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Monday, April 18, 2005

Chair

Ms. Bonnie Brown

Standing Committee on Health

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● (1535)

[*English*]

The Chair (Ms. Bonnie Brown (Oakville, Lib.)): Good afternoon, ladies and gentlemen. Welcome to the 33rd meeting of the Standing Committee on Health.

This afternoon, in our review of expenditures and the estimates, we are welcoming the chief operating officer of the Canada Health Infoway, Mr. Michael Sheridan.

Mr. Michael Sheridan, you will have the floor first, and then we'll proceed to questions and answers.

Mr. Michael Sheridan (Chief Operating Officer, Canada Health Infoway): Thank you very much, Madam Chair, for the invitation to appear today.

I am the chief operating officer for Canada Health Infoway. I'm accompanied today by Mr. Brian Philbin, who is the chief financial officer for Canada Health Infoway.

[*Translation*]

I would like to begin my remarks by emphasizing the kind of work we are fortunate enough to be engaged in. Infoway is accelerating the development of secure, compatible and electronic health records Canada-wide, based on joint investment with the provinces and the territories. Working directly with the 14 Deputy Ministers of Health, we are contributing to improving the safety, access and efficiency of health care. The goal we have set for ourselves is to have electronic health records across 50% of Canada, by population, by the end of 2009.

[*English*]

Today, I can travel anywhere in the world and, with my bank card, I can be recognized at any bank machine and access my accounts. Airlines can thank robust interoperable information systems for quantum leaps in aviation safety. Yet, if I'm taken to a hospital down the street, the emergency doctors will most likely have no idea of my medical history and which medications I take, and will likely have no idea of which test or treatments I've had. When I'm discharged, my family physician is unlikely to receive a discharge report or, for that matter, follow-up directives.

[*Translation*]

Achieving our goals for an electronic health record will better enable clinicians to provide coordinated care and help ensure health professionals have the right information at the right time, to provide the right care.

[*English*]

Canada's first ministers understood the need to exploit the power of information technology to achieve this vision. Four years ago, they unanimously agreed to work together to develop a Canada-wide health info structure to improve the quality, access, and timeliness of health care for Canadians. The first ministers also recognized that Canada's challenges would best be met with a national commitment to develop solutions that would operate across health care organizations and clinical systems. Infoway's capitalization, allocated in three tranches since 2001, is $2.1 billion.

Each of Canada's provinces and territories has its own road map and implementation timetable for automating vital patient information. From the start, Infoway recognized that electronic health records would need to roll out incrementally, program by program and region by region. To support this approach, Infoway invests in nine program areas. Each of these programs delivers value on its own, while contributing to the longer-term goal of providing Canadians with a private, complete lifetime record of their key health history and care.

● (1540)

[*Translation*]

Four programs focus on systems which capture and share clinical information, such as medication and prescription drug profiles, lab results and diagnostic imaging. Another focusses on the system that integrates these or glues them if you will—the interoperable electronic health record.

[*English*]

Two other key programs are telehealth investments, to provide access by providing remote diagnosis and treatment, and public health surveillance systems, to help public health officials quickly identify and contain outbreaks of infectious diseases, such as SARS.

I'd like to point out that Infoway is not a granting agency. It operates as a strategic investor with our provincial and territorial partners. We play an active role in project planning, design, and deployment, but we do not actually build or implement the systems. That work is done by the provinces and territories. They benefit from Infoway's cross-Canada experience, while Infoway ensures that jurisdictional results and learning are reusable across the country.

Joint investment is a condition of our funding agreement. It enables us to lever additional funds from other governments to ensure value and mitigate risks by gated funding and gated funding requirements to achieve specific deliverables and adoption targets for each project before Infoway funds are disbursed. We also measure results and benefits.

One key underpinning for moving electronic health records ahead is the need for compatible standards to allow information to be shared between hundreds of systems across Canada. Infoway takes a leadership role in standards development and promotion. We have also developed a technical electronic health record blueprint adopted by every province and territory, and we are encouraging vendors to create less costly commercial, off-the-shelf solutions. Infoway strives for reuse and replication of proven solutions.

Ultimately, Infoway's progress is allied and clearly defined with the success of our jurisdictional partners. Understanding this, a three-year joint technology and investment plan was developed with each province and territory, resulting in a road map that aligns national and provincial e-health strategies.

Infoway has been criticized on several fronts for the pace of its project approvals and its overall expenditures. Indeed, some work did progress more slowly than we would have liked, but developing the foundational pieces of interoperability needs to be right and is fundamental for any future successes. Further, in our necessary cost-sharing investment model, Infoway can only move as quickly as our members can match funds and deliver the projects. Their pace has been impacted by jurisdictional readiness, competing investments, and long procurement processes. Consequently, our pace of actual expenditures has lagged behind our project approvals, and because of our requirement for results and adoption prior to payment, it will probably continue to do so.

We believe the current pace must be accelerated and have aggressively addressed this. In particular, last month our board approved an increase in Infoway's funding ratio from an average of 50% to 75% in key areas, which should noticeably accelerate progress.

[*Translation*]

Infoway has focussed on creating a practical and solid foundation on which to cost effectively realize our goals, while reducing risks. We have built on that foundation in the past year.

[*English*]

We have increased the investment pace. With all nine programs in place and approved by our board, we are accelerating project approvals, with over $320 million approved in more than 100 projects, 60% of which were approved in just the last 12 months. We are pleased to report that joint projects are under way in every province and territory, and our plan for next year foresees an investment of at least an additional $300 million. We estimate by the end of this fiscal year, Infoway will have approved project investments of more than $600 million.

We have also begun to bring tangible results on our joint investment to patients, clinicians, and the health care system. For example, two diagnostic imaging projects in B.C. and southwestern Ontario show impressive results. In both cases two large hospital networks are going digital, implementing shared digital diagnostic imaging networks among the many hospital sites. In B.C. the shared network allows clinicians at any of the 11 connected hospitals to electronically view, share, manage, and store patients' test images regardless of where the test was conducted. Because the system is shared, small sites can economically justify the technology and the hospitals can pool their scarce radiologist and specialist resources. Patients' X-rays and MRIs are now ready in less than an hour instead of the previous four hours, as radiologists now read images without physically travelling to the sites where they were taken. Emergency physicians have faster and more complete access to critical information to make diagnoses.

All this adds up to improved patient care at a lower cost. It's estimated that the shared digital imaging systems alone can save Canada $350 million a year by reducing duplicate tests, eliminating the cost of manually handling and storing physical films, and cutting wait times for diagnostic imaging results. Based on the positive experiences of both B.C. and Ontario, all eight remaining provinces have launched projects to reuse and build on these successes.

Before closing, I would just like to quickly review Infoway's accountability regime. Infoway was created as an independent, not-for-profit, shared governance corporation, and it is rather unique in its mandate, joint investments, and structure. It is neither an agent of the Crown, nor a crown corporation, nor, as I mentioned earlier, a granting agency. Infoway is equally accountable to all its members, which are Canada's 14 federal, provincial, and territorial governments represented by their deputy ministers of health. A collaboration of each member government is required on an equal basis. Each member has an oversight role in Infoway and no individual member or government has a priority oversight role. Oversight is further enhanced by a regionally constituted knowledgeable board of directors appointed by the members. The board has two federal appointees, one representative from each of Canada's five regions, and six independent directors elected by all members. The federal deputy minister appoints the board chair.

Infoway also has a strong public accountability regime that includes an independent third-party performance evaluation, the first of which will be completed by March 2006 and will be submitted to all members and available publicly; an annual independent compliance audit, submitted to all our members; an annual independent financial audit, submitted to all the members and available publicly; an annual business plan, presented to the members and a summary made available publicly; and an annual report that tracks results against the corporate business plan of the preceding year, submitted to all members, distributed to all MPs, senators, and the Auditor General, and available publicly.

In conclusion, our mission, I believe, is critical. We understand that our contributions to advancing electronic health records respond directly to improved patient safety, care delivery, access, and productivity in the health care system. Infoway, with the provinces and territories, is substantially ahead of where we were twelve or, for that matter, even six months ago. In these efforts we support the need for transparency and direct accountability to all our members and the Canadian public.

● (1545)

[*Translation*]

I thank you for listening today, and welcome your questions.

Thank you.

[*English*]

The Chair: Thank you very much, Mr. Sheridan.

We'll begin the questions now with Mr. Merrifield.

Mr. Rob Merrifield (Yellowhead, CPC): I also want to thank you for coming in. We've actually talked about Infoway a number of times, and it's good that you're actually dialoguing with the committee.

I don't think you have to convince anyone around this table on the need for Infoway and the value of having medical records following patients. We just completed a study on pharmaceuticals, and some of the numbers are absolutely astounding when you see studies—and I refer to the Baker Norton study of last June, with 24,000 deaths in our hospitals. On the need to have medical records following patients, I don't hear a voice anywhere arguing against it.

I want, first of all, to ask you to clarify the number, because my number is $1.2 billion from the federal government, and you just said $2.1 billion. Can you explain the difference in the numbers?

Mr. Michael Sheridan: The correct number is $1.2 billion. If I said $2.1 billion, I apologize.

Mr. Rob Merrifield: Okay. That's only a $1 billion mistake, not a big deal.

Voices: Oh, oh!

Mr. Michael Sheridan: A billion here, a billion there—pretty soon we're talking real money.

Mr. Rob Merrifield: No, not to make light of it, but about that $1.2 billion...the project started four years ago. There was an intense need to move this along. We're really talking many thousands of lives here, if in fact medical records could facilitate in helping save some of these lives from the medical errors being made right across this country. But it's four years, and we're really seeing very little spending.

Correct me if I'm wrong on this, because you went through the numbers fairly quickly, but did you say it's $320 million and 12 projects?

● (1550)

Mr. Michael Sheridan: No, we have over 100 projects now in place.

Mr. Rob Merrifield: But is it $320 million?

Mr. Michael Sheridan: The amount of money we have in approved projects is $320 million.

Mr. Rob Merrifield: Most of that in the last three months, is that fair to say?

Mr. Michael Sheridan: Mostly in the last six months. That's fair to say.

Mr. Rob Merrifield: Okay. I'm just trying to get a handle on exactly what we're doing with this money.

You're saying it's a 50-50 share with the provinces, and with some of the projects now you're moving to a 75-25, because the provinces aren't able to come up with the extra money. Is that fair to say?

Mr. Michael Sheridan: That's fair to say.

Mr. Rob Merrifield: Understandably, some of the provinces are absolutely stretched to the max just finding doctors and nurses, let alone computers and programmers. I can understand that, to some degree, but what I can't understand is....

I come from Alberta, and I'm fairly familiar with what has been happening in Alberta. My facts may not be quite accurate, and I'm certainly open to your correcting them, but I believe their goal was to have medical records follow their patients by the end of last year. I also believe they've accomplished that. Is that fair to say?

Mr. Michael Sheridan: In some care delivery regions, yes, that is fair to say. The premier has outlined an overall plan for all Albertans to have an electronic health record. I believe the deadline he has established for that to happen is 2008.

Mr. Rob Merrifield: What percentage is done now?

Mr. Michael Sheridan: In Alberta?

Mr. Rob Merrifield: Yes.

Mr. Michael Sheridan: I don't have that figure with me. I couldn't say.

Mr. Rob Merrifield: It's the majority, though?

Mr. Michael Sheridan: No, I don't think we're anywhere near the majority. The issue here for the electronic health record, to make it interoperable, is that there are four fundamental tranches to it. One is diagnostic imaging, and we have just invested in a very large project with Alberta to complete their diagnostic imaging.

In the critical care facilities, I think over the next year or so we'll probably see completed the diagnostic imaging nodes in the province that bring the information from all of the critical care facilities.

Mr. Rob Merrifield: I can understand diagnostic imaging being a highly technical area that you're working with. I have no argument with that, other than what we're actually seeing is that a significant problem is the adverse events and the amount on the pharmaceutical side. From that perspective, I believe that's the part of Infoway where the province has accelerated.

Mr. Michael Sheridan: The province has accelerated in that particular area. Again, one of the very first projects they undertook or invested in was with Alberta—

Mr. Rob Merrifield: I realize that.

Mr. Michael Sheridan: —in the pharmacy information network. We learned a number of things out of that investment, including that, first of all, doctors want all drugs for all people. When we started off on that project, there were some fundamental issues about getting access to all drugs for all people.

So we had seniors, but the interface with the system, in terms of going to a hub and reading the drug history or the prescription history for a senior, but not being able to do that for somebody who was not on the seniors drug plan, caused some major modifications in that particular project. We are still working with the Province of Alberta to alleviate the problems associated with getting all people and all drugs into a province-wide pharmacy information network.

Mr. Rob Merrifield: Give us a percentage for how far along you are on that.

Mr. Michael Sheridan: The issue on that one was basically adoption. One of the issues we had was that for care practitioners, we have specified in our funding agreements an adoption rate, and Alberta did not hit that adoption rate. So there were two issues: getting all people and all drugs into the system, and getting it adopted and used by the actual doctors and physicians in the province.

Mr. Rob Merrifield: We knew that was going to be a problem, getting physicians up to speed and using it.

Mr. Michael Sheridan: And doing that one.

● (1555)

Mr. Rob Merrifield: Yes.

On that side of it, on the drug side of it, are there more advances in other provinces that we're not aware of, or is it the province that is sort of leading the way?

Mr. Michael Sheridan: I would say right now, as we look at the investment strategies and roll out our blueprint, in the area of drug information systems Alberta is probably in the lead at this particular juncture, followed by British Columbia, in terms of Infoway investments.

That said, the provinces all have their road maps per se, so we're dealing with 13 jurisdictions over four or five sets of critical programming to develop an electronic health record. Some provinces have pushed forward with client registries and provider registries and have set those as a priority ahead of, perhaps, their drug information systems.

So we're dealing with a variable set of priorities in terms of the 13 provinces and how they need to proceed to accommodate this blueprint.

Mr. Rob Merrifield: When you look at the numbers, let's say Michael Decter's, and even your numbers, you're saying your goal is 50% by 2009. Michael Decter is saying it would be 2020 to get every Canadian on this system.

If you're just doing the math—and they say math doesn't lie—24,000 deaths a year means a significant number of Canadians are going to be at risk and potentially die. We don't know what the variable there is. We don't know how many deaths we'll save with this information, but I certainly hope it's considerable.

Maybe we need to be talking to some of the provinces as far as what their priorities are, but what province would have areas of higher priority than the drug side of it?

Mr. Michael Sheridan: Well, the drug information systems, I think, are clearly a priority. The issue is in terms of some provinces. For example, Ontario is now in the process of developing a province-wide drug information system. We are investing in that particular project as well. So the fundamental issue, I guess, is what are the priorities, and how do they roll out to help fulfill the blueprint and the road map?

In some places, looking internationally, certainly we've seen a rip and tear type of approach where people have abandoned what they have now. Certainly in Great Britain it looks like there is a rip and tear approach. It's a £16 billion project for Britain to replace their current system with electronic health records.

I think we recognize that our approach on this would be both a provincial-level approach and a health region approach, so we could build both from top down and bottom up on this and not necessarily have a rip and tear approach, but perhaps a modified approach.

The Chair: Thank you very much.

Next, we'll hear from Mr. Ménard.

[*Translation*]

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

I do not clearly understand your status. You say that you are not a Crown corporation and that you are relatively independent. What is the federal government's contribution to your overall budget?

I'm a little surprised to see that we don't have your operating budget. Would it be possible for you to table a chart indicating what progress has been made in each of the provinces? For example, can you tell us anything about what is happening in Quebec?

How is each province's contribution to the work Canada Health Infoway is currently carrying out determined?

Mr. Michael Sheridan: Most of our funding has been allocated by the federal government. That money has been paid out in three separate installments: an initial endowment of $500 million in 2001, a second amount of $600,000 in 2002-2003, and a third installment of $1 million in June, 2004.

In terms of investments, our structure provides for an approval process requiring that the provinces meet certain commitments. Contracts are signed by Infoway and the provinces based on results and investments. I should point out that not all costs are eligible for Canada Health Infoway funding.

In terms of your last question, I would be very pleased to table a chart indicating the amount approved for each province as of March 31, 2005.

● (1600)

Mr. Réal Ménard: Do you consider yourself to be a foundation? I'm sure you know that there is quite a debate going on here in Parliament, thanks to the vigilance of my colleague, Mr. Sauvageau, the Member for Terrebonne, regarding the accountability we have every right to expect. We are talking here about investments of considerable amounts of public funding: $500 million, $600 million, and $1 billion. What is the federal government's involvement in your work? What accountability mechanisms are currently in place? Would you agree to the Auditor General's looking at your books?

Mr. Michael Sheridan: I would like to answer in English.

[*English*]

The accountability structure that was established for the corporation makes the corporation accountable to all of its members, which include the federal government, the 10 provinces, and the three territories. And the corporation, the way it was established in terms of its governing principles, basically has an accountability to each one of its members, with no member having a priority over the other.

So it's a kind of unique structure. It's a structure that seeks compromise, and it seeks a balanced approach to moving the agenda ahead with respect to electronic health records.

[*Translation*]

Mr. Réal Ménard: The budgets we are called upon to review include those of the Public Health Agency of Canada, the Canadian Institutes of Health Research, and the Patented Medicine Prices Review Board, although we have no information about you. Do you not find it rather strange, given what we are expected to do, under a system of ministerial accountability, that amounts of money as large as the ones you have mentioned would be subject to no parliamentary overview whatsoever? How could we get involved?

I've been hearing about Canada Health Infoway for several years now, but I have never seen the slightest report. And today, you are appearing before the Committee even though we have no budget documents, no summary of what you have achieved, and we have no idea what kind of progress has been accomplished in each of the provinces. Would you agree to the Auditor General having a look at the way you're managing your operations in terms of sound management, accountability and reporting? And, please don't forget to tell me about the situation in Quebec. Just give me a yes or no answer. Do you think the Auditor General should be involving herself in your affairs?

[*English*]

Mr. Michael Sheridan: Just to clarify what's available in terms of information financially, our financial auditors, Ernst & Young, prepare each year in our annual report a set of financial statements, and those financial statements are available publicly and provided according to appropriate accounting practices. So the issues around the financial status and the financial operations in terms of both operating budgets and investment for Canada Health Infoway are public and have been made public, in terms of information.

I'm not quite sure what the reference was you were making, the document you had, but if it's this year's main estimates, Infoway was not granted any additional funds for this—

[*Translation*]

Mr. Réal Ménard: Do you agree with the idea of the Auditor General having access to your books?

[*English*]

Mr. Michael Sheridan: Well, there are two acts before Parliament now that speak to that particular issue with respect to having the Auditor General be able to audit foundations. At this particular juncture neither of those bills has passed, so it would be inappropriate on my part to comment on the machinery of government and the parliamentary process.

[*Translation*]

Mr. Réal Ménard: But what do you think?

[*English*]

The Chair: Mr. Ménard is deftly trying to get you to agree with his party's policy on this issue.

Ms. Dhalla.

[*Translation*]

Mr. Réal Ménard: We're talking about $2 billion here. It wouldn't be a bad idea for the Auditor General to have a look at that. Madam Chair, I think we would have been in our rights to expect to see some documents today, and a clear answer to our question. That's why we were sent to Parliament. We're not talking about sponsorship here, we're talking about publicly funded budgets.

[*English*]

The Chair: Yes, I know. It's already been done. Let's not have repetition.

Ms. Dhalla.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): Thank you very much for coming today. I'm going to just change the line of questioning slightly.

I think you elaborated on this a little bit earlier while Mr. Merrifield spoke. He was asking in particular about his home province of Alberta and its partnership role with Canada Health Infoway.

My question is in regard to my home province of Ontario. What is its role with Canada Health Infoway, and what types of partnership agreements have they entered into with your organization thus far?

● (1605)

Mr. Michael Sheridan: As with all other provinces, it's a...I hate to use the word “shareholder”, but the reality is that the shareholders of the corporation are the provinces, territories, and the federal government.

Certainly, Ontario has been an active member in terms of moving along the agenda for electronic health records. Currently, we have invested about $47 million in projects approved in Ontario. They are primarily around viewer and hub systems associated with moving ahead or advancing the agenda on labs and lab information. Those projects have recently been approved and are starting now.

I think one of the important things to understand in terms of the money flowing via Infoway as expenditures is that these projects are taking, on average, about three years after approval to come to full implementation. I think we realized that this wouldn't be a big bang approach to implementing electronic health records. I think we're seeing some of the consequences of that in terms of how fast jurisdictions and provinces are able to keep pace with the targets and objectives established.

The amount of time to completely change a laboratory information system in a particular province to make it electronic, and to follow the standards and to follow the protocols and have accessibility to those results, requires very large investment projects and very large IT projects.

Ms. Ruby Dhalla: Are you on a 50-50 partnership with Ontario or a 75-25 partnership, as you mentioned?

Mr. Michael Sheridan: After the board decision last month, all of the jurisdictions will now be moved to 75-25 financing.

Ms. Ruby Dhalla: You talk about targets and vision. Is it with Canada Infoway, or who else, that targets are established and developed? Whether you look at some of the areas that are mandated for diagnostic imaging, laboratory information, telehealth, who are those targets established in conjunction with? Is there a national standard? Is it done in collaboration with each specific province?

Mr. Michael Sheridan: It's done in collaboration with each specific province. The timetables and schedules for each of the projects are established with the province and Canada Health Infoway, along with the definition of the project architecture to make sure that it meets the blueprint specifications, to make sure that systems will interoperate, and to make sure they will be reusable and re-portable in other provinces in other jurisdictions.

Ms. Ruby Dhalla: Would it be the same for Alberta and Ontario, or would it vary between and be unique to each province?

Mr. Michael Sheridan: The adoption standards might vary depending upon the project, but the measurable results and gated funding in fact apply in every project, every province, and every territory.

Ms. Ruby Dhalla: The other question I have as a health care provider, which is of great concern to me and I think to many patients, is in regard to privacy. As you develop a lot of these particular systems, which hopefully are going to be much more effective and increase efficiency within the system, you're also providing a greater number of network users for particular systems. What types of protocols are being put into place to protect the privacy of Canadians in regard to many of their records?

Mr. Michael Sheridan: I think there are two aspects to that piece: one is security and one is privacy. Certainly in the area of privacy, some recent survey results we've seen show that about 85% of Canadians support the development of interoperable EHRs. In addition, they strongly believe that interoperable electronic health records will improve the type of care they get, their access to care, and the productivity within it. That was an EKOS survey conducted about 12 months ago. If you wish, I could see whether we could find and share its results with you.

They also have expressed some concerns. The concerns they have expressed are that they want to understand who has access to their information, under what roles and what conditions and for what purposes. Over the last six months we have been working with privacy experts, software vendors, and privacy commissioners' offices to establish an architecture that will fit into the interoperable record and that will permit both security and privacy—in other words, rules to have access to data and information: who has access, by what means they would have access, and how that data would be stored and secured.

We're just finishing the results of that work now. It's going to be incorporated into the standards for our architecture, and we're moving the agenda along on that.

One of the issues that's been a conundrum for us on that particular piece is how to get data suppressed. We're dealing with 31 million Canadians who are in ten provinces and three territories and who all have different interactions and interfaces not only with the drug system but with the health system per se. One of the elements we have built into the architecture would be suppression of information for individuals within those electronic health records.

The second piece is, who has access and in what role to that particular piece of information? Are you accessing this as the nurse? Are you accessing it as the surgeon? Are you accessing it as the specialist? The roles and role structures in terms of how the care provider interfaces with that electronic health record are extremely complicated. Building the architectural and security systems around them to enable it certainly has been a challenge for us, but one we've had great cooperation on from the privacy commissioners. Their offices have participated in our discussions on this.

● (1610)

The Chair: Thank you, Ms. Dhalla.

Ms. Crowder.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): Thank you, and thank you for your presentation. I want to come back to Mr. Ménard's comments around accountability.

Just so I'm clear, there's $1.2 billion of federal money in Infoway, and you indicated that the projects are cost-shared, moving to a 75%-25% split, but I would presume there's no provincial money in this fund, that in the projects themselves you're not managing provincial funding.

Mr. Michael Sheridan: No.

Ms. Jean Crowder: You made a comment that said one of your governing principles is that Infoway is accountable to its members. I noticed in the briefing note that was prepared that there are a couple of federal representatives on it, but a lot of them are actually other than federal representatives.

What's the line of reporting and accountability to the members of Parliament?

Mr. Michael Sheridan: The accountability of the corporation to the members of Parliament would be through the members, who are represented by their deputy ministers.

Ms. Jean Crowder: Would they report back to the health committee or to Parliament?

Mr. Michael Sheridan: They're reporting back to a number of committees and they're reporting back to a number of ministers responsible for health in the provinces.

Ms. Jean Crowder: I guess what I'm getting at is, how does Parliament, which has a significant number of dollars invested in this fund, make sure there is a reporting relationship between the not-for-profit corporation and the funder? The Canadian government is the funder, so how is that reporting relationship?

Mr. Michael Sheridan: The reporting relationship is specifically a three-tier relationship. The management at Infoway is responsible to its board. The board is constituted regionally, with five of the members of the board from the regions and identified by the members. Ultimately we have an annual general meeting every year, for which we have to submit a business plan and an annual report, a set of audited financial statements, and a compliance audit to assure our members, particularly in the area of compliance, that we are in fact following the funding agreement with the federal government.

Ms. Jean Crowder: But if the federal government itself had some difficulties with whatever came out of this, there would really be no mechanism for them to deal with it, because you're arm's length.

Mr. Michael Sheridan: If the federal government has difficulties with the process for the actual management and allocations of the fund, there is a recall clause in the funding agreement that says the money would come back.

Ms. Jean Crowder: So really, the only way for Parliament to deal with it is to invoke the recall clause.

Mr. Michael Sheridan: There are a number of ways for Parliament to deal with this. One of the ways, basically, is to have a look at our annual report. One of the ways is to—

● (1615)

Ms. Jean Crowder: But if we didn't like it, we really couldn't do anything about it.

Mr. Michael Sheridan: I'm not so sure about that, because the Deputy Minister of Health is a member of the Infoway organization, and as a member—

Ms. Jean Crowder: But again, he would come back to the Minister of Health; he wouldn't come back to Parliament.

What I'm getting at is, I don't see a mechanism for parliamentary oversight here. You have the ADM for health, who doesn't report to the health committee or to Parliament; he reports to the Minister of Health. If we had some difficulties with it, unless we all yelled at the health minister, there'd really be nothing we could do about it.

Mr. Michael Sheridan: Yes, but at the end of the day, what we're talking about here are the initial objectives in creating the corporation per se. The corporation, established with its funding agreement and with the rules as applied, exists as per the works that basically created this foundation in the first place.

Ms. Jean Crowder: I'm not sure there's a degree of comfort in that. I think many of us would prefer to see more parliamentary oversight with such a significant amount of funding.

I want to ask you another question about data, just to switch off the accountability. Recently the Canadian alliance for wait lists talked about some of the challenges with data across Canada, saying there's not a consistent way provinces gather information, there aren't consistent benchmarks for a number of things like wait lists, and some provinces don't even report on some of these things. Will these various projects move towards a more consistent format for reporting?

Mr. Michael Sheridan: I'm not sure it will help with the consistency of the reporting format. I think for measuring tangible results and for baselines established for funding agreements we have and products that have to be delivered, the project may certainly be a contributor to adding to the information that is now already available.

The notion of benefits measurement for us in terms of our own report card we've established...it is clear that in some areas the data is very strong, the data is very well founded, and they're a good benchmark. In other areas it's not clear in terms of adoption, in terms of use of the information systems, and in terms of the ultimate benefits provided. Some of those, I would argue, are intangibles with respect to patient satisfaction or practitioner satisfaction with those systems that are implemented.

The Chair: Mrs. Chamberlain.

Hon. Brenda Chamberlain (Guelph, Lib.): I just want to follow up a little bit on Ms. Crowder's question on the wait times. What is your role in that? How would you ever report that with this system?

Mr. Michael Sheridan: Let me just use diagnostic imaging as an example. We established a set of baselines before we made the investments in the diagnostic imaging programs, with a certain set of targets for adoption. The targets for adoption were to move from where the cluster of institutions, the critical care facilities, were with respect to the percentage of paper or film they were using to a state that was digital. We've basically established our benchmark at 98% digital.

For the relationship between that and wait times, what we're seeing, at least in the two areas where we've made investments, are reductions of up to 75% in the time using...film world versus the diagnostic world, with those images being read. We have a calibration from several of the radiologists in southwestern Ontario, where they've actually said their productivity has increased by 20%. We're putting these into the data and information systems we're developing for tangible benchmarks and are moving the benefits yardsticks, and many of those are dollar benefits.

The intangible ones become very difficult to measure. How much better did this make the patient's interaction with the health system per se? I'm not sure we'll ever get solid benchmarks on those types of measurements.

● (1620)

Hon. Brenda Chamberlain: That's really good, though, if some things are going to obviously speed the process along. Would you ever have any sort of reporting mechanism to the government that eventually would contribute to, for instance, the final outcome of the waiting lists for people? Or is it just your little component, your little corner?

Mr. Michael Sheridan: I would say our component could certainly add to the overall information and the aggregate understanding of the wait lists—

Hon. Brenda Chamberlain: Yes, agreed.

Mr. Michael Sheridan: —but I think we'd probably be looking at national agencies like the Canadian Institute for Health Information and Statistics Canada to be making the big advances in terms of actually coming to grips with measuring those. But certainly our data and our information could offer an underpinning.

Hon. Brenda Chamberlain: When you report this, who do you report it to, about your benchmarks? Who does that go to?

Mr. Michael Sheridan: The benchmarks established within the projects for adoption are available. We've published some of those in our annual reports. They're there. This year we've focused on diagnostic imaging.

Hon. Brenda Chamberlain: When you were talking about who has access to the info, who is it? Who do you see having access to this information?

Mr. Michael Sheridan: Information with respect to...?

Hon. Brenda Chamberlain: Your testing, for instance, on the patient. Who really gets that information? Is it just the doctors, or do you see it going wider?

Mr. Michael Sheridan: That's part of the architecture in terms of privacy and security. There's a protocol with respect to the role and access to the particular record. It depends on what role or intervention you have in the patient's treatment; you would be accorded access based on what your role is in the care system. As I say, that's one of the difficulties in building both the security and the privacy side of that blueprint and that structure for the privacy and security architecture.

Hon. Brenda Chamberlain: If any of that information ever, in some way, was accessible to someone who really shouldn't know it, and any damage came to the patient, how would you work through that? What would happen with that? You'd plug the leak, or how would you do that? Sometimes health information being at large is very damaging to people.

Mr. Michael Sheridan: Sure. In this particular case, we have to understand that Infoway isn't holding any information or data. All the information and data are either held at the local regional area or in a jurisdictional repository for the information and data. The question of the care of, control of, and access to information is absolutely a key one, but in terms of Infoway, we don't hold or build the systems associated with the data.

The provincial jurisdictions, however, are certainly subject to their own individual privacy laws and privacy acts. That was part of our challenge in developing this security architecture so it would respond in a generic fashion to each of the 10 provincial jurisdictions as well as the three territorial jurisdictions.

Hon. Brenda Chamberlain: Thank you.

The Chair: Mrs. Chamberlain is such a pro. She's just at five minutes and she's finished.

Hon. Brenda Chamberlain: I'm very respectful of the chair. I know you'll yell. I'm afraid.

The Chair: I never yell.

Mr. Fletcher is next, please.

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

Could you table to this committee the last four audits from Infoway, and also the reports Ms. Chamberlain was referring to?

Mr. Michael Sheridan: I would be pleased to do that.

Mr. Steven Fletcher: Okay.

The Auditor General has noted there is no provision for performance audits of foundations such as yours to be reported to Parliament. Would you have any objection to the Auditor General's auditing your activities and investments?

Mr. Michael Sheridan: Well, we're in the process of doing a performance audit. Part of our funding conditions and the funding agreement clearly stipulate that we will produce a performance audit. It's quite specific with respect to that audit.

● (1625)

Mr. Steven Fletcher: Do you have a problem if the Auditor General does that performance audit?

Mr. Michael Sheridan: That question is probably.... Whether I have a problem or not is not for me to say. It's clearly an issue we would probably have to bring to the board, and it's clearly an issue to be discussed with the members of Infoway.

Mr. Steven Fletcher: This committee has passed such a motion to have such a performance audit done. Supply day motions in Parliament have passed. Unfortunately, the governing party was less than agreeable to those. It is very important, especially in light of other scandals that the government has been involved in, that these books are audited, and any barrier to allowing these types of performance audits casts a cloud over Infoway, and the board must be made aware of that. I would ask then that you or your representative make them aware of that.

You talked about accountability and you talked about the federal government being one of 14 stakeholders at the table and the provinces each having a role to play in accountability. So we have a situation where government is reporting to government. I think the people viewing this on CPAC would be shaking their heads in disbelief, because governments, particularly non-Conservative governments, are not known for their proper use of taxpayers' money. I wonder then if that is not another argument to having the Auditor General review the books as a third-party non-biased individual.

Mr. Michael Sheridan: I think on the issue of reviewing the books, it's fairly easy to do in the context of the financial statements for the corporation, which we made public.

Mr. Steven Fletcher: I want a performance audit. I want to know that I'm getting a bang for my buck.

Mr. Michael Sheridan: Right. So on the performance audit, the agreement to create the corporation as such with the federal government has a very specific set of processes around performance audit. Generally, everybody has equated that performance audit with value for money. It's certainly the way we've understood it to be. The independent third-party audit that Infoway has to subject itself to and that will be approved by its board and its members specifically identifies in the performance audit 12 outcomes that are expected out of Infoway by March 2006 that would be done by an independent third-party audit. The tender for that process is now in the market.

Mr. Steven Fletcher: Okay. The fact is that other independent individuals like Michael Decter have said that at the rate Infoway is going at their mandate, we won't see results until 2020, and that is just not acceptable.

I'm just going to shift gears for a second. When we examine the list of projects that Canada Health Infoway is funding, we see many small regional initiatives. This seems like a recipe for massive duplication and inefficiency. Shouldn't there be one electronic health record program in each province, and wouldn't it be cheaper to set the goal and use that template and bring it across provinces? Wouldn't that be a better way to go?

Mr. Michael Sheridan: I think we've set the template. We have an architecture that has defined how interoperability will work in terms of the process. We've defined a set of standards for communication, communication hubs for interfaces with records. So the notion that one size would fit all in terms of dictating either what the contents of the EHR would be or how those EHRs would be managed, I don't think, is the approach that we've started with. It's not the approach that's reflected in our blueprint or our architecture per se.

The other issue here that I think is important for the committee to understand is that in a lot of cases we are working with vendors in this. There are a number of vendors in Canada that are supplying health information systems. Part of the process is to engage the private sector in this process too. We've been working very hard on that front. If imitation is the best form of flattery you can get, I was at a presentation for IBM last week and I saw a piece of our architecture coming up in their presentation. Unfortunately, it wasn't labelled Infoway. But at the end of the day, one of the big issues for us in terms of adoption is to have vendors actually take this up and move the agenda, and I think we've had enormous success with that.

● (1630)

The Chair: Thank you very much, Mr. Fletcher.

It's now Mr. St. Amand.

He's passing. We'll go to Madame Demers.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Madam Chair.

Mr. Sheridan, you referred to a hundred or more projects worth some $320 million. Did I understand you correctly? Does that amount include the $51 million that had been spent up until March 31, 2004?

I would also like to know which provinces or territories are benefiting most from that $320 million investment and those 100 projects. As we all know, building computer architecture is a very costly proposition. That's why I'm having difficulty believing that we could really go very far with a total investment of $320 million for a hundred different projects.

I would also be interested in finding out whether some provinces and territories have not been able to benefit from Canada Health Infoway thus far. I also want to say that in Quebec, we have an excellent program which goes by the name of Info-Santé CLSC. Under that program, an information service staffed by nurses is currently in place which takes the pressure off hospitals, clinics and other health care facilities. I would like to know whether Info-Santé CLSC has received any part of that $320 million in funding.

Finally, about $900 million remains in the fund. Is it your intention to leave that money aside for quite some time or do you want to spend it quickly? In the latter case, why was nothing invested in the fund in 2005? Do you believe the government will continue to invest in this fund? And if not, I would like to know why, since so many people are signing its praises.

Thank you.

Mr. Michael Sheridan: Thank you.

In answer to your first question with respect to who is benefiting from the investments made by Canada Health Infoway, I do intend to table information with the Committee with respect to the investments we have made thus far, by province and territory. Once you have that, the answer will be clear.

As regards Quebec, I would point out that Quebec only became a member of Canada Health Infoway in 2004. As a result, that province is slightly behind in terms of the electronic health record process.

[*English*]

Having said that, next year Infoway has plans in the budget, and has agreed with the province, to invest $100 million in the province of Quebec on electronic health records. We have two very major electronic health record projects in two of the health districts in Montreal, one in Laval and one in the downtown area of Montreal, to move forward the electronic health records. Next year we hope to see some fairly significant and substantive projects and movement in the electronic health records in the province of Quebec.

As far as the remainder of the funds and the assets in Infoway are concerned, I think I need to make it clear to members of the committee that once the funds for projects are approved and identified, they are earmarked and set aside in our financial structure. If indeed we can move the agenda ahead next year, in terms of our goal to invest $300 million in projects across Canada, what it would mean is that Infoway will have identified and earmarked approximately 50% of its total funding. Those funds can't be reused.

The issue here for us, and the problem when people look at the progress, is the billings against the actual project approvals; we have a lag time there. We have a lag time for a number of reasons. As I indicated earlier, these projects are taking, on average, 36 months. Certainly we have a set of gated fundings, and if those gates aren't met, the funds don't flow. The reality, in terms of the $1.2 billion we have, is that 50% of that, if we meet our targets next year, will have been identified and allocated to projects.

● (1635)

[*Translation*]

Ms. Nicole Demers: Are there any provinces or territories that have derived no benefit whatsoever from Canada Health Infoway?

Mr. Michael Sheridan: No, we have invested money in every province and territory.

Ms. Nicole Demers: Thank you.

[*English*]

The Chair: Thank you, Madame.

Mr. Carrie.

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

You may have noticed that we've had quite a few questions today on accountability. As politicians, we're concerned. There have been so many cases—you've heard of the gun registry, of course, which was supposed to register one little thing costing $2 million, expanding to close to $2 billion. I guess it's getting up there.

You've mentioned a budget of $1.2 billion, and I see this is just the start. Have you estimated what this is actually going to cost, once we get everything put in place? How much is it going to cost the Canadian taxpayer, as far as your estimates are concerned, to have Canadians covered with an electronic health record?

Mr. Michael Sheridan: When we started down this road I think people realized, even at that juncture, that the $1.2 billion would not be sufficient funding to get 100% of Canadians into an interoperable EHR with all of their health data. Infoway recently conducted a study, which we contracted to Booz Allen Hamilton, the results of which we will be publishing in the next couple of weeks. Let me give you a couple of pre-indicators on it.

The first one is that right now we're playing in the critical care field. The total estimated cost to deliver it, for both info structure and EHRs, is estimated at $4.4 billion by Booz Allen Hamilton. In terms of the eligible funds we pay into it, Infoway is really only paying 27¢ on the dollar. The provinces are paying the differential on it and also assume the long-term operating costs and maintenance costs for those systems.

Mr. Colin Carrie: I realize that, but being as there's only one Canadian taxpayer, what we have is a federal program that's been started and then again downloaded to the provinces. Once it's set up, they're going to be responsible for continuing with it over the years. We've seen a lot of evidence in the past of investment for investment's sake—get it up and running. But we're starting this huge undertaking, which everybody agrees is a great idea, but we're starting it without knowing the cost. So do you have a bottom line for me?

Mr. Michael Sheridan: The total estimated cost to have 100% of Canadians with an IEHR, coming out of this study, is about $300 per Canadian.

Mr. Colin Carrie: So we're looking at around $10 billion.

Mr. Michael Sheridan: Yes, $10 billion. That same study, however, also has done some analytical work with respect to the long-term benefits of that investment. Six years out, the study indicates that the savings to the system would be, on an annual ongoing basis, $6.1 billion. So there is an offset in the study and in the investments as well.

Mr. Colin Carrie: That's great to hear; it's just that we are very concerned about things of this size.

You mentioned that you're talking to the different shareholders, but you didn't mention whether you're talking to the professional associations. Being a health care provider, I think you could get a lot of information if you talked to the Canadian Medical Association, the Chiropractic Association, the Dental Association, to find out ahead of time what type of data you want to have collected for this electronic health record. Have you been discussing it with the professional associations?

● (1640)

Mr. Michael Sheridan: We have been actively networking and discussing with the professional associations. For the large e-health conference that's coming up in Toronto next month, in May, we've developed, and Infoway co-chairs, an associations collaborative. We meet face to face probably three or four times a year and we have regular conference calls with them.

More importantly, however, Infoway has recently brought on a chief medical adviser, who has done a significant and substantive amount of networking with physicians, physicians' associations, and with the provincial associations. We've spent quite a bit of time and effort developing relationships with those associations, helping them understand the architecture. Basically, of course, getting back from then, this is a huge challenge in terms of change management: how people will change their interactions in moving from a paper-based system to an electronic-based system. There's been a very open and productive set of dialogues and discourses with the associations.

Mr. Colin Carrie: Are you just starting that right at this time? Is there nothing concrete yet—just the networking?

Mr. Michael Sheridan: We have been working on this for some time, but I think it's starting to come to fruition now.

The Chair: Thank you, Mr. Carrie.

On behalf of the committee, I thank you very much, Mr. Sheridan. I think you're a very courageous man trying to manage the change, with 13 jurisdictions to juggle, not to mention a variety of professionals and all interfacing with the newest technology. It's quite a challenge you've taken on, and we wish you well with it.

Mr. Michael Sheridan: Thank you very much, Madam Chair.

The Chair: Thank you for coming here.

I would now like to invite the representatives of the Patented Medicine Prices Review Board to the table. I'm going to have to cut back time because all of us took an hour and fifteen minutes for that one. Why don't we start with eight minutes for you—four and four—and four for everybody else, or whoever is starting on this?

Mr. Rob Merrifield: I'm okay with that.

The Chair: Good.

Ladies and gentlemen, I introduce to you the vice-chairperson of the Patented Medicine Prices Review Board, Mr. Réal Sureau. He is assisted by the executive director of that organization, Ms. Barbara Ouellet.

Mr. Sureau, the floor is yours.

Mr. Réal Sureau (Vice-Chairperson, Patented Medicine Prices Review Board): Good afternoon.

● (1645)

[*Translation*]

Good afternoon.

[*English*]

I welcome the opportunity to appear before you as vice-chairperson of the Patented Medicine Prices Review Board to address our activities and recent developments in the area of pharmaceutical pricing in Canada. Most of you know, or those older members I see, Dr. Robert Elgie, chair of the PMPRB from 1995 to 2005, completed his mandate in early March. Dr. Elgie was an exceptional CEO and chairperson of the board, and we wish him the best of luck in his new endeavours. The responsibilities of the chairperson are now incumbent on the me as vice-chair until a new chairperson is appointed.

With me today is Barbara Ouellet, recently appointed executive director of the board. Most of you will certainly remember Madame Ouellet, who has appeared before this committee on a number of occasions as the director responsible for pharmaceutical policy issues at Health Canada.

I would like to take this opportunity to thank Wayne Critchley, former executive director of the PMPRB for 15 years, for his invaluable contribution to the organization. I wish him the best in his retirement.

Following my opening remarks, I will be pleased to answer any questions you may have.

As published in the report on plans and priorities, the 2005-06 PMPRB budget is $4.3 million.

[*Translation*]

Since our last appearance before this Committee in the fall of 2003, pharmaceuticals have remained front and centre in public policy discussions. Given the importance of pricing considerations in any discussion of pharmaceuticals policy, I would like to devote a few minutes to reviewing the responsibilities of the PMPRB in the context of Canada's public policies on pharmaceutical pricing.

Although today's consumers are taking a more active role in decisions on the use of prescription drugs, they do not make the final decision—physicians do. Physicians, in consultation with the patient, determine if drug therapy is appropriate and, if so, which medicine should be used. That is why pharmaceutical manufacturers continue to spend considerable resources marketing their products particularly to physicians. And in most cases, patients do not pay the full cost of the drugs they take. Fortunately, most Canadians have access to public or private insurance, which helps to mitigate costs.

In addition, manufacturers enjoy full patent protection for their inventions. These market conditions give drug manufacturers considerable market power and, given the importance of pharmaceuticals to health care, governments have long recognized a need to intervene in this market in the public interest.

[*English*]

The PMPRB was created as an independent quasi-judicial administrative agency through amendments to the Patent Act in 1987. The decision by Parliament to strike a new balance of pharmaceutical patent policy and consumer protection came about following lively public debate.

Among other things, the 1987 amendments increased patent protection for pharmaceuticals by restricting compulsory licensing and established the PMPRB out of concern that patentees might abuse the increased patent protection provided by the act.

The role of the newly created PMPRB was to influence the pricing of patented medicines to much the same extent that the competition fostered by compulsory licensing used to influence it. The brand-name pharmaceutical industry agreed to price controls as part of the 1987 package of expanded intellectual property rights and has since largely complied.

With the adoption of these amendments, the industry, through Rx and D, made a public commitment that the industry would increase its annual R and D expenditures as a percentage of sales to 10% by 1996, a commitment that was met earlier in 1993. However, the R-and-D-to-sales ratio has decreased in recent years.

The PMPRB was given a twofold mandate: regulatory and reporting. Let me remind you of it. Under the regulatory responsibilities the PMPRB ensures that the manufacturers' prices, i.e. ex-factory gate prices of patented medicines sold in Canada, are not excessive. The board reviews the price at which a drug product is sold by the manufacturer to all purchasers, including wholesalers, hospitals, pharmacies, and others.

With respect to the second portion of its mandate, the PMPRB reports annually to Parliament through the Minister of Health on drug price trends of all medicines, analysis of cost drivers and drug utilization for public drug plans, and the R and D performance of pharmaceutical patent-holding manufacturers.

We do not set prices. Neither do we attempt to establish prices based on the cost of production, nor on determining the rate of return to the manufacturer. Instead, Canada's price control system is based on protecting consumers by limiting the price manufacturers may charge to ensure that these prices are not excessive. The effect of this type of regime is to establish the boundaries in pricing, to define the parameters in which manufacturers may set prices.

The board operates at arm's length from government. It has the powers, following a public hearing, to order a price reduction or other remedial action if it finds that the price of a patented drug is excessive. It makes that decision based on factors set out in the act, including the prices of drugs in the same therapeutic class in Canada and other countries, and changes in the Consumer Price Index. The factors in the act have guided the board to establish the objective that prices for patented drugs in Canada, on average, should not exceed the median of prices in the other countries that we compare ourselves to, those being France, Germany, Italy, Sweden, Switzerland, the United Kingdom, and the United States. This principle reflects the apparent objective of the act that Canadians should not pay more than their fair share of the international costs related to the research and development of new medicines.

When we review this evidence, the system has worked to protect consumers from excessive pricing for patented medicines. In 1987, Canadian prices for patented drugs were second highest in the world, 23% above the median of the foreign prices and higher than the six European countries used for comparison purposes. After the creation of the board and the introduction of its guidelines, that ratio declined, but Canadian prices were still approximately 10% above the median in the early 1990s. Concerned that it had not achieved its objectives, the board amended its guidelines effective in 1994, and since then, Canadian prices have consistently been just slightly above, or even 5% to 10% below, the median of foreign prices.

● (1650)

[*Translation*]

Over the past decade, most new and existing patent drugs were priced within the guidelines in the first instance. During this period, we approved 20 Voluntary Compliance Undertakings.

[*English*]

These are mostly known in the industry as voluntary compliance undertakings.

[*Translation*]

These undertakings offset excess revenues, as appropriate. They provide direct evidence of the impact of the PMPRB, but represent only a small portion of the total impact. They do not measure all the occasions where a manufacturer, either on its own or following advice from board staff, chose to set its price within the guidelines in the first place, and not challenge the regime.

[*English*]

That said, last year we began to read reports in the media of price increases and to receive questions from public drug plans about price announcements they had received. In all, we estimate that manufacturers of about 35% of patented medicines currently on the market had made public announcements of price increases. While it appeared that these increases could be within our guidelines, they will have to be reviewed after the fact. In most cases we had been given neither advance notice nor the opportunity beforehand to ensure that these prices were non-excessive.

If such increases were to come about, they could represent a change in the pricing trend in Canada over the past decade, which has shown stability. We will need to consider if such a trend might in future set Canada apart from the European countries we use for comparison purposes.

Under the circumstances, the board decided it was appropriate to launch a public consultation on these questions, and it issued a discussion paper last month on how we should be thinking about price increases.

Of course, the board has not reached any conclusions, nor even made any proposals to change how the CPI factor is considered in price reviews. Instead, it is proceeding in a consultative way, seeking input from all stakeholders. Submissions have been requested for May 9, following which the board will determine the next steps.

It is important to note that over the last decade, the patented drug sector has grown significantly. Their share of total sales in Canada has increased from 45% to 67%. The growth in total sales of all drugs, patented and non-patented, was also significant, reaching $15 billion in 2003. These increases were reflected in expenditures by governments and by consumers through their private insurance coverage and as out-of-pocket costs.

The PMPRB annual report for 2004 will be forwarded to the Minister of Health on May 31 and will provide the most recent information on manufacturers' sales of drugs for the current year. In its latest report, the Canadian Institute for Health Information, CIHI, estimated that total expenditures by Canadians on medicines reached $22 billion in 2004, and that drugs now represent nearly 17% of total health care spending in Canada, ranking second to hospitalization costs. As a result, public programs have sought a greater understanding of the reasons for such growth and whether it is appropriate. They have introduced new approaches to contain costs, and they have sought out new approaches to collaboration.

● (1655)

[*Translation*]

Increasingly, the PMPRB has been asked to do more to examine the broader questions. Our studies have shown that the major factors driving up drug costs have been the impact of the introduction of new drugs and increased utilization of drugs in the health care system. Price changes for existing drugs have not been a cost driver.

The PMPRB has undertaken a number of initiatives in the context of its role in the National Prescription Drug Utilization Information System (NPDUIS). In 2001, Ministers of Health established the NPDUIS to provide critical analyses of price, utilization and cost trends so that our health system has more comprehensive, accurate information on how prescription drugs are being used and on sources of cost increases. Currently, we have a number of projects in progress that will supply the participating jurisdictions with such information.

[*English*]

Last September, the first ministers agreed to build on this collaboration by developing and implementing a national pharmaceutical strategy as part of their comprehensive agreement on health care. They declared, and I quote, that "affordable access to drugs is fundamental to equitable health outcomes for all our citizens".

A ministerial task force is focusing on a number of key areas relating to, among others, catastrophic drug coverage; introduction of a national drug formulary based on safety and cost-effectiveness; improving access to breakthrough drugs and accelerating access to non-patented drugs; and achieving international parity on prices of non-patented drugs.

We're seeing greater collaboration, not only between the various levels of government in Canada, but also among all participants in the health care system to improve pharmaceuticals management in the coming years. The PMPRB is both cognizant and proud of the contribution it has made to ensuring that Canadians do not pay excessive prices for patented medicines. I want to assure the committee that the board is committed to continuing to fully carrying out its mandate to protect Canadian consumers.

Madam Chair, we are now ready for questions.

The Chair: Thank you very much.

The members will note that we don't have a lot of time, so we're not going to be able to use the amount of time per person that we usually have. We have about three and a half minutes each.

Is Madam Demers coming back?

[*Translation*]

Mr. Réal Ménard: I think she's coming back.

[*English*]

The Chair: About three and a half minutes, beginning with Mr. Merrifield.

Mr. Rob Merrifield: Thank you for coming in.

Very quickly, just to capture what you said, I believe you say you don't set prices; it's free market. You restrict prices only when they bounce above the seven-country average. Is that right?

Mr. Réal Sureau: Yes. The goal is that the Canadian prices should not exceed the median of those international prices.

Mr. Rob Merrifield: Have you looked at generic prices at all in those others?

Mr. Réal Sureau: No, it's not part of our mandate. Our mandate is limited to patented medicines.

Mr. Rob Merrifield: I realize that. I'm just asking the question. If we did look at generics and used that same formula, would our prices be higher or lower than the median? Do you know that?

Mr. Réal Sureau: We have made studies recently at the request of the FPT on single-source and multiple-source non-patented drugs in order to inform them of price trends. These, I think, were made public by the federal, provincial, and territorial bodies.

Again, we do carry out some studies whenever we are asked, but at the moment it's not part of our mandate.

Mr. Rob Merrifield: I realize it's not part of your mandate. I just thought you might have the answer to that question. It's a pretty basic question. If you used the same formula for generic or non-patented drugs, would we be above or below the median of those other countries?

Mr. Réal Sureau: I think that study determined that we would be above.

● (1700)

Mr. Rob Merrifield: Okay. Thank you.

We are in the middle, actually, of a study on Internet pharmacy, which certainly lands right in your lap. I noticed—I don't know whether it was deliberate or not—that you never mentioned it in your deliberations. I'm wondering what your position is with regard to Internet pharmacy, how that might impact drug prices and your role.

Mr. Réal Sureau: In the sense of your question, if there is a concern about the Internet pharmacies, we do look at them as an interested party, but we regulate prices of patented medicine at the factory gate. So whenever it's reported as sales, if it's sold through a virtual Internet pharmacy, it's part of the sales that have to be reported by patentees. But we don't look at the whole chain. We don't look, after that, at wholesalers, because we regulate prices at the factory gate.

Mr. Rob Merrifield: Right. So they could be higher or they could be lower than the average. You would have no jurisdiction, is what you're saying. You're just at the manufacturer—

Mr. Réal Sureau: Internet pharmacy, you understand, is for export, for cross-border sales, and for this....

Mr. Rob Merrifield: Not always, but most of them.

Mr. Réal Sureau: If it's sold in Canada, it is part of the sales that are declared to us. If it's re-exported, then it's beyond.... It has to be a sale in Canada. I understand that those are initiated in Canada.

The Chair: Mr. Fletcher.

Mr. Steven Fletcher: You've talked a lot about price, but what about supply? Do you play any role in guaranteeing supply of the drugs?

Mr. Réal Sureau: No.

Mr. Steven Fletcher: I've heard anecdotal evidence about rolling supply shortages. Usually, supply, demand, and price are interlinked. If there is a shortage of supply, does that affect the price in ways that are not intended?

Mr. Réal Sureau: Would you like to jump in?

Ms. Barbara Ouellet (Executive Director, Patented Medicine Prices Review Board): Sure. Our mandate is strictly related to the price manufacturers charge when they distribute their products to wholesalers, hospitals, pharmacies, and others. There's certainly an influence in terms of supply and demand, but that's much more likely to happen at the next level, at the retail level, where they compete for supply and they compete for product from different manufacturers.

Mr. Steven Fletcher: Okay. If drug X needs to be approved and there's some sort of shortage, what is the guarantee that Canadians will have access to that drug?

Mr. Réal Sureau: There is no guarantee, as I understand it. On the other hand, we have not heard of any complaint.

Mr. Steven Fletcher: I come from the province of Manitoba where Internet pharmacies are a big deal. However, I'm very concerned, as the national health critic. If price or supply are affected, then action would need to be taken if that is indeed the case.

The minister has been all over the map on this issue, and I only have three and a half minutes to ask my questions. I'm wondering if you have any comment on what the minister is saying. Is price or supply being affected by the Internet pharmacies? Is that trend going up or down due to international pressures and other competition?

I'm just trying to get my last question in before my three and a half minutes are up. Do you have any advice on how we can address the Internet pharmacy issue to ensure that Canadians' interests are protected, whether it's distributors or suppliers of Internet drugs or retailers in general?

● (1705)

Mr. Réal Sureau: First of all, I wouldn't dare to comment on the comments of the minister unless he was completely wrong about our mandate. We do have communication with Health Canada, his department, to make sure he knows exactly what we're doing and what the boundaries and the rules are.

About the shortages, what can I say? We're not investigating that. It's not reported to us. We have to line up with the information we're getting. It's not part of our mandate.

The Chair: Just prices, Mr. Fletcher, not supply.

Mr. Ménard is next.

[*Translation*]

Mr. Réal Ménard: Thank you. I have three brief questions.

You mentioned that one of the causes of rising drug costs is new drugs coming on to the market. I believe the Board, though its work with the provinces and territories, has developed an econometric model its uses to assess factors that contribute to higher drug costs. I would like you to tell us more about that, because this obviously raises the question of new drugs coming on to the market: according to your previous reports, less than 10% of drugs have new therapeutic properties and thus belong to category 2. Shouldn't we be concerned about this?

If the Chair is sufficiently generous, kind and forgiving, I will have a third question for you.

Mr. Réal Sureau: In our annual report, we identified the different reasons behind increased drug costs. Here we're talking about retail costs for people on plans and for Canadians generally. We, however, base ourselves on the prices we regulate.

Mr. Réal Ménard: So, there is a distinction to be made between the price and the cost.

Mr. Réal Sureau: Yes, you first have to distinguish between the price and the cost.

Mr. Réal Ménard: Tell us again what that distinction is.

Mr. Réal Sureau: I stated earlier that factory-gate drug prices for patent holders amounted to $15 million, according to our data.

Mr. Réal Ménard: That's $15 billion, not $15 million.

Mr. Réal Sureau: Yes, $15 billion, whereas CIHI says it's costing Canadian consumers $22 billion. The difference between $15 billion and $22 billion is the money that goes to wholesalers' profits, profit margins, dispensing fees and finally, marketing costs.

● (1710)

Mr. Réal Ménard: It's the profit margin.

Mr. Réal Sureau: Yes, that's right. So there is a difference between the prices we regulate and the final costs paid by consumers.

But let's talk about the reasons why drug prices are increasing by 15% a year and now represent 17% of overall health care costs. In our annual report, we identify the two main reasons for this. First of all, new drugs are being marketed at a fairly high cost, to treat diseases for which no treatment was previously available.

Mr. Réal Ménard: But why is the cost of these drugs prohibitive? Are pharmaceutical companies taking advantage?

Mr. Réal Sureau: No, manufacturers are not taking advantage. Just by way of background information, it's important to know that the cost of marketing a new drug is now about $800 million a year. Only one drug in 10,000 actually ends up being marketed.

Drug companies try to recover their costs over a relatively short period of time. The clock on their 20 year patent starts ticking from the date the project request is originally filed, but the drug is not actually marketed until about ten years later.

When we look at the price of a new category 2 drug, a so-called breakthrough drug—and there have been some—we compare the introductory prices with the price that are charged in seven reference countries.

Mr. Réal Ménard: And you were justifiably concerned about the fact that pharmaceutical companies are now only spending about 10% of their revenues on R&D.

Is there any truth to the rumour that some marketing costs are being included in research and development costs? How do you define “research and development”?

Mr. Réal Sureau: The definition of “research and development” that we use is the one found in the Income Tax Act. Marketing expenses are not eligible expenses, according to the Income Tax Act definition.

We did note a drop last year. For the first time, the percentage of revenues spent on R&D dropped to about 9%, even though their commitment was 10%.

Basic research is also an area of concern for us. The percentage has dropped there as well, and we noted that in our annual report.

Our report presents a lot of information with respect to research and development. Our mandate is not to regulate in that area, but to keep you informed, because we do receive that information. It is broken out by province and by type of research. We wanted to alert you to the problem by pointing out that…

[*English*]

The Chair: Thank you very much.

Mr. Thibault.

[*Translation*]

Hon. Robert Thibault (West Nova, Lib.): Thank you very much, Mr. Sureau, for being with us today and for bringing us up to date on what is going on in your area. You have given us a very good explanation of the difference between prices and costs, as well as your particular role in that regard.

However, I am somewhat concerned about research and development. The 10% figure was not something that we picked out of the air. It was negotiated during discussions back in 1997 when…

Mr. Réal Sureau: Those discussions took place in 1987.

Hon. Robert Thibault: Yes. In 1987; my mistake. And what the large pharmaceutical companies were given in exchange was protection against the development of generic drugs.

Mr. Réal Sureau: Yes, mandatory licences were abandoned and they were given increased protection, or more of a monopoly.

Hon. Robert Thibault: What kind of leverage do we have in terms of getting theses companies to bring their R&D spending back up to 10%, or even up to 20%?

Mr. Réal Sureau: Our role is to report to the Committee, but we do not necessarily have the needed authority to force the industry to keep its commitment.

That responsibility rests more with the Minister or the Committee than it does with us, in terms of applying whatever pressure can be brought to bear. Our role is strictly to report this information to you.

In the studies we carried out, we even made comparisons between Canada and the seven reference countries in terms of R&D spending. Our R&D spending here in Canada has increased considerably, but we're still at the back of the pack in percentage terms.

Hon. Robert Thibault: Regarding rising drug prices…

Mr. Réal Sureau: Just to give you more complete information, I want to point out that in those countries where marketing is less controlled, the system fosters increased research and development.

We have seen international corporations transfer their research mandate from Europe to the United States. It's not that easy for the Canadian industry to receive international mandates, but Merck Frosst Canada has done well in that regard. It is up to each company to seek those mandates. Indeed, our Canadian laws are more favourable in terms of providing incentives for R&D. That was noted in a report prepared by KPMG four or five years ago. I can provide the reference to the Committee, if need be.

Hon. Robert Thibault: You are showing price increases of about 15% a year. Do you think that prices will continue to rise at that pace? Is there a trend here?

Mr. Réal Sureau: We have included two charts at the end of our brief. Table 4 shows manufacturers' sales of all drugs and patented drugs in 1990. Total sales then were $3.7 billion, and that had risen to $15 billion by 2003. You can see the percentage increases. Since 1997, we are talking about an annual increase of more than 10%.

As to the other point, there is the cost of marketing new drugs, but there is also consumption. The number of prescriptions has greatly increased.

That's the other major phenomenon we are seeing: new drugs are more expensive if they are introduced to treat illnesses for which no treatment was previously available. However, the price is not excessive, because it never exceeds the median of drug prices in the seven reference countries, if the drug is considered to be a breakthrough drug.

There is also the matter of consumption. That's why you sometimes hear people saying that we should be taking action with consumers, plan claimants and doctors, who have a tendency to prescribe more and more drugs.

[*English*]

The Chair: Ms. Crowder is next.

Try to keep your answers short, Mr. Sureau, please.

Ms. Jean Crowder: When there are pilot projects for testing drugs, oftentimes, when the pilot is finished, the cost of the drug is so high that patients can't afford it. We have a case right now of a child who's on a drug that costs thousands and thousands of dollars, and the pilot is now over and the child no longer has access to the drug. Do you get involved in those kinds of things? Are those costs reported?

● (1715)

Ms. Barbara Ouellet: Our mandate stipulates that a drug comes under our jurisdiction when it is both patented and sold. As long as it's being given away by the manufacturer, it's not under our jurisdiction, but for the first direct purchase it would, as long as it's patented.

Ms. Jean Crowder: In your priority two, “Report on pharmaceutical trends”, you say—this is part of the estimates—the purpose of the NPDUIS is to provide critical analyses of price, utilization, cost, and so on. One of the things you talk about in here is that you provide accurate information on how prescription drugs are being used, so you report to Parliament on how those drugs are being used. Do the trends in that analysis go out anywhere else? Are they provided to any other body or any other research body?

Mr. Réal Sureau: They're given to the provinces and they're available on our website.

Ms. Jean Crowder: They're just available on the website, so there's no proactive way trends or whatever else is happening is dealt with. You just report, and it's up to somebody else to do something with it.

Mr. Réal Sureau: It could trigger action by any provincial drug plan. If we identify what the cost drivers are, then they could revisit—

Ms. Jean Crowder: But I'm just thinking, if there were some unusual patterns in utilization that were emerging besides cost, for example, it would be up to somebody else to look at that information and do an analysis on it.

My last question is on the U.S. I noticed the United States is included in what you look at when you're determining whether or not the median is appropriate. Now, my understanding is that drugs in the U.S. are actually quite a bit higher in cost.

Mr. Réal Sureau: On average.

Ms. Jean Crowder: If we excluded them from the package, how would our costs look?

Mr. Réal Sureau: We're in the middle of the pack with the six other comparators.

Ms. Jean Crowder: With the U.S. included?

Mr. Réal Sureau: With the U.S. excluded.

Ms. Jean Crowder: We're in the middle, with them excluded.

Mr. Réal Sureau: Yes. In our report we put ourselves at 100. I'll give it to you by rank. France and Italy are lower normally, and then in the middle of the pack we have the others, the U.K., Sweden, and Germany. Then you have Switzerland a little higher, like 104, and then you have the United States at 160 and above from year to year.

Ms. Jean Crowder: I think that's it.

The Chair: Thanks, Ms. Crowder.

We'll move on to Ms. Dhalla for three and a half minutes.

Ms. Ruby Dhalla: I just wanted to touch on a topic that was listed in the review estimates you had forwarded to us.

There was an issue in regard to voluntary compliance with Sanofi and a drug called Fasturtec, where they had voluntarily undertaken to lower some of their prices. However, as mentioned here, this wasn't done. Their public price continues to be the same. Can you please elaborate a little bit on this and on where you see the mandate of the PMPRB in terms of voluntary compliance?

Mr. Réal Sureau: The drug, when it was examined by our staff, was found to be selling at an excessive price, around $295. To bring it into line, they had to reduce the price to $125, which they did through a voluntary compliance undertaking. They also committed to keeping that price within the non-excessive concept for the remainder of the patent of the drug.

What we found out thereafter was that they did not adjust their list price. They kept it at $295, and then there was a dual-pricing concept making its way through the industry as a possibility for a new marketing way of announcing selling prices. We questioned that, because having received an undertaking to comply at $125, we were not happy about that.

That's why we raised the issue here that we were going to look into that kind of practice with a view to discouraging it. It's part of our ongoing consultation that we'd like to see price increases well in advance so we can react, and we'd like the industry to comment on that type of behaviour.

● (1720)

Ms. Ruby Dhalla: In your opinion, what in particular needs to be done, though, to enforce compliance? Do you need a broader mandate or broader powers?

Mr. Réal Sureau: No, I think if they have agreed to list the drug at $125, they should stick to that. I don't know why they would keep the former price of $295 and then try to.... We don't know that, but we will examine the reporting for the second period of 2004, and we'll see if they've abided by their undertaking. We'd like to hear comments that it's not a proper practice to keep two prices.

Ms. Ruby Dhalla: But my question was, do you need to have a broader mandate, then, in terms of implementation? How do you enforce...? You can have voluntary compliance, but if you have a company such as Sanofi that doesn't follow through, what are the necessary steps that need to be taken?

Mr. Réal Sureau: Well, I think if we found out it's becoming a general practice, we would like to react by issuing a discussion paper to discourage the industry from giving that type of wrongful, misleading information.

Ms. Ruby Dhalla: I think that's something that's of tremendous importance to Canadians, to ensure these prices are regulated.

Thank you.

The Chair: You don't want Mr. Sureau to apply to be head of the RCMP, because you're trying to get him to suggest how we could make people comply and he's saying he'd issue a discussion paper.

But that is because you're constrained by your mandate, is that not right?

Mr. Réal Sureau: Right.

The Chair: I have a question for you that follows up. Considering this mandate that has been in use and that even the countries you compare us with have been the same countries since the outset, also bearing in mind table 4, where the patented drugs, the more expensive drugs as a percentage of the total, have been constantly increasing—of course, they're more expensive than the generic drugs—don't you think your mandate should be reviewed and revamped and brought up to date, particularly when you consider that the incidence of breakthrough drugs, the kind we were encouraging at the outset, has actually been declining in number?

Mr. Réal Sureau: I can say that our mandate is strong and we have remedial powers—

The Chair: You have what?

Mr. Réal Sureau: We have remedial powers if prices become excessive.

You were referring to an extension of our mandate or a strengthening of our mandate. We don't need any strengthening of our mandate. We have a full mandate to—

The Chair: But you just said if somebody didn't comply, you would issue a discussion paper. This does not strike me as a very strong mandate.

Mr. Réal Sureau: I was referring to the dual pricing practice that could evolve over time. If dual pricing becomes a practice, this is something we've not been used to in the past, and probably some might think it would be misleading.

The Chair: Yes, we all do, but the only thing you've talked about in the way of implementation of your will is getting voluntary compliance from companies, and then you're also reporting to us that some of the companies say they're going to voluntarily comply, but you find out afterwards they didn't.

What we're trying to find out is how we can come down on these companies. What is the sanction? Is this right?

Hon. Robert Thibault: What is the remedial thing?

The Chair: What is the remedial thing? If it's issuing a discussion paper, it's not good enough.

Ms. Ruby Dhalla: To me it's not one company that's not complying; it's one company too many.

The Chair: Exactly, and they should be fined or something.

Mr. Réal Sureau: I think Barbara wants to add something.

Ms. Barbara Ouellet: I think the issue is that the company would be in compliance with the board as long as its average transaction price was within our guidelines, and the information we're looking at for 2004 will be to assess that. The problem is that at the same time they've agreed to that average transaction price, there's a high price on the website. That's a list price. That list price is beyond our mandate. We can only make sure, and we do make sure...and as Monsieur Sureau has indicated, if they do not maintain the average transaction price, then in fact that would be contrary to our guidelines, and we do have the powers to enforce that.

● (1725)

The Chair: How?

Ms. Barbara Ouellet: The board can undertake to hold a hearing and, as a result of a hearing, make an order to roll back the price and to require excess revenues to be paid.

The concern we have is that a high list price sitting on a website of a company is confusing to Canadians, but we can only regulate the ex-factory price, which we do regulate, and we have the powers to make sure that is maintained.

Hon. Brenda Chamberlain: Where does the excess price go? Is that back to the consumer?

The Chair: There's another question that goes with that. Who decides if the price is excessive? Is that when it goes above the median?

Mr. Réal Sureau: No.

[*Translation*]

Ms. Nicole Demers: Madam Chair, is this a round table? Have we transformed our Committee hearing into a round table?

[*English*]

The Chair: I'm sorry. I got so excited by Ms. Dhalla's question.

[*Translation*]

Ms. Nicole Demers: Madam Chair, you clearly like talking about pharmacies.

[*English*]

The Chair: I think Ms. Crowder is next. Oh, she went. Then it was Ms. Dhalla. I think it's Mr. Carrie and then Madame Demers.

Mr. Carrie, I'm sorry for interrupting. It was so exciting.

Mr. Colin Carrie: Thank you very much, Madam Chair.

This was my line of questioning too, which Dr. Dhalla brought up, because I was curious to know what investigations are currently under way in regard to pricing. If you're looking at 1,000 drugs and you're looking at the pricing just to make sure the Canadian consumer is not getting gouged some way, how many as a percentage do you actually investigate?

Mr. Réal Sureau: To give you an idea, a flavour, we follow normally around 1,100 patented drugs. About 80 to 95 new ones a year come under our jurisdiction, so we look at the introductory prices of each of those that come on the market.

Sales made within the first 30 days are to be reported within 60 days to us and then we have a scientific review done. We have a scientific review, a human drug advisory panel, that would try to find a good comparative, because in principle a drug product cannot sell more than another one to treat the same condition. That's a general statement.

So we would look into the introductory price of all those that come on the market, and after extensive back and forth with the company when they've made up their scientific presentation indicating what comparatives should be looked at, if we find out that the price could be excessive, there is an ongoing investigation. At the end, if the staff make a report that the price of a new drug is considered excessive, they will make a report to the chair. The patentee is then offered a voluntary compliance undertaking, and if he doesn't accept, we launch a notice of hearing.

Mr. Colin Carrie: Could I ask you a quick little question in between there?

Mr. Réal Sureau: Well, the price increases in the existing drugs are limited by inflation. So investigations would be triggered if prices increase by more than inflation. The backlog of our investigations normally has to do with the introductory....

Mr. Colin Carrie: How many successful investigations per year would you actually...?

Mr. Réal Sureau: We review all of those. Over the years, when I answered that we would consult, it is because on a voluntary basis it's worked so well. Our guidelines are very clear. There were six times we went into a notice of hearing.

Mr. Colin Carrie: When you're saying they work really well—I'm just looking at the numbers and the price—can the Canadian system afford these increases consistently going up 10% per year? In a lot of other types of industries, prices actually go down as we start utilizing more of a product.

I just don't know if your guidelines would be acceptable, because they're going to bankrupt the entire system. Give it a couple more years. If we have another 10 years like this, it's going to bankrupt our whole system. I was wondering what we as parliamentarians can do to assist in that.

● (1730)

The Chair: We will investigate next fall, for sure.

Ms. Chamberlain, go ahead, please.

Mr. Réal Sureau: May I answer?

The Chair: No, I'm sorry. I have two people who haven't spoken yet, and the next committee is already in the room. So we have to close up as quickly as possible.

Hon. Brenda Chamberlain: I just have a question on Velacade. Do you know that product? Are you familiar with that?

Mr. Réal Sureau: No.

Hon. Brenda Chamberlain: Okay. It's for a constituent, and they're having trouble getting it. I wondered if you knew anything about it.

Mr. Réal Sureau: No, but I encourage you to phone the office and you will be lined up with an officer who can tell you more about it.

Hon. Brenda Chamberlain: Oh, can I get that? Can I get a number?

Mr. Réal Sureau: Sure.

Ms. Barbara Ouellet: I'll leave my card.

Hon. Brenda Chamberlain: Good. Thanks. I'll let you go.

The Chair: Thank you.

Madame Demers, you'll be our last questioner today.

[*Translation*]

Ms. Nicole Demers: Thank you, Madam Chair.

Mr. Sureau, Ms. Ouellet, thank you for being here today.

I'm very concerned about the overmedication of seniors who are given Ativan and similar drugs to help them sleep or to relax. When you receive the results of studies carried out by the National Prescription Drug Utilization Information System and pass that information along, do you ever raise a little red flag, to let people know that drugs may be overused?

I have a second question. You stated that in the last ten years, you have occasionally required that pharmaceutical companies lower the prices of some of their products that you deemed to be too high and that excess revenues had been repaid. What is your estimate of excess revenues repaid over the last ten years?

Mr. Réal Sureau: In answer to your last question, I would just like to give you an example. We considered the price of the drug Remicade to be excessive. That drug is used to treat Crohn's disease. The Voluntary Compliance Undertaking resulted in a reimbursement of $7.8 million.

Ms. Nicole Demers: For just one drug?

Mr. Réal Sureau: Yes, exactly.

This year, $3.8 million was repaid for Evra, a birth control pill.

Ms. Nicole Demers: Where does that money go?

Mr. Réal Sureau: That money is returned to the Receiver General for Canada. We generally recommend to the Minister of Health that the money be repaid to the provinces, where possible. Two years ago, some $10.7 million in such repaid amounts had accumulated. That money was then redistributed to the provinces.

However, the amounts I just referred to have not yet been redistributed. That is beyond our control.

Ms. Barbara Ouellet: On our Website, you will find a list that provides all that information.

Ms. Nicole Demers: Thank you very much.

[*English*]

The Chair: Thank you.

[*Translation*]

Mr. Réal Sureau: Using the information we receive, we are able to analyze prices from one province to the next. We can provide information…

[*English*]

The Chair: Thank you very much, ladies and gentlemen. On your behalf I'll thank Mr. Sureau and Madame Ouellet for coming.

This meeting is adjourned.

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