somewhat ...

When I was a young person, I was fascinated by politics and how government works and I always dreamed of going to Parliament and I had to wait until I was in my thirties or forties before I arrived. But it's nice to see you bringing your young daughter out here.

**A voice:** It sounds like a nightmare.

**Mr. Greg Thompson:** It does, yes. I'm often reminded of John Diefenbaker in terms he said he went into the House of Commons, he was always kind of scratching his head and just amazed at how he got there and finally after about 30 days of watching all the other characters he's trying to figure out how they got there. But anyway, just a little bit of humour.

But your information, as you noticed during your testimony, I was going through it and I'm impressed by the work that you've done and I'm going to take that home for future reading. I don't want to pass up the opportunity, Madam Chair, to talk to our Metis group here today and understand their concern.

⊕ (1510)

**The Chair:** They're not Metis. They're non status.

**Mr. Greg Thompson:** Non status, why did I say Metis? Did I say Metis?

I'm looking at my wrong paper here, excuse me for that but non status.

I was taken, Mr. Kirkness, by your presentation in terms of the affordability of drugs and the difficulty that it imposes on your community. And again, anything that we could

do to help that I'm sure we will. I guess if we could take one message back to the Minister of Indian Affairs, what would it be?

**Grand Chief Andrew Kirkness:** Well I guess you should tell him to recognize Indians as Indians. About a few years ago, I was a non status Indian. But now I'm a status Indian. Bill C-31, I presume you've all heard about Bill C-31, when the court case came out that that the people ... a lot of the women who lost status because they married non Indians lost their treaty. On the other side, when a white woman married an Indian, she became treaty. I mean it was really crazy. It was absolutely crazy. Do you know what I mean? But now that they put that in order now we have a lot of these Indians caught out there, can't get their treaty number.

**Mr. Greg Thompson:** What do you think we have to do to find a way or solution around that, because when you're talking about the number of your people who don't have income, 90% not working, and the hardships that would bring in terms of their medical health? We know that the diabetes issue is just one example of that, but it's a huge problem.

Madam Chair, I'll turn it over to you and Mr. Dromisky will have his chance. Again, if there's any information you can provide to us additionally to what you have, we'll do whatever we can. I'm not on the aboriginal affairs committee, so anything you provide to me will be very helpful.

Thank you.

**The Chair:** Thank you, Mr. Thompson.

Mr. Dromisky.

**Mr. Stan Dromisky:** Thank you very much, Madam Chairperson.

I'd like to talk about the non-status natives who are in Winnipeg, for instance. There are thousands of native people living in Winnipeg at the present time. Is a very large percentage of them non-status, or do they still have their status?

**Grand Chief Andrew Kirkness:** I believe approximately 10,000 Indians in Manitoba, or close to that, got their treaty status back. I don't know how many still ... you know, you fill out a form and you send it down to the reinstatement unit. They keep asking for more information and we can't make the connection. But there's lots of them. Don't get mixed up with the Métis--Métis are Métis, and Indians are Indians, period, whether they're status or non-status. These are Indians. Now, don't ask me how you'd describe a Métis, because I don't know anything about it.

⊕ (1515)

**Mr. Stan Dromisky:** There are many reserves in Manitoba, just like in northwestern Ontario and other parts of Canada, and when a native person leaves a reserve and comes to live in Winnipeg, do they become non-status?

**Grand Chief Andrew Kirkness:** He's an off-reserve Indian. You see, that's the other catch.

**Mr. Stan Dromisky:** Okay, off-reserve. Now, we know that for every person registered in a band, say there's 1,000, each one gets an allocation of so much money that comes into the chief and the council to spend on whatever they have to spend it on. When someone leaves that reserve and there's no longer 1,000 people there, does the money follow the people who leave, or is the money decreased?

**Grand Chief Andrew Kirkness:** No, the money stays there. I'm a member of a band and I've not been there for a number of years. Whatever money goes in there, I guess it stays there. I don't get any benefit out of it because I'm off-reserve. This off-reserve thing is kind of a ... we're caught between a rock and a hard place. But what happens is, even for funding, you go to the government. Say you're the provincial government, you say it's your responsibility, as the Department of Indian Affairs, your federal responsibility, so you go to them for funding or something and they say, yes, but you're an off-reserve Indian. So where the hell do you go? It's difficult.

Right now we're working on diabetes.

**Mr. Stan Dromisky:** Those natives who left the reserve in Winnipeg, and the money is going to the reserve, wouldn't the chief and council be responsible for covering the cost of those people who are living in Winnipeg are concerned as far as their drugs are concerned?

**Grand Chief Andrew Kirkness:** Yes.

**Mr. Stan Dromisky:** So they have no problem then? They should be able to get their drugs.

**Grand Chief Andrew Kirkness:** Not too much trouble, no, it's the non-status, those are the ones.

**Mr. Stan Dromisky:** Okay, I've got that clear in my mind. I see the problem

Now, is the problem of non-status Indians here in Alberta because certain treaties have not yet been sort of recognized or ratified, or they're going through negotiations pertaining to certain treaties?

**Grand Chief Andrew Kirkness:** No, not necessarily. The thing is for a long time some of the things happening was that people who were off-reserve.... I remember my dad, that's how I was out. He lived in the community away from the reserve and they

were telling him that to get the benefits you have to stay over there. In other words, you're fenced in. He lived in a community about 25 miles out. What happened was he didn't speak English or anything and he didn't understand. In those days they used to have Indian agents, so he gets a form and it enfranchises him. Anybody in that family under 21 was automatically enfranchised. That's what happened to me and one of my brothers. So, like you say, there's many ways that Indians lost their status.

**Mr. Stan Dromisky:**

I know there were natives from Manitoba who went to war and when they joined up, they couldn't join up until they signed the paper and got rid of their status category. They could not be status Indians--

**Grand Chief Andrew Kirkness:** What would you say was the reason for that?

**Mr. Stan Dromisky:** Pardon?

**Grand Chief Andrew Kirkness:** What would you say was the reason for that?

**Mr. Stan Dromisky:** Oh, I don't want to go into that. You know why.

So there you are. These people have come back and they have not been able to reclaim their status.

⊕ (1520)

**Grand Chief Andrew Kirkness:** They should be able to under Bill C-31 but then there are some who didn't--

**Mr. Stan Dromisky:** I know, but I'm talking about all those years that have gone by where they went to fight and many of them died and they gave up their status because they wanted to do the right thing for the country and for their own people and for the rest of the country, and whatever. So there you have a situation where these people were penalized for many, many years.

**Grand Chief Andrew Kirkness:** together.

**Mr. Stan Dromisky:** And even Bill C-31 is not helping some of them.

**Grand Chief Andrew Kirkness:** No, it's still discriminatory.

**Vice-Chief Glenn McIvor (Indian Council of First Nations of Manitoba):** Under section 6(1) and 6(2) of the Indian Act, it's discriminatory. For example, if I were to marry a non-status woman--a white woman, for example--being an Indian male I can pass my status under section 6(1). If I was a status Indian under 6(2) marrying a white woman,

then I wouldn't be able to pass my status to my children, and Indian, that's where the cut off is.

We would like to see Indian people, off-reserve or regardless, if you're an Indian you should be recognized as an Indian and not anything else, like 6(1) or 6(2). Categorizing your people is not a good thing to do in Canada.

**Mr. Stan Dromisky:** They've done that in Edmonton. An Indian is an Indian, is an Indian. It's absolutely clear.

**Vice-Chief Glenn McIvor:** Yes. For example, I have a granddaughter who can't be Indian but I'm a treaty Indian. My kids had the 6(2) status because my wife wasn't eligible for status. That discrimination shouldn't be there in the year 2000. That should be excluded and an Indian should be an Indian.

I guess when you're talking about drug costs, the other thing I wanted to bring up was that we've had a meeting in the past where other organizations in Winnipeg had meetings in Manitoba regarding discontinuation of delivery of drugs to U.S. . If you lived in , we'd have to ship drugs from here to you, so we're trying to discontinue that and you can't do that.

The primary sickness in first nations people is diabetes and the cost of that is \$1,000 to \$2,000 per month. If you start paying for your own costs when you don't have a job it's pretty hard to try and pay for your \$300 drug bill when it comes in, to try and receive the drugs. I guess that's the main concern we have about drugs, the cost to deliver them to the reserve.

They tried that up north and we said, "No". We're recognized under section 35 of the Constitution and we want these services delivered to us. As I said, diabetes is the primary sickness among first nations.

Going into a little bit of that, we did have a program with from Ottawa. It's called the Diabetes Options Project Initiative and we had a contract with them under Ottawa and the Indian Council of First Nations of Manitoba, Inc. for 2003-2004. We're having problems with them. We're trying to get funding, trying to continue the project. We're trying to go to the communities. Maybe we can eliminate some of the costs if we can educate them ahead of time to exercise with diabetes and trying to work against diabetes, but it's hard when you don't have funds to do that.

That's what it costs for shipment of diabetes because people are not education about this stuff. They're not being given information ahead of time to try and work against it, especially the younger generation now who should have that information. They should be able to look after themselves without having to go through all the complications of what diabetes can be, as well. It's pretty hectic.

**The Chair:** Thank you, Mr. McIvor. Thank you, Mr. Dromisky.

I have a question. If an Indian is a non-status Indian and is unemployed--as you said in your community about 90% are--it means they don't have a card to give them access to the pharmaceuticals they may need. But if they're non-status, do they not have access to social assistance and if they're accepted as recipients of social assistance, does that not give them access to free prescription drugs?

**Grand Chief Andrew Kirkness:** It should be covered, I guess, if they're on welfare.

**The Chair:** Yes, that's what I mean.

**Grand Chief Andrew Kirkness:** But this welfare system is an off and on thing. It's difficult, some people work part time. That's the only kind of jobs they have, for instance, fishing....

**The Chair:** Oh, so they're seasonal workers or they're part time workers. So they're not totally unemployed.

⊕ (1525)

**Grand Chief Andrew Kirkness:** Sometimes they have three months and they get cut off the minute they start to make a few dollars. But nevertheless they have a great deal of problems with drugs regardless of....

**The Chair:** So essentially it's a matter of poverty, working sometimes, not working other times and then getting a little bit of part time work. You're not totally unemployed, therefore you can't get social assistance, but you don't have a card. All right, so it's something like Ms. Boscoe's clientele.

We're talking about lack of access to pharmaceuticals, to prescription drugs due to economic conditions and it would be the same thing with your clientele.

I have just one comment to Madeline Boscoe. I'm really glad you came today, because I work single-handedly trying to enlighten Mr. Merrifield about feminist theory and his homework is going to be to memorize all the words in your pamphlets over the weekend. We're going to try to keep him out of Ottawa on Friday when Bill C-13 is up.

**Ms. Madeline Boscoe:** I did want to say that is absolutely true around this issue of unemployment insurance and welfare and working in the employed sector.

When we did our research on our women, income and poverty project, quite a huge big document again, one of the things we found when we did focus groups with women and it would be the same for working men is in that movement from welfare where they did have some minimal coverage, not maybe as robust as it should be, but some minimal coverage to working, the gap between minimum wage and the benefits that those entry level jobs had and welfare meant that in fact it was better for them to stay on welfare because they lost income.

So that, to me, is another issue around getting a handle on a pharmacare program where we don't have some of the crazy shenanigans that end up going down.

**The Chair:** Mr. McIvor wishes to say something else.

**Vice-Chief Glenn McIvor:** I guess also the hard part of it is, for example, if you come down with a sickness and you don't have...if you're off the job for a couple of months and you don't have any options and when you do get your paycheque all that paycheque goes to medication, but you don't have anything to go to cost of living, food, stuff like that. That makes it hard, especially if you go for a period....I listen to the radio a lot of times and you hear about people going through cancer treatments, six months and they don't have any money to buy medication. A lot of people, because they lack that financial help just go on and they pass away, but there should be no need for that.

I was in a situation like that one time, but I'm not going to go through that, but that's the bad part of things like that when people can't help themselves.

**The Chair:** Mr. Thompson, do you have another comment?

**Mr. Greg Thompson:** I had a short question for our youngest witness and if we could put the youngest witness' name into the record, Madam Chair, it would be helpful.

**The Chair:** I'm sorry, I missed it.

Give us your name.

**Kay Schwartzman:** Kay Schwartzman. My full name is Katherine.

**Ms. Madeline Boscoe:** Katie was hoping you were going to ask us a question about emergency contraception.

**Mr. Greg Thompson:** I have a question for the youngest witness, Madam Chair--

**The Chair:** Yes, please go ahead, Ms. Schwartzman.

**Mr. Greg Thompson:** --and I think this might sum up the entire sense of the meeting, the feeling of all the meetings we've had.

An answer that most politicians don't give, it's going to be a yes or no answer and hopefully it'll be yes or no, but do you think the price of drugs in Canada should be lower to help all sick people? Yes or no.

**Kay Schwartzman:** Yes, actually, because they want to keep the population up so we can keep our country running and if they want to help people get better, why have the price of prescription drugs so high or any other drug for that matter?

**Mr. Greg Thompson:** That's a pretty darn good answer.

I have nothing to say, Madam Chair. I think that sums up a whole week's work don't you?

**The Chair:** On behalf of the members of Parliament, I want to thank you very much for coming down from The Pas and for coming from your very big responsibilities at the Women's Health Centre and presenting your ideas to us and putting them on the public record which they now are. We will be reviewing what you've said as we move forward and try to develop the framework and the meat around the framework of a report.

Thank you very much for your time and your effort.

Before we adjourn, ladies and gentlemen, I would like to thank the interpreters who have followed us in our western tour and our technicians, thank you very much and our researcher and our clerk. I think we should give them a little hand.

**Some hon. members:** Hear! Hear!

**The Chair:** With that, I will adjourn these hearings and look forward to see you all in Ottawa.

The meeting is adjourned.