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Chair

Ms. Bonnie Brown

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● (1530)

[*English*]

The Chair (Ms. Bonnie Brown (Oakville, Lib.)): Good afternoon, ladies and gentlemen. It's my pleasure to welcome you to the 24th meeting of the Standing Committee on Health.

We are studying the *Report of the Auditor General of Canada*, chapter 4, “Management of Federal DrugBenefit Programs”, which you will recall we started a couple of weeks ago. This time we are going to hear from the Department of Citizenship and Immigration, the Department of Veterans Affairs, and the Department of National Defence. Following that in the question and answer period, we will also have the advantage of the Auditor General and representatives of the Department of Health to help answer these questions. However, the statements will be limited to the people from whom we have not yet heard.

So we'll begin with the Department of Citizenship and Immigration and hear from Lyse Ricard, who is the assistant deputy minister, operations. She is assisted by Sylvie Martin, directorof strategies and policies, medical services branch.

Ms. Ricard.

[*Translation*]

Ms. Lyse Ricard (Assistant Deputy Minister, Operations, Department of Citizenship and Immigration): Thank you, Madam Chair.

I am pleased to be here today to speak about Chapter 4 of the Auditor General's November report on management of federal drug benefit programs.

I am accompanied today by Dr. Sylvie Martin, Acting Director of Policies and Strategies, Medical Services Branch at Citizenship and Immigration Canada.

Citizenship and Immigration Canada is pleased to welcome the recommendations of the Auditor General. The action plan we have tabled with the Committee outlines our response to the report.

CIC's Interim Federal Health Program provides health care coverage for certain classes of migrants under immigration's jurisdiction. The main groups are individuals seeking asylum in Canada and refugees while they are ineligible for provincial health insurance. It also covers the health costs of individuals detained for immigration reasons as well as persons subjected to risk assessments performed before removal from Canada.

The Interim Federal Health Program bridges the gap of health coverage for these individuals from their arrival in Canada, to when they gain access to standard health insurance available for permanent residents. The Interim Federal Health Program is not meant to provide long term health benefits and may not be as comprehensive in its coverage as other federal health programs or as provincial programs. On average, an individual may benefit from this health coverage for a period of 18 months.

[*English*]

The main objective is thus to provide basic and essential health care for certain classes of migrants who would otherwise be without health coverage and who cannot afford to pay for their own medical expenses that they may require.

The department endeavoured to apply cost control effectiveness to the program. For example, we have outsourced claims processing and payments. We are limiting drug coverage to essential or emergency and lowest-cost alternatives, which are modelled after the provincial social security benefit programs; for example, we are replacing brand name drugs with generic equivalents as they become available. We are matching provincial rates for medications and prescription fees to benefit their buying powers and price negotiations. Our drug benefit portion accounts for approximately $5.5 million for the 2003-04 financial year, which is about 10% of the cost of the total program. We cover only low-cost, generic and first-line medication when possible. In addition, due to the nature of the program, the list of medications covered is subject to time constraints and limited to essential medications only.

CIC will collaborate with other federal programs to seek and develop strategies to optimize effectiveness of its programs. In addition, we agree that sharing best practices between federal drug benefit programs will enhance cost savings for all departments.

Thank you.

● (1535)

The Chair: Thank you very much.

We'll move on to the Department of Veterans Affairs and hear from Verna Bruce, the associate deputy minister, assisted by Ron Herbert, director generalof the national operations division.

Ms. Bruce.

Ms. Verna Bruce (Associate Deputy Minister, Department of Veterans Affairs): Thank you very much, Madam Chair, for inviting us here today to talk about Veterans Affairs Canada's pharmacy program in relation to the Auditor General's November report. In our minister's words, it “acts as a tonic to further improve our drug plans and providesVeterans Affairs Canada with an opportunity for even more focused collaboration withour Federal Healthcare Partners”.

[*Translation*]

Before I get down to the business at hand, I would like to introduce Mr. Ron Herbert, Director General of our National Operations Division, and Ms. Orlanda Drebit, Director of Operational Guidance and Direction.

[*English*]

As chair of the Federal Healthcare Partnership, I would like to recognize as well Marie Williams and the work she has been doing with the partner departments in response to chapter 4.

Veterans Affairs Canada delivers a national health care program that includes 14 kinds of treatment benefits, the well-known veterans independence program, long-term care in institutions, and health promotion. Qualified clients can access these benefits through the use of their Veterans Affairs Canada health identification card. Our annual health care budget is approximately $800 million.

Our pharmacy program is sizable. This year we estimate spending $119 million on pharmacy as a result of some estimated 4.5 million transactions. The Auditor General's report identified 133,400 clients. More than half of our clients are 80 years of age and older, and their health care needs are becoming more intense and complex.

I think we would all agree that our veterans are pretty special Canadians and are deserving of an enhanced level of health care benefits. We believe all of Canada's veterans deserve the same level of care, regardless of where they live. Essentially, we top up what the provinces provide to ensure this consistent level of care.

Other examples of our enhanced services to veterans include coordinated case management and our pharmacy program. Safety is our first concern when it comes to pharmacy. I will speak in a few minutes about our drug utilization review process.

After safety, our next priority is the most appropriate and effective treatment for our clients. Like other departments, we have a formulary that lists the most common drugs that can be used to treat various conditions. However, Veterans Affairs Canada also has a special authorization unit that works with veterans' health providers, including doctors and pharmacists, to provide more customized treatment to address unique, complex, and multiple conditions. This customized treatment could very well include drugs that are not on the formulary but are the most appropriate for the situation.

As the Auditor General noted in her report, our drug utilization review process has been in place for seven years. For example, an 83-year-old veteran who has diabetes, a heart condition, arthritis, a pulmonary condition, and cancer—not uncommon—could easily be taking 20 different medications. Our drug utilization review process would look at the interrelationships between all these conditions and ensure that one medication does not increase or decrease effectiveness of another medication. The process also serves to reduce overmedicating.

As a direct result of the Auditor General's observations, we have already increased the complement of resources attached to this process. We are holding a workshop this month to review existing criteria and develop a more robust model. Also, a team of health professionals is conducting a thorough review of the situation cited in the report, that our clients appear to be receiving quantities and/or combinations of pharmaceutical products that could have a negative impact on their health.

In closing, I want to stress that since 1994 the Federal Healthcare Partnership has capitalized on economies of scale for the purchase of health care benefits. As you know, a Government of Canada first-level action plan has been tabled with both the Auditor General and your committee. At Veterans Affairs Canada, we're providing strong support to the Federal Healthcare Partnership task groups, which are exploring cost-effective drug use and system efficiencies.

Again, thank you for the opportunity to discuss our pharmacy program. It's a program that we're proud of and that balances the needs of our clients with the need for cost-effectiveness.

Thank you.

● (1540)

The Chair: Thank you very much, Ms. Bruce.

We'll go now to the Department of National Defence to hear from Major-General Lise Mathieu, commander of the Canadian Forces health services group, anddirector general. She is assisted by Lieutenant-Colonel Régis Vaillancourt, pharmacy policy and standards.

Ms. Mathieu.

MGen Lise Mathieu (Commander, Canadian Forces Health Services Group, and Director General, Department of National Defence): Thank you Madam Chair.

Thank you for the opportunity to be with you today to discuss DND's response to recommendations in the Auditor General's report, chapter 4, “Management of Federal Drug Benefit Programs”. Lieutenant-Colonel Vaillancourt, the Canadian Forces chief pharmacist, accompanies me today.

During the next few minutes, I will provide you with a broad overview of the Canadian Forces health care system, with particular emphasis on our drug benefit program and our approach to chapter 4.

[*Translation*]

The Constitution Act of 1867 assigns sole responsibility for all military matters to the federal authority. Section 91(7) of the Constitution Act serves as the constitutional basis for the Canadian Forces' health care mandate. The Canada Health Act specifically excludes Canadian Forces members from its definition of insured persons. As well, CF members are excluded from insurance coverage under the Public Service Health Care and Dental Care Plans.

[*English*]

Accordingly, I am responsible for providing comprehensive national and international health services coverage to the regular force, to the reserve force as dictated by their conditions of employment, as well as to anyone else as determined by the minister. In all cases, despite the exclusion, I must abide by the principles set forth in the 1984 Canada Health Act.

[*Translation*]

The Canadian Forces provide health care and services to approximately 60,000 Regular Force personnel and to 25,000 Reserve Force personnel in two distinct contexts: at home, which is referred to as in-garrison; and on deployment, which can extend to working under nuclear, biological and chemical conditions.

In-garrison, CF members receive non-emergency, outpatient medical and dental care at 70 military installations across Canada. Secondary, tertiary and quaternary care as well as after hours primary healthcare are provided in civilian healthcare facilities. Health services are provided overseas when and where CF personnel are deployed through a variety of arrangements ranging from locally purchased services to partnerships with other military health services, to full service by the Canadian Forces Health Services.

[*English*]

Specific to our drug management initiatives, a new drug management program was implemented in April 2000 to ensure the best use of resources while maintaining quality health care for CF members. A key component, the CF Drug Exception Centre, is managed by pharmacists and physicians, thereby providing an evidence-based medicine approach to the decision-making process. Our drug management program goal is to achieve positive health outcomes for CF members. This is accomplished by offering a process of individualized clinical assessment for drug coverage where the objective is cost-effectiveness rather than cost reduction.

[*Translation*]

The CF Drug Exception Centre program is guided by three key principles: operational readiness, which ensures that the Canadian Forces Health Services Group will be able to meet medical supply requirements in operational settings; fairness, which ensures all members are entitled to the same drugs regardless of whether the prescription is filled at a base or civilian pharmacy; and equality, which ensures that Canadian Forces members have access to drug therapy similar to that provided by other federal departments and provincial governments.

● (1545)

[*English*]

The Canadian Forces drug benefit list provides a wide variety of both prescription and non-prescription drugs to its members. Our published research has concluded that the provision of over-the-counter medication not only reduces cost but also results in positive patient health outcomes and is associated with a high level of satisfaction for its members.

[*Translation*]

Drugs to be included in the Drug Benefit List are identified by the Canadian Forces Pharmacy and Therapeutics Committee. The decisions made by the CF Pharmacy and Therapeutics Committee are based on the recommendations of the Federal Pharmacy and Therapeutics Committee, an advisory body of health professionals who provide impartial recommendations on drug therapies. The CF Drug Benefit List is continuously under review, to reflect current standards of therapy. The Canadian Forces

[*English*]

also has representation on the advisory committee on pharmaceuticals, which provides the federal pharmacy and therapeutics committee with evidence-based recommendations for all new medications.

[*Translation*]

DND has procedures in place to ensure that effective and appropriate drug care is being provided to our military personnel. These procedures include quality control measures and procurement processes that ensure cost-effective drug therapy is being provided to our Canadian Forces members. Currently, DND purchases drugs using competitive, low-cost acquisition practices.

[*English*]

DND does not maintain an override monitoring system for internal operations, given the highly controlled nature of our operations. However, we recognize that an upgrade to our existing claims processing system is required. Through ongoing collaboration with the Federal Healthcare Partnership, we are working on a project to integrate our claims processing system into the electronic health record.

[*Translation*]

There was no DND specific recommendation in Chapter 4. However, DND was included with the other federal drug plans in many of the recommendations. Accordingly, we will not be tabling a DND-unique response to the recommendations made in Chapter 4. The Federal Healthcare Partnership Action Plan previously tabled before this Committee serves as DND's action plan and reflects our commitment to work diligently with the other federal departments in this endeavour.

[*English*]

In conclusion, the core value of our program is to achieve positive health outcomes for CF members. We are committed to working in collaboration with the Federal Healthcare Partnership to optimize our drug management program.

[*Translation*]

Thank you for your attention. I would be pleased to respond to any questions.

[*English*]

The Chair: Thank you, Ms. Mathieu.

We'll now go to the question and answer section of our meeting, and we'll begin with Mr. Merrifield.

Mr. Rob Merrifield (Yellowhead, CPC): I want to thank you for coming in and sharing a little bit about what you each do with regard to the drug programs.

This committee has witnessed testimony regarding some astounding numbers over the last year with regard to drugs in Canada, and actually just a couple or three weeks ago we had the authors of one of those studies come forward telling us there have been 24,000 deaths within our acute care centres alone, and that those numbers could be underestimated by 100%. Those are astounding numbers if they're anywhere close to being accurate. We also know that Health Infoway has had $1.2 billion put into it, so now we're getting into the dollars of it. We also know they have a considerable amount of that money still left.

In your respective department, which is 100% federal, with regard to health care, how are we doing with your electronic medical records following a patient? We know that is the goal for Infoway, and we know Alberta is a long way along on this, and their goal is to have everyone on it within the year. Each of you working on this has alluded to a number, but before we get into the actual numbers of dollars, I'd like to know how far along you are on the performance of that.

● (1550)

Ms. Verna Bruce: I can start from the perspective of Veterans Affairs and also my role with the Federal Healthcare Partnership.

It's fair to say that we all understand that the electronic health record is going to be critical to us for the future, but it's also fair to say that in terms of working together on an electronic health record, that's something we've just started to do more recently.

Mr. Rob Merrifield: So how far? Give us a goal. Give us a timeline.

Ms. Verna Bruce: I'll get Marie Williams, who's our executive director, who knows—

Mr. Rob Merrifield: Okay, and that leads me to another question that's a little more pointed.

Infoway was launched back in 2001. I'd like to know, maybe from somebody else around the table, how you're linked to that, are dollars going into it, and what is the hold-up? I can understand provincial and federal jurisdictions being somewhat difficult to work with when you have different jurisdictions, but we don't have different jurisdictions here, and I would like to know where the roadblock is with regard to medical records following a patient.

Ms. Verna Bruce: I'm touching base with Marie, and our goal for this year is actually to build that strategy in terms of how we connect into Health Infoway.

I think a couple of things are happening, and I'll speak for Veterans Affairs. We are really focused in terms of providing services to our clients, and their health record is a part of it. A major amount of the work we do is around pension benefits. So I think it's fair to say that while we recognize that electronic health records are important, we haven't been spending huge amounts of time on them, and the information we would collect on our clients may be somewhat different from what would be collected by other departments.

So we are just beginning. We hope by the end of this year to have a strategy for what we need in common and how we work together.

Mr. Rob Merrifield: So what you're describing to me isn't a matter of roadblocks being put in your way; it's a matter of not having the political focus, if I might put it that way, to push that agenda.

Ms. Verna Bruce: I think it would be the priorities: there are so many competing priorities in terms of delivering health care.

This is coming up very high on our agenda, but the first step is to figure out how we can work together to create one electronic health record. Then, on the things we need—things that would be very different from, for example, what CIC would need—how do we make sure we're not duplicating the system?

Mr. Rob Merrifield: Yes. Those questions alarm me as well when I look at what's happening in my own home province of Alberta, where employees put $15 million, I believe, into the Wellnet program. They're going to accomplish this within the year, supposedly. Now, that's 3 million out of a population of 30 million—10%. I'm not great at math, but I know that if you multiply that by 10, you shouldn't come up with $1.2 billion; you should be at around $150 million.

That may be unrealistic, to do it in the whole province, but I don't understand where we see numbers coming forward—and maybe the Auditor General can answer this one—with suggestions of $10 billion to be able to accomplish this not by this year, or by next year, or by 2010, but by 2020. When I see those numbers, I guess I'm looking for some answers.

I don't know if it's a fair question to ask you, but is there anything perhaps in your study of this that would give us some answers here? Where do you see the roadblocks on the performance side?

Ms. Sheila Fraser (Auditor General of Canada, Office of the Auditor General of Canada): I'm afraid, Madam Chair, that's not an issue we looked at. We looked at the management of drug benefit programs within the six departments.

As members know, Health Infoway is considered one of the foundations to which we do not have access, so we have no information as to where they're going. Perhaps the Department of Health.... I mean, they may have some information in their performance report, but I don't know; we haven't looked at that specific issue.

Mr. Rob Merrifield: We'll have further questions on that, I'm sure, before we're done here with regard to Health Infoway and your ability to look at that.

Are there any other comments from any of the other departments with regard to medical records, following through?

MGen Lise Mathieu: From a National Defence perspective, we were working at electronic health records for quite a while, even before Infoway started. We have in fact a project on the books. For us, it's a very high priority, because it's very difficult to keep track of changes in the health of service personnel who are deployed all over the place if you have to rely on a system that's entirely electronic.

So we are well into putting in place an electronic health record. When we started discussion with the partnership, we wanted to work together with the other departments. There are areas where we've had success putting things in place. We're very embryonic in terms of doing the collective aspect of this.

● (1555)

Mr. Rob Merrifield: If you started before Infoway and you're at the embryonic stage of this, help me to understand why the provinces are so much further along, when you're dealing with just one jurisdiction yourselves. Is it the lack of resources? Is it the lack of priority? You said it was a high priority, so I fail to see it as being that.

I just need to understand this, and I think the committee needs to understand, especially in light of some of the reports coming out about how important this is to the health of Canadians as well as the individuals you serve.

MGen Lise Mathieu: I would say that the reason why in the CF we're not as far along as we would like to be at this point in time is largely because we had a fundamental change in requirement and change in approach. That caused us to have to revisit our entire architecture for the electronic health record. Once we had everything aligned and on the right track, that's when we managed to actually go to the pilot phase, which we've completed. Now we're in the process of putting in the clinical application.

We actually think we're doing quite well at this point in time.

Mr. Rob Merrifield: That leads me to another question, then, on Canada Health Infoway. Have you been in contact with them with regard to your initiative and where you're going, which is exactly the same direction as supposedly their mandate? Are you working collectively with them so that when you do come up with a program you can at least talk to each other?

MGen Lise Mathieu: Absolutely.

Mr. Rob Merrifield: Do you talk to everyone who is around the table with regard to purchasing and working towards medical records?

MGen Lise Mathieu: We certainly do.

Mr. Rob Merrifield: You do or you will?

MGen Lise Mathieu: We do.

We have, we are, and we will.

Voices: Oh, oh!

Mr. Rob Merrifield: So that means you're all in this together; that's what you're saying. And you're all not getting a glowing mark, from my estimation of it.

But I'm trying to impress upon you the need to move that agenda along as quickly as possible when we see these kinds of numbers. I believe the example Ms. Bruce had was of an 80-year-old with 20 medications. In your own words, you need to "develop a more robust model"; that was the way you put it. That's putting it mildly. We need a pretty significant model that hopefully can help model what we need right across the country. I guess that's my frustration, that we have a federal government that should be leading the charge on this, and yet it's farther behind than many other areas of the country.

That takes us to the money side of this issue. You've recovered $1.7 million. Can you explain where the other $2.1 million is, and are you going to get that overpayment back?

I don't know who wants to answer that.

Ms. Sheila Fraser: I think that's a question that should go to Health Canada.

Mr. Ian Potter (Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health): I think that refers to the evidence in that initial review, where we identified possible overpayments in pharmacies. After the initial review, we send out the auditors and go through the information the pharmacists have. Sometimes it's because the information was lacking in their files. They then provide the information, which then returns the audit. The audit then doesn't default that. On the basis of that, we determine what is owed to us and we collect that.

I think my colleague Leslie MacLean might have the details of exactly how much we've reclaimed.

Ms. Leslie MacLean (Director General, Non-Insured Health Benefits Directorate, First Nations and Inuit Health Branch, Department of Health): Over a three-year period, where we did about 265 audits of the dental and pharmacy parts of our program, we identified, as Mr. Potter said, a possible amount of over $2 million, and actually recovered closer to $1.7 million.

If it would be helpful for committee members, we could provide the further detail of exactly how much of that was against the pharmacy program.

● (1600)

The Chair: Thank you, Ms. MacLean.

Thank you, Mr. Merrifield.

We'll now move on to Mr. Ménard.

[*Translation*]

Mr. Réal Ménard (Hochelaga, BQ): Thank you, Madam Chair.

I have two questions. The first one is directed to the Veterans Affairs representatives and the second to the DND witnesses.

I'm trying to get a sound grasp of this issue. Drug costs are increasing. Your department's clients are quite elderly and suffer from disabilities and illnesses. This accounts for the fact that drug use patterns among this group differ from those observed in the case of a 23-year-old refugee or other persons.

However, per capita figures supplied to us are nevertheless disturbing. I'd like some assurances about the information system control mechanisms put in place to ensure some kind of follow up on prescriptions and drug interactions. You're not responsible for the fact that generally speaking, drug costs have increased even though, unlike the Americans, our health care system is controlled. However, on reading the Auditor General's report—the AG naturally weighs her words but she can also be blunt when necessary, and we appreciate both sides of her personality—questions do arise as to information system control mechanisms in place.

Can you reassure us in some way about such matters?

[*English*]

Ms. Verna Bruce: I guess I'm not 100% sure what your question is getting at.

[*Translation*]

Mr. Réal Ménard: Why type of system controls do you have in place to stop duplicate prescriptions from being issued to the same beneficiary? How do you control the situation? The impression we have on reading the AG's report is that the process is very loosely controlled. We have seen situations where 20, 25 or even 30 prescriptions were written for the same Veterans Affairs client. Where are the controls?

I believe my question is clear enough and not too difficult to understand.

[*English*]

Ms. Verna Bruce: In terms of making sure that a veteran doesn't get the same prescription twice, we actually have very good systems in place. We have a point-of-sale system where the pharmacies are connected to our database, so we feel quite comfortable that a veteran will not be getting the same prescription twice.

In terms of the number of veterans who are getting multiple prescriptions, you're absolutely right, the average age of our World War II veterans right now is 82. We find that people, as they age, certainly do use a lot more prescription drugs. We also have a lot of people in institutions, and the physicians there are very careful about making sure the veterans are not on prescriptions for long periods.

In fact, some prescriptions are provided on a daily basis because they're very strong and we're not sure what kind of interaction there may be. You could have a veteran with a prescription taking a drug only for one day while the doctor checks to see how he is doing. Maybe tomorrow he will need a prescription for the same thing. We feel quite comfortable that we don't have a lot of duplicate prescriptions being filled for the same client, but we do have a pretty good tracking system to understand why people are getting large amounts of drugs.

[*Translation*]

Mr. Réal Ménard: And that is your explanation of the situation? Each client receives an average refund of $794, whereas in the case of Health Canada, refunds average $394. In your view, the difference is attributable to the health of the clients in the group.

I would now like to put to the DND official a question that I asked Ms. Fraser two weeks ago. The impression one has on reading the AG's report is that there is no coordinated drug purchasing policy in place.

Ms. Mathieu, you made one comment on page 5 of your presentation which pleased me, but I'm curious as to what prompted the following remark: “Currently, DND purchases drugs using competitive, low cost acquisition practices”. What exactly do you mean by that?

LCol Régis Vaillancourt (Pharmacy Policy and Standards, Department of National Defence): I can answer that question.

DND employs two procedures for purchasing drugs. Firstly, it uses standing offers, which consist of agreements with pharmaceutical companies for the purchase of certain products. Secondly, it relies on large volume drug purchases. Canadian Forces submit their figures to the FPT Committee on Pharmaceutical Issues and sign agreements each year.

● (1605)

[*English*]

The Chair: Mr. Ménard, you're over your five minutes.

We'll move now to Ms. Dhalla.

Hon. Robert Thibault (West Nova, Lib.): It's Mr. Savage. Ms. Dhalla is in the second round.

The Chair: Mr. Savage, then, will begin.

Mr. Michael Savage (Dartmouth—Cole Harbour, Lib.): Thank you, Madam Chair.

I'd like to welcome all the witnesses. Thank you for coming today.

My question is for the representative from the Department of Citizenship and Immigration, Madame Ricard.

I'm interested to note that the plan for CIC, as indicated in your presentation today, provides health care coverage for certain classes of migrants—the groups are individuals seeking asylum and refugees—while they're ineligible for provincial health insurance. It also indicates: "We only cover low cost, generic and first line medication when possible. Inaddition, due to the nature of the program, the list of medications covered bythe IFH Program is subject to time constraints and limited to essentialmedications only."

Do these people get a lower quality of care than other people in the system?

Ms. Lyse Ricard: They're not getting a lower quality of care; they're not getting the same coverage. For example, we don't provide over-the-counter medications. The program wouldn't cover treatment for infertility or cosmetic surgery, for example, but they receive the same quality of care. When they attend a hospital in Canada, we will reimburse the hospital at a set rate—any hospital in Canada.

Mr. Michael Savage: Specifically on medications, would they get medications equal in quality to those available to Canadian citizens?

Ms. Lyse Ricard: They would get generic drugs of equal quality. When the generics are approved, they're approved by the required authorities. We replace the brand name drug with the approved generic.

Mr. Michael Savage: Can you tell me a little bit about the health profile of these clients? What would be their medical issues in general? Is it possible to categorize that?

Ms. Lyse Ricard: It's difficult to describe—unless my colleague Dr. Martin would like to add—because as I've said, it's a temporary program. People come and go. Some may be covered for three weeks, some for three days, and some for three years. For example, people detained at immigration detention centres may be there for ten days or for one day. So it's difficult to describe.

The people coming to Canada to claim asylum are required to go through a medical assessment within 30 days of their arrival. The reason is that we want to know right away if there's any communicable disease in their condition so that we can refer them to the province for treatment. We don't provide treatment; we reimburse the health authorities.

Mr. Michael Savage: In understanding the transitory nature of some of these clients, is there any way of judging the effectiveness of the system? Do you have measures in place that indicate how well we're treating these people while they're under the care of Citizenship and Immigration Canada?

Ms. Lyse Ricard: As I said, I don't think we've done research on that to see differences in the quality of service of health care providers.

Mr. Michael Savage: Are we under any international standards or regulations in that area, or do we govern that ourselves?

Ms. Lyse Ricard: As I've said, this program was put together at the federal level due to the temporary nature. Some provinces used to provide and pay, but as we have received more refugee claimants in Canada, some provinces have asked to be compensated for that.

What I could do, Madam Chair, is see if we have some research on that in the department and forward it to this committee.

Mr. Michael Savage: Thank you.

I was just interested to know if there are international regulations that govern how refugees would be treated while they're in a country awaiting the result of whether they will be granted citizenship.

● (1610)

Ms. Lyse Ricard: In terms of health care, I do not think so. But again, I will verify. Canada is probably one of the world leaders in terms of refugees.

Mr. Michael Savage: I hope so, and I'm sure it is.

Thank you.

The Chair: Thank you, Mr. Savage.

Ms. Crowder.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): Thank you.

Thank you for your presentation.

The last time the Auditor General came before us I specifically asked some questions around the first nations insured health benefits. From that interaction, my understanding was that pharmacists were not actually interviewed when they were looking at the whole drug dispensing process, record keeping, and all those kinds of things. I think most of the committee members received the response from the Canadian Association of Chain Drug Stores, which actually raised some interesting questions.

I wonder if the Auditor General and Health Canada could specifically answer those questions.

The chain drug stores have specifically talked about recommendation 4.106, which talks about establishing a centrally managed process. I think many of us are very concerned about accountability, how funding is spent, patient reactions, and those kinds of things. They've raised some interesting questions around the process of implementing a national system, given the varying levels of jurisdiction, the various departments—systems that don't interrelate.

I wonder if you could specifically address the reality of that system actually being implemented, the timeframe, and what sort of accountability measures would be in place to make sure it's effective.

Ms. Sheila Fraser: Madam Chair, I'll let Mr. Barrett respond to that. Perhaps Ms. Bruce would want to as well, because that's a large part of the work of the federal health care partners.

Mr. Frank Barrett (Director, Aboriginal Issues, Office of the Auditor General): Madam Chair, it's an interesting question. We did have a chance to see that letter as well.

In recommendation 4.106, we recommend the federal government establish a centrally managed process to establish a single federal schedule for dispensing fees. We don't specifically say that we're recommending there be one dispensing fee all across Canada. A national system need not mean one size fits all. The question, and what prompted some of this recommendation, was whether the pharmacist who's dispensing the same drug for a veteran and for a first nation client should be paid a different amount for the two different schedules.

Ms. Jean Crowder: I would assume that managed process would essentially incorporate more than the management of dispensing fees. I would assume we're looking at some sort of centrally managed system that deals not only with drug dispensing but also with the fact that clients cross over between departments.

Ms. Sheila Fraser: We certainly talk, Madam Chair, about more than just the dispensing fees. We talk about things like the common formulary, which in fact already exists to some degree with the federal–provincial–territorial committee. The federal pharmaceutical and therapeutic committee does go through and approve drugs, but not all departments are using that formulary as their core formulary.

We say as well that they ensure that they get best value for each drug product listed, so what is the use of generics in that? We talk about a less costly means of processing over-the-counter benefits, and then about a common risk profiling and auditing process. I'm sure the pharmacists, if they are getting different auditors coming in from different departments, are being approached by those auditors in different ways.

We're recommending that the departments work together when doing this work in order to try to establish core principles whereby there can be common schedules of fees or drugs, that they use those, and that they work together as well, for example, on auditing.

Ms. Jean Crowder: I don't disagree with that, but I guess I'm really asking if that's realistic. Organizations that have dealt with federal government departments over a number of years have consistently asked for more consistency around the requirements from different departments, but over a number of years things haven't shifted or changed. I think it's great to have the recommendation, but what's the reality of implementing it?

This is probably more for Health Canada. What are the specific steps they're going to take to actually make it happen, so that two years or three years down the road you're not then looking at a report? I looked at the accountability and performance measures that you talked about in 2000, or whenever it was, and they're still not there. It's now four years later.

● (1615)

Ms. Sheila Fraser: I think one of the solutions to this, one of the tangible signs that it can be done, is the action plans that have been produced. As for how realistic they are, it's really up to the departments to determine what actions they think can be done and within what timeframe.

Then again, I would perhaps turn to Ms. Bruce, who has done that on behalf of all of the departments.

Ms. Jean Crowder: Perhaps Ms. Bruce could help us.

Ms. Verna Bruce: I'd be happy to respond to that, because it's an area we're very concerned about as departments. We've been working together in different ways over the last ten years. Obviously, as a result of some of the recommendations from the Auditor General, we're going to be working harder and faster, and that's fine. Those recommendations have been a really good impetus for us.

In terms of some of the very basics, we have tabled the action plan. When you have time to read it, I think you'll find it helpful. One of the things we've decided to tackle first as a group of six departments is that whole notion of a common core formulary. What are those drugs that we all use in our various programs? Once we've identified what those common drugs are, the next step will be to take a look at whether there are better ways to try to do some pricing. Are there better deals we can get if we're all trying to buy the same drug?

We have done some things on dispensing fees. For example, in the province of Saskatchewan we have a common dispensing fee that's used among many of the federal government departments. So there are definitely things we can do.

We believe it will take us some time. We're not going to make commitments we can't live up to, but we really believe that by trying to prioritize the work and take it in sizable chunks, we can make huge progress. As for whether we'll ever be totally perfect, probably not, but I think we can make a huge amount of progress to ensure that we're getting good prices and that we're also delivering on those very different mandates that each department has as well.

The Chair: Thank you, Mrs. Crowder.

Ms. Dhalla.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): I again want to thank everyone for coming and for their presentations today. I think they've provided us with tremendous insight in terms of some of the recommendations that were made by the Auditor General and some of the work that has been done by the respective departments.

My question is for the Department of National Defence.

You had mentioned, both when you were speaking and in the notes we received as well, that there have been certain agreements reached with the pharmaceutical companies in regard to procurement of some of the medications and the prescriptions. If you could, please elaborate on what the system is for procurement. Second, is it your department that's directly responsible, and how often is it evaluated to ensure that there is cost-effectiveness in place for the types of medications that are being purchased?

LCol Régis Vaillancourt: As I started to explain earlier, we have standing offer agreements for most of our drugs. For the drugs for which we don't have standing offer agreements in place, we submit our volume of drugs to the federal–provincial–territorial buying group for drugs—it's under the auspices of Public Works—and we go out for contracts to buy these drugs. We actually have a document that we can table later on showing that most of our top fifty drugs in volume and also in cost are procured through the system, either through a standing offer agreement or the standard process.

What this means is that they're mainly for our on-base care. When they're for off-base care, we try to use the best drugs available, at the best price, by making full use of generic products. But on base we can use a brand name if it's cheaper than a generic product, because we go for the lowest-cost alternative. We have the flexibility to tell our on-base pharmacy to buy a specific brand of generic product that gives us better pricing.

Ms. Ruby Dhalla: And is that under the department itself?

LCol Régis Vaillancourt: It's done at the federal-provincial-territorial level. Usually most of the other departments would use this for vaccines, but we use it for vaccines and drugs.

Ms. Ruby Dhalla: The other question was this. As we move forward in the arena of health care and as was mentioned by the Department of Veterans Affairs, there are individuals who are 80 years old and have a number of complex conditions, hence requiring a multitude of different drugs. Within both the Department of National Defence and the Department of Veterans Affairs, what is being done in terms of educating the individuals on prevention and promotion of certain respective diseases? What initiatives is the department undertaking?

LCol Régis Vaillancourt: There are two elements to the question. One of them is the system in place. We have a contractual agreement with Veterans Affairs, so we have a system in place to monitor the use of drugs. On top of this, where drugs have been used outside of a base gets reported back to the base pharmacist, and then he can do another assessment. So there's a two-tier level for assessment about drug use.

Also, the FHP, which is Forces Health Protection, has a program that promotes well-being physically—exercise, smoking cessation, and weight loss. It's part of an ongoing healthy living approach to health. Not too long ago they produced a pamphlet on natural health products, so it's ongoing.

● (1620)

Ms. Ruby Dhalla: How much money is spent by the department for that initiative for healthy living?

MGen Lise Mathieu: I could provide that information at a later date.

Ms. Ruby Dhalla: If you could provide the committee, if you don't mind, with what initiatives are in place and what that program is in detail, that would be helpful.

Perhaps Health Canada could please answer the same respective question with regard to what type of initiatives are taking place for healthy living and the amounts of money that are put toward those initiatives.

Ms. Lyse Ricard: For Citizenship and Immigration Canada, as I said, the nature of the population we look after is very temporary—they come and go—therefore we don't have per se within this program initiatives to the effect of promoting healthy living.

However, we do have settlement and integration initiatives that are either delivered by the department or the provinces—it varies—and we're working with NGOs to help immigrants and refugees getting settled either permanently or temporarily in communities. There is a variety of initiatives in those communities with these people that could vary from very basic—here is Canada, here's how it works in Canada, these are the values—to healthy living, but very basic.

Ms. Ruby Dhalla: Wonderful.

Thank you.

The Chair: Thank you, Ms. Dhalla.

Mr. Fletcher.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Madam Chair.

My colleague Mr. Merrifield has raised the issue of Canada Health Infoway. If the Auditor General did have the ability to go in and audit these foundations—for example, Genome Canada, CFI, and so on—could she comment on whether she thinks that would be a valuable exercise and whether we'd see perhaps quicker progress on these programs?

Ms. Sheila Fraser: Madam Chair, we have made our position known to the public accounts committee, that we believe the Auditor General should have access to the foundations, but in the context of program audits where foundations play a significant role.

I don't see the office going in to audit a foundation in and of itself, but rather as part of a broader program within government—so let's say, innovation or education or climate change or medical records, for example. If a foundation played a significant role in that, then we would want to see how their activities were being coordinated with other government departments and agencies and whether the objectives were being met for which the funds had been appropriated by Parliament. It would be in a broader context than simply an audit of the foundation per se.

Mr. Steven Fletcher: Madam Chair, I think the Auditor General will be pleased to know that I did move a motion to have the Auditor General have that power. All the opposition parties supported that motion except, interestingly enough, the governing Liberal members of the committee. But I am pleased you would agree with the motion that it would be helpful to have you or your office have the ability to audit those foundations. Hopefully after this committee meeting that power will be granted.

I have just one other question along these lines. One of the reasons I understand the governing party voted against having you.... The claim was made that everything was hunky-dory, they were meeting their objectives, and there was no need for you to go in. Do you have any comments about that?

Ms. Sheila Fraser: As you know, we recently did an audit on the accountability of foundations to Parliament. In that audit, we noted that there had been improvements in the reporting of foundations, and more information was being provided to Parliament. So we do see improvements, largely because of announcements made in recent budgets, but we still believe that in order to give complete information to Parliament on audits of programs in which foundations play a significant role, the Auditor General should have access to them. Those audit reports are tabled in Parliament, unlike audits conducted in the foundations, which go to their governing boards.

● (1625)

Mr. Steven Fletcher: So the bottom line is there would be benefit and it would be great to have you there. Hopefully we can make that happen.

My next questions are along a different line. They relate to the First Nations and Inuit Health Branch. Health Canada cited privacy concerns as the reason for discontinuing interventions in cases of suspected drug abuse, yet according to the Auditor General, Veteran Affairs intervenes in such cases because it considers it to be a service to its clients. That's in paragraph 4.44.

I have one question for Mr. Potter and one question for Health Canada. For Health Canada, is privacy still a concern for Health Canada? For Mr. Potter, it seems that in one case it's a service to the clients, but in another case it's an issue of privacy. I wonder if the contradiction could be explained.

Mr. Ian Potter: My colleague Verna Bruce may have more information with respect to the differences in that part of the Auditor General's report.

Ms. Verna Bruce: Sure, I'm happy to take that question.

There are a couple of things. One, we're all federal government departments so we're all bound by privacy legislation. I think it's fair to say we operate now in a more similar way than we did some time ago. In Veterans Affairs Canada, when we have great concerns about the drug patterns of a client and that client refuses to give us consent, there are a couple of things we need to do. We may be really concerned about that individual's health and believe they're not providing consent because of an addiction or a mental condition that prohibits them from making decisions, or they may just refuse. If we're very concerned about something in that particular client's pharmaceutical file, we go to the Privacy Commissioner to let them know we will be divulging information to the physician or the pharmacist, perhaps without the individual's consent, just to make sure we're not violating in any way the consent and the rights of a Canadian citizen.

I understand a number of improvements have been made in Health Canada as well, which I'm sure Ian will want to talk to. But we are working very much across the six departments to make sure we're handling privacy issues in a similar way.

Mr. Steven Fletcher: But on the aboriginal side—

The Chair: Mr. Fletcher, I'm sorry, you're over time.

We'll now go to Mr. Thibault.

Hon. Robert Thibault: I'd like to raise a point of order prior to starting my question. I didn't want to interrupt Mr. Fletcher in his line of questioning. I recognize that he's a new member, and I think it might be worthwhile for the chair to instruct the committee on matters like this, if the chair agrees with me.

The member raised the point of a vote that happened in the House after a motion on an opposition day motion and impugned the motive as to why one party would have voted one way in a very simplistic answer to that—a very simplistic motion.

I think if you remember the debate, it was quite complex. In the case of the Auditor General auditing the books, I spoke specifically to Infoway. I never questioned the capability of the Auditor General's department, but the fact that Infoway is a multi-jurisdictional organization—an equal federal-provincial partnership. Of course, we pointed out at the same time that all of these foundations can be asked to appear at committees. I further agreed in questioning that some of them should be audited by the Auditor General, and the Auditor General should be the auditor of choice. We didn't vote against all of that. But it was a very simplified answer to a very complex situation that was raised.

The Chair: On reflection, Mr. Fletcher, one has to be very careful, in describing history either from the committee or from the House, that the interpretation is acceptable to most people here. One has to be careful, Mr. Fletcher, that's all.

● (1630)

Mr. Steven Fletcher: I have a point of order, Madam Chair. I was not referring to the House motion, but the motion that was passed by this committee, the motion that I put forward at this committee. I think the majority of people, as demonstrated by the vote, agreed with that motion. You and one of your colleagues disagreed with that motion, but the majority of the committee highlighted the importance of having—

Hon. Robert Thibault: The same argument applies.

Mr. Steven Fletcher: Well no, you mischaracterized the event.

The Chair: I've already checked with the clerk, and Mr. Fletcher is correct. His motion at committee passed by seven to two.

But once again, Mr. Fletcher, I would suggest you not characterize what the chair thought about your motion, because I didn't vote; so you have no idea.

Mr. Merrifield.

Mr. Rob Merrifield: Yes, I think the point is well taken. I understand where Mr. Thibault is on this, but I don't believe that's what Mr. Fletcher was saying. He was referring, if you check the blues of the committee—

The Chair: We did. We just did here.

Mr. Rob Merrifield: He was referring to the vote at the committee. So I think that point of order is out of order and that we should continue with the debate.

Hon. Robert Thibault: Prior to doing that, even on that same point at the committee, the answer was not that clear. I did not say that I could not support the motion because everything was hunky-dory, which is what was suggested by this allusion.

The Chair: I think we're now moving into debate. I think we should move back to Mr. Thibault, as the next questioner of the panel assembled before us.

Mr. Thibault.

Hon. Robert Thibault: Thank you very much.

My first question is to the Auditor General.

Madam Fraser, thanks again for appearing. This will seem a little bit repetitive because it is, but you appeared at the public accounts committee to deal with these essential issues, and you appeared again at the health committee not so long ago to deal with these issues with different panellists.

You expressed at the time, and justifiably so, your frustration at the amount of time it had taken to implement or agree to implement some recommendations in previous reports of the Auditor General, specifically on the aboriginal health care side, which is probably more acute than others. We had that discussion at the time on the question of the Privacy Act and how it applied and what the interpretations of it have been. We have received the plans of the Department of Health, from the First Nations and Inuit Health Branch, as well as the plans of the Department of National Defence, Veterans Affairs, our justice system, and I can go on and on. We have received those.

I would ask you once again, do you remain cautiously optimistic about the situation for going forward with the recommendations of your report?

Ms. Sheila Fraser: Thank you, Madam Chair.

I'm always encouraged when I see action plans with specifics and timelines and actions that are going to be taken to address our recommendations. As I have said before, I am cautiously optimistic. I will be truly pleased, I guess, when we come back at some future point in time and say all the issues have been addressed.

Hon. Robert Thibault: I'll put a question to the Department of National Defence, though it's a little bit outside the scope of their report.

[*Translation*]

You alluded to human resources problems in the health care field, whether it be with doctors, pharmacists or other health care professionals. Is the military still experiencing problems and if so, are these problems similar to the ones encountered by civilians in the regions? Do you see any solutions? Down the road, is there any chance of getting the job done or of acquiring the needed resources?

MGen Lise Mathieu: In terms of human resources challenges, Canadian Forces Health Services are a reflection of the ongoing situation in Canada. It is extremely difficult to recruit uniformed pharmacists, doctors, social workers and nurses. In fact, we are experiencing a serious shortage in all categories of uniformed trades.

We have all kinds of programs in place and we have adjusted our recruitment practices and introduced incentives for certain occupations. We're trying to get the message out about life in the military to civilian health care suppliers.

Often, we seem to be battling unrealistic stereotypes about life in today's Canadian Forces. We face a formidable task, primarily because the best person to recruit a clinician is another clinician. Currently, our clinical practitioners are finding it difficult to do their job in the Canadian Forces.

That being said, we're doing everything conceivably possible, whether it be in terms of improving the climate in the workplace, resolving problems or ensuring some geographic stability.We're also working with authorities and with Treasury Board on remuneration issues. We're trying to do everything we can. We rely heavily on the Canadian health care sector to meet our needs.

● (1635)

Hon. Robert Thibault: Recently, someone brought up the subject of army medical assistants and pointed out that many of the people in this profession had retired. Military personnel often retire at a fairly early age.

Some military personnel resume their civilian lives in the community. They could be called upon to fill the human resources void in society in general. Could you share with us your experiences with this CF occupation?

MGen Lise Mathieu: We've had excellent results with medical assistants. We've been working for years with these health care workers who are trained to diagnose and treat patients under specific conditions, and particularly in remote areas or regions.

Over the past five years, we have worked very diligently to have this profession recognized in Canada by the Canadian Medical Association. We now have a school in Borden to train medical assistants and this facility has been accredited by the Canadian Medical Association.

Overall, this profession is considered absolutely critical to both our operational and in-garrison capabilities. We have doubled our output of trained medical assistants to keep pace with demand.

Hon. Robert Thibault: Thank you.

[*English*]

The Chair: Thank you, Mr. Thibault.

Do I have the committee's permission to change the order a little bit and move to the only two members who have not yet had a chance? Is that agreeable? If so, we'll go with Mr. Lunney, and we'll follow it with Mr. Carrie, and then everyone will have had a turn.

Mr. Lunney.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you, Madam Chair.

Well, to begin with, going back to paragraph 4.38, the Auditor General noted concerns about clients with prescriptions for multiple narcotics and multiple benzodiazepines. I'm alarmed when I see that some clients had up to 46 different combinations of doctors and pharmacies. One client was able to regularly acquire large quantities of seven different narcotics through 29 different doctors and 21 different pharmacies in one year. That to me is alarming, considering that 974 tablets, each containing 30 milligrams of codeine, were obtained for three of these prescriptions in one month.

The question really is, considering the potential for abuse and harm in using multiple narcotics and multiple benzodiazepines, why has Health Canada not put an alert system in place? Secondly, if Veterans Affairs was able to do it, why did Health Canada not? Are you saying it's just the privacy concerns?

Mr. Ian Potter: I can respond to that, Madam Chair.

Health Canada did have an alert system in place. It did not use the same alert system that Veterans Affairs is using. Both Veterans Affairs and Health Canada use a system that is supported by the Canadian Pharmaceutical Association, or the pharmacists' association, and it's called the point-of-sale system. It means that when a pharmacist gets a prescription that they would like our plan to pay, they enter that information—the client's name, the drug—into an Internet system that gives them immediate feedback on a few codes. It tells them if this is a duplicate prescription. It tells them if this is a prescription that was filled before another prescription. It tells them if this prescription would interfere negatively with another prescription the patient is receiving.

Our code system would pick up these things in general. Veterans Affairs was using a specific code that talked about the interaction of benzodiazepines and other opiates. Health Canada has indicated that it will be introducing that code in September.

● (1640)

Mr. James Lunney: You're saying your code couldn't pick up this kind of excess—46 different combinations of doctors and pharmacies? Your system just didn't pick that up?

Mr. Ian Potter: Yes, we would pick that up.

The question I believe you were asking is whether or not there was a specific warning for the possible danger to a patient using these multiple medications. There are those warnings, which are given to the pharmacist. We are increasing the specificity of the warnings so there is more detailed information being given to the pharmacist at the point of sale.

We are also doing what we're calling now a retroactive review of cases like that. We will look at the pharmaceutical use of a client, and in cases like that we will identify them and talk to the pharmacist. We have done that. We started it last year in November, and we have identified that in some cases there is a legitimate reason a patient might be using that number of drugs and that number of physicians.

We actually have a case where a person was a multiple sclerosis client who was on quite a number of different drugs, receiving them for short periods of time. He had moved, couldn't find a physician who would take him, and therefore had to receive his drugs—which were being given for a very short period of time, like weekly intervals—at walk-in clinics.

So in that case, he went to walk-in clinics and it would be a new physician all the time, getting the drugs for short periods of time.

We now have a system in place where we can identify cases where that might be a problem. We will then phone the pharmacy or the physician and alert them. Sometimes when we get explanations we find that it's not a problem. Sometimes it is a legitimate problem, and we work with the pharmacists and the physicians and take action.

The Chair: Thank you, Mr. Lunney.

Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you, Madam Chair.

Paragraph 4.4 of the audit says that the federal government's prescription drug costs have gone up 25% in the past two years. When I read that I was shocked that it's gone up so much in the past two years, and I was wondering if there have been any predictions made for the next couple of years. Do you think it's going to continue at that rate?

Ms. Sheila Fraser: Madam Chair, this is simply a statement of fact. I think some of the departments, perhaps Health Canada, might be able to give you comparisons with the provincial costs. In previous testimony I think it was brought up that this is in line with what is happening elsewhere within the country.

I don't know if we looked at projections. The departments might have that information for you.

Mr. Colin Carrie: My concern was whether, with the limited amount of resources we do have, we are getting judicious use of those funds and getting value for the money. I notice that Veterans Affairs and Health Canada clients sometimes were taking over 15 different drugs, and some had received 50 or more prescriptions during that period of time.

I was wondering, are those rates going up? Are the number of drugs being prescribed going up, and how would it compare to, say, a few years ago? Are we noticing a trend that we are starting to treat people with more of a drug-based treatment? Is that what we're seeing?

Ms. Verna Bruce: From a Veterans Affairs Canada perspective, we would say that our patterns of drug use are going up, but so is the age of our clientele. We're also bringing in clients to Veterans Affairs Canada who we've never seen before.

A lot of the projections were that our client numbers were going to go down because veterans were getting older. In fact, they're going up, because people were fine without us until they turned 81 or 82 years of age, and now they need help from us. Our client numbers are going up. They're coming in at an older age. They're coming in at a point in their lives where they're probably a lot sicker. We're finding that our drug utilization is definitely going up, but so is the number of our veterans.

Mr. Colin Carrie: Are we finding that people are better off with the therapies we're promoting? We see in Ontario that they're delisting services like chiropractic and physiotherapy. I notice that a lot of seniors, in my community anyway, are wondering why we're cutting certain services. It seems that we're spending more and more on pharmaceuticals.

Do you have anything in place to let us know if we are getting good value for our money by doing this type of promotion of pharmaceuticals and prescriptions more and more?

● (1645)

Mr. Ron Herbert (Director General, National Operations Division, Department of Veterans Affairs): In terms of whether we are getting therapeutic value, I don't think I can respond to that question per se. What we can say is that from a financial value perspective we feel that we're getting good cost controls in our programs, but I really can't speak to the therapeutic values.

Mr. Colin Carrie: Is there anything in place to start looking at that to see if we're getting good value for our dollars compared to, let's say, if somebody goes to a physiotherapist or an occupational therapist or a psychologist for different forms of therapy?

Ms. Verna Bruce: We're doing a lot of work in cost containment. For example, our costs net two-year period would have gone up by about 13% instead of 25%, so we've been doing a lot of cost containment.

We haven't delisted other types of services, if that's where your line of questioning is going. From a Veterans Affairs Canada perspective, we look at whatever the best is that we can provide for our veteran clients and we try to find a way of doing it.

Mr. Colin Carrie: I'm just wondering if we are getting a good value for the dollar by sticking to, say, more medication as opposed to maybe more proactive approaches. My colleague was asking about wellness programs and getting a lot of seniors involved with nutritionists, exercise therapists, chiropractors, physiotherapists. I'm wondering if anybody is looking at that to see if we're getting good value for the dollar.

Mr. Ian Potter: Madam Chair, I can respond.

This is an important issue that is being looked at through a number of research initiatives. The Canadian Institutes of Health Research has a program that looks at the efficacy and efficiency of the health system in general, and there are a number of research projects being funded from this. There are also a number of specific foundations looking at that same issue. We could provide a summary of some of the findings to the committee should they request it.

Mr. Colin Carrie: If you had those numbers, that would be great.

The Department of National Defence has two relevant objectives for analyzing drug use: to enable the provision of patient care through judicious use of medication; and to administer a drug program based on the four principles of operational readiness, fairness, equality, and health outcomes. I am wondering how you define “judicious use of medication”.

LCol Régis Vaillancourt: A process to list a drug is based on the Federal Pharmacy and Therapeutics Committee recommendation. As peer professionals, they look at the cost-effective use of drugs. So it's the first step, and as you can see in the Auditor General's report, we comply a high percentage of the time—I think it's 70% or 80% of the time—with the Federal P and T recommendations for the use of drugs, or the listing, and we're more restrictive in 17% of the cases. That's one aspect of it.

We also look at it from these four perspectives, making sure that it's going to achieve the health outcomes of our operation population and decrease side effects.

I can give you an example of a study that we did internally on Zyban. We had noticed a significant increase in adverse drug reaction reporting with Zyban, which is a smoking cessation drug. We did an internal study and discovered that, yes, we had a lot of side effects, but the effectiveness of Zyban was much greater than what was reported in the literature, and we made a move towards changing our policy. We changed the policy so that it would be dispensed for only two weeks at a time to ensure that there would be pharmacist counselling because of the high incidence of side effects. But it was worthwhile keeping.

So that's the type of effectiveness we have on a regular basis. We conduct a series of drug use evaluations internally when we make a change in policy on the use of drugs.

Another good example is the CFC-free inhalers. We looked at implementing the CFC-free inhalers before the ban on CFC. We looked at the impact of this on our operation population and discovered they didn't like the taste of it and they were not compliant with it, so we went to dry powder inhalers.

That's another way we look at outcomes. We have ongoing assessments of this. The latest one that is ongoing right now is the compliance for drugs for hyperlipidemia, or high cholesterol. If we see there is a problem with the compliance of these patients, we come up with a program to increase compliance as a measure to prevent disease in these conditions. We have a series of measures in place either when we select a drug or when we make a selection to see if it's going to be used properly.

The Chair: Thank you, Mr. Carrie.

Mr. Merrifield.

● (1650)

Mr. Rob Merrifield: I have just a quick question, a follow-up, and this has to do not so much with the medical records as with the adverse events and the reporting of them. That's following up on Mr. Carrie's line of questioning. How are you dealing with those adverse events and reporting them? What percentage are being reported? That becomes quite critical.

Then I'd like to ask another question. When someone passes away who is under your program, is there anything that shows what kind of medications that individual was on at the time of passing?

I wonder if you could answer those questions.

LCol Régis Vaillancourt: I'd like to talk about adverse events first. First of all, there are two types of adverse events. There are expected adverse effects from the drugs that are based on the pharmacology. A drug to make you sleep, a hypnotic drug, will leave you drowsy the next morning, and that's expected. Usually these don't get reported that much. Then there are the unexpected adverse events, the events that you don't expect will happen, and they get reported more closely.

What we have done in our system is this. I cannot tell you what percentage of adverse events overall have been reported, because not all of them are relevant to be reported. But we have built into our drug management program that if someone wants to use a drug that is not on our benefit list, which is based on the most cost-effective drug therapies, because there's an adverse event, we make them report back to Health Canada, to the adverse drug reaction program, to make sure they are in compliance with the current federal program on adverse drug event monitoring. I can provide you a table with the types of reports we received in the last year, and it's only focusing on cases where someone wants to use a drug that's not part of our benefit list.

We also have a monitoring system for vaccines. We are a heavy user of vaccines, because we like to travel in the military. “Like” is a big word, but....

Some hon. members: Oh, oh!

LCol Régis Vaillancourt: We take very seriously the monitoring of vaccines, and we also report them to Health Canada. We have this in place.

Is that answering your question?

Mr. Rob Merrifield: Well, sort of. Maybe I'll make it a little more specific.

For the benzodiazepine line of product that is used primarily with seniors—and maybe Ms. Bruce would have some answers there as well—Health Canada's recommendation is seven to ten days—

Hon. Robert Thibault: On a point of order, we agreed that we'd forgo our normal rounds so that the last two questioners could go, and here we're getting into a whole new area that I don't know is completely related. Although it's very important and we should have a study on it, I don't believe it's necessarily related to the Auditor General's report.

Mr. Rob Merrifield: Yes, I'd like to answer that.

It is and it isn't, because of the performance of the drugs. You're right, it's a little bit off. It's also very much related to some of the work we've done as a committee, and I thought I'd take advantage of a question near the end, after everybody had finished, to get some of that information on the record.

The Chair: Everybody had finished because the Conservatives had two extra turns without the Liberals, and then you came in for a third extra turn for the Conservatives, so I can understand the point of order.

Mr. Rob Merrifield: If you're not interested in the answers to these questions, I'll get them from them afterwards. I can certainly do that.

The Chair: That would be great.

Mr. Rob Merrifield: But I think this is information you might want to avail yourselves of. That's fine. If you want to call it out of order, I'll respect that, but I think you're wrong.

The Chair: I think your suggestion that it could be given to you after the meeting is probably true, and seeing as the Liberals agreed to this change in the to-ing and fro-ing that we usually do, I think this should be respected. If you don't want to do it that way, then we'll go from Mr. Fletcher to the Liberals, from Mr. Lunney back to the Liberals, and from Mr. Carrie back to the Liberals. I hadn't seen a lot of hands for a second round, so I was trying to accommodate the fact that everybody had one turn. So if you agree to that and then you come back with the second turn, then you can expect your counterparts on the other side to want to get in.

Mr. Merrifield, do you agree that you will take the answers to those questions privately after the meeting?

Mr. Rob Merrifield: I certainly could, but if you'd like to fro, go ahead and fro. I would like to to, so....

Some hon. members: Oh, oh!

The Chair: Well, I would have to let two Liberals talk after Mr. Lunney and Mr. Carrie in order to get the balance back before you would even come in.

So it was probably my mistake for letting Mr. Merrifield in without coming back to a Liberal before that. In other words, to get out of this conundrum, I suggest that Mr. Merrifield get his answers later, and that this end the one-turn round we've had, unless there's someone who would like to challenge that. Are most of the members happy with that? I think the majority of the members are.

On your behalf, I would like to thank the very large group of people who brought us information today. Thank you for the work you do every day on behalf of Canadians and for Canadians, taking care of their need for health care and pharmaceuticals, etc. We know you'll continue to cooperate with the Auditor General, who gives us the overall picture of what's going on.

We'd also like to thank the Auditor General for her work and the way she can enlighten us and, through us, Canadians.

Thank you very much, ladies and gentlemen.

● (1655)

Mr. Steven Fletcher: Madam Chair, can you inform the committee if the motion dealing with the foundations has been communicated to the powers that be, as in, have we let the Prime Minister know, or the House?

The Chair: We adopted the motion, but we didn't decide what to do with it. If they're paying attention, they would see it in the minutes of the committee meeting. If you want something else done with it, I suggest you bring that suggestion to the next meeting. Could you do that?

Mr. Steven Fletcher: I can do that.

The Chair: Thank you very much.

Mr. Savage.

Mr. Michael Savage: I had forwarded a letter to you that I wrote on Friday. I'm not sure if you have seen it. I didn't circulate it to the committee, but it's related to Mr. Szabo's bill. In Thursday's *National Post* there was an article that referenced Dr. Gideon Koren, I think his name is, at the Toronto Hospital for Sick Kids, who had indicated an interest to appear on that bill. I mention that because this morning on CBC I heard him speaking about fetal alcohol syndrome—not related to the bill, but on another topic. He appears to be a very respected expert. I'd like to encourage this committee to hear him.

The Chair: Yes, we have been talking about that and the fact that we have a lot of people lined up to come who have a commercial interest or maybe a parental interest—all those kinds of things. I felt we were a little bit short of scientists, so I've encouraged the clerk to look back through the requests to appear and to try to bring in a few more people who may have done studies and have scientific results to share with us.

Ms. Dhalla.

Ms. Ruby Dhalla: To elaborate on what Michael has said, I think both I and other members of the committee may have received a copy of an e-mail from Dr. John Trevithick as well. We can forward that in regard to his interest in appearing before the committee. You can consider that.

The Chair: The clerk has that one.

Ms. Ruby Dhalla: In addition, if we can just request that Mr. Potter, as he had mentioned earlier, forward the documents regarding the efficiency and effectiveness of some of the programs that are being done by the various research institutes, that would be appreciated.

Thank you.

The Chair: Thank you very much, ladies and gentlemen.

This meeting is now adjourned.

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