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Chair

Mr. Rob Merrifield

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● (1535)

[*English*]

The Chair (Mr. Rob Merrifield (Yellowhead, CPC)): We'd like to call the meeting to order.

We have a very interesting set of witnesses today who are going to testify, some here in the room, and we have Dr. Miyasaki from Toronto.

Doctor, do you hear us? Are we coming through all right?

Dr. Janis Miyasaki (Associate Clinical Director and Chair of the Technology and Therapeutics Assessment Subcommittee, American Academy of Neurology, University of Toronto): Yes, I can hear you fine.

The Chair: At this stage we will bring our witnesses forward and allow them to present. We'll allow all the witnesses to present first and then we'll move into questions and answers. So I'll introduce you and give you the floor at the appropriate time.

This is pursuant to Standing Order 108(2), a study on prescription drugs, the common drug review. I believe this is our sixth meeting on the common drug review.

We have with us someone from York University, and we have some individuals. We also have the University of Toronto, by video conference; Best Medicines Coalition; and Ward Health Strategies. Now we'll introduce you individually as we yield you the floor.

We'll start with York University. We have Joel Lexchin from the School of Health Policy and Management. You've been to our committee before. I recognize the face; the name I'm sometimes fuzzy on.

Thank you for coming, Professor. The floor is yours.

Dr. Joel Lexchin (Professor, School of Health Policy and Management, York University): Thanks very much for the opportunity to appear here.

My name is Joel Lexchin. I'm an MD. I teach health policy at York University, as you pointed out. I also work as an emergency physician, and I have authored a number of books prescribing guidelines for general practitioners and emergency doctors.

What I want to present now are the results of some research that I have undertaken with a colleague of mine, Barbara Mintzes.

There's been a lot of criticism about the decisions the CDR, the common drug review, makes. We wanted to compare the decisions that CDR makes to decisions made by comparable bodies in other countries, for the same drugs, with the same indications.

Initially, we identified 47 drugs that CDR had made decisions on, up to the end of September of 2006. We set up a series of criteria for how we would choose the comparator agencies. They had to evaluate at least half the drugs the CDR did. They had to publish material on their websites, in either English or French. And there were a few other criteria that I won't go into.

We ended up with two organizations, the Pharmaceutical Benefits Advisory Committee, or PBAC, which is in Australia, and the Scottish Medicines Consortium, which is in Scotland.

Out of the 47 drugs that the CDR had evaluated, the Australian body had looked at and made recommendations on 31, and the Scottish agency had made recommendations on 29. The recommendations broadly fall into three categories from each of these organizations. The first is fund without restriction, the second is fund with restriction, and the third is no funding at all.

When we look at the drugs that are in common between CDR and the Australian group, there are 31, as I said, and between CDR and the Scottish group, there are 29. When you look at these three different categories, you find that all the agencies do the same thing. The percentage they recommended for full funding is broadly the same, the percentage they recommended for restricted funding is broadly the same, and the percentage they entirely rejected is broadly the same.

The second thing we did was to look at individual drugs. Were the recommendations for the individual drugs the same or not? We found that although some of the recommendations for the individual drugs were the same, there wasn't a lot of agreement among the Canadian agency and the other two, nor was there in fact much agreement between the Scottish agency and the Australian agency. We concluded that in applying the criteria all three agencies do, which is looking at the clinical effectiveness of the product and doing pharmaco-economic analysis, they're all equally as lenient or as strict in broad terms.

For individual drugs, they take into consideration things like what price the drug is being offered at in the individual country, what other drugs are available in that country for the same condition, what the prices of those are, and how many people are affected with the disease. They then make their decisions. Because these are locally based decisions, you would expect them to be different from country to country.

The conclusion from this piece of research is that the CDR is not out of line with other international agencies that do the same thing—in other words, that use a combination of clinical data and pharmaco-economic analysis in making their decisions. They don't make the same decisions as other agencies, but they don't make them because of local factors. In fact, the three agencies we examined all make different decisions about the same drugs because of local factors.

Our conclusion is that what the CDR is doing is a good thing. They're doing an appropriate job. The drugs they reject are rejected because of things that are specific to Canada. It's the same for the ones they approve. They are approved because of factors specific to Canada. It's the same thing for the other agencies.

Thanks very much.

● (1540)

The Chair: My researcher is asking if you could provide us with the study you referred to.

Dr. Joel Lexchin: Unfortunately, when I was coming up on the train with VIA, one of the train attendants spilled water on the computer. I now have a dead computer, at least for a couple of days. Once the computer is resuscitated, I'll be happy to send a version, but it probably won't be until next week.

The Chair: That's fine. We appreciate that very much. We understand the complications of this new modern era in technology. We live with it every day. That would be great.

We'll now move on to our individual presenters.

We have with us Mr. David Bougher. Mr. Bougher is a former member of the federal-provincial-territorial pharmaceutical issues committee. We actually go back quite a ways.

This is the second time you've presented before this committee, I believe, but the first time on CDR. You go back to our days in provincial government in Alberta. It's good to have you with us. You're sharing your time with Linda Tennant, who is a former member of the federal-provincial-territorial pharmaceutical issues committee as well. It's good to have you with us.

The floor is yours.

Mr. David Bougher (Former Member of the Federal, Provincial and Territorial Pharmaceutical Issues Committee, As an Individual): Thank you very much, Mr. Chairman.

Our thanks to the committee for the opportunity to present our perspective on the common drug review. Linda and I will be speaking from a prepared text, following which we will provide a number of recommendations that are contained in the text but which we would like to highlight for the committee.

We are here as former drug plan managers and pharmaceutical policy advisors to our respective governments in Ontario and Alberta, and as Canadians interested in whether the common drug review is serving the interests of patients. We are not here to provide data, the results of research studies, nor are we here to support the position of any particular interest group.

As drug plan managers, we both supported the creation of the common drug review as a valuable tool in streamlining drug reviews and coordinating drug program activities across the country to the advantage of Canadians. We continue to support CDR, and the views that we express are intended as suggestions to strengthen the CDR process in order to promote its ongoing success.

One of our primary functions as former drug plan managers was to serve as the liaison between the minister and the committee of scientific experts who provide advice on what drugs should be covered under our drug plans. We're therefore very familiar with the issues and the problems that face governments and expert committees, as well as other interested parties, in trying to make the best decisions on behalf of patients and program beneficiaries.

Expert advisory committees on drug funding for individual programs have considerable power, and this is even more so for the Canadian expert drug advisory committee under the CDR. A recommendation not to list or cover a drug is adhered to in almost all cases, in view of the ministers' commitment and agreement that no means no and yes means maybe.

It is essential, therefore, that CEDAC and the CDR maintain the highest possible level of satisfaction and endorsement, not only by governments but by all other interested parties. The CDR must remain relevant to everyone affected by its recommendations in order to ensure its future success.

It is well established and widely accepted that, in principle, sound evidence should be the basis for decisions on health care and drug funding. However, not all evidence is as clear nor as extensive as we might like it to be. And not all drugs lend themselves to the same level or type of scientific research and study.

In addition, most studies are carried out before funding decisions are made, and experience in the real world may not match study results. It is widely acknowledged that an insufficient number of studies are carried out in real world situations once a drug has been approved for marketing. It should also be noted that manufacturers fund all but about 10% of the drug studies that are carried out.

Experience in working with expert committees reinforces the view that Canada is among the top countries in the world in scientific expertise, and that drug programs have access to a range of highly dedicated and knowledgeable people. That being said, it must be acknowledged that expert committee members bring their own biases and views to the discussion of the evidence, according to their professional experience and opinions.

Since much scientific evidence is open to interpretation about the value placed on the perceived benefit, it is not surprising that different individuals and committees present different advice to governments. These differences are extremely perplexing to decision-makers, patients and families, health care providers, and manufacturers. It is difficult to accept that a committee in one province can come to an opposite conclusion from that of a committee in another province or country.

The funding recommendations and decisions made by expert advisory committees, such as CEDAC, are based on cost-effectiveness rules that are complex and considered somewhat arbitrary by some parties. As with differences in interpretation of scientific studies, there are differences in opinion about what constitutes cost effectiveness.

This committee has already heard how these differences have led to different funding decisions on cancer drugs, for example, between British Columbia and other provinces.

● (1545)

It is these differences that brought governments to the decision to create the common drug review.

Moving on to a discussion of the effectiveness of CDR, the evaluation of CDR released in the fall of 2005 concluded that the founders—that is, governments—were pleased with the results, while industry and consumer groups had serious concerns. CDR met its timelines for reviews, refined the review processes, and achieved a level of transparency not seen in some other public drug plans.

While CDR has met its original objectives, there are some overarching issues that have not been considered and that lie within the domain of participating federal and provincial governments. It appears that some duplication or extension of drug reviews occurs because "yes" recommendations may be taken to local expert committees for further analysis, the application of special criteria for coverage, or for information and discussion. The extent to which local committee reviews duplicate CDR's work should be studied further, and, as CDR expands to include other drugs, the roles and functions of these committees should be evaluated. It is likely that some follow-up work will always be needed at the local program level in order to operationalize CEDAC's recommendations.

While decisions on implementing CEDAC recommendations lie within the domain of governments, the "no means no" policy adopted by ministers has been fairly rigorously adhered to. This means that CDR is in fact, one could say, making listing decisions for the drug plans in the case of drugs rejected for funding. Some exceptions have occurred where certain individual drug programs are funding some drug products on a case-by-case basis, however.

Given the impact of CEDAC recommendations, it is incumbent upon CDR to ensure that its processes are continuously re-evaluated, taking into account all stakeholder comments and concerns. Any review of expert committees, in general, should take into account the amounts that governments invest in drug programs and their rising share of health care budgets. Expert committees are a valuable tool in the ongoing management of large and costly drug programs.

On the issue of access to new medicines, a particularly important question for the discussion today is whether Canadians are being well served by the CDR in terms of their access to new medicines. The CDR processes ensure that rigorous standards of evidence are consistently applied in arriving at recommendations for listing drugs. However, it is important to consider whether the same standards of evidence can and should be applied to all drugs.

An example at the extreme end of the cost spectrum is expensive drugs for rare diseases. Some of these products can cost more than $100,000 a year and may be the only treatment option that's available. In some instances, because of factors such as the nature of the disease and the size of the population, it may be difficult or impossible to meet the standards of rigour applied by CDR. So the question is whether the current model or approach can be applied fairly and consistently to all classes of drugs.

Drug plan costs are largely driven by categories of drugs used in high volume, such as drugs for reducing cholesterol. For example, in Ontario, in the fiscal year 2005-06, drugs for cardiovascular and central nervous system treatment accounted for fully 50% of costs for the Ontario drug benefit program. It is therefore important to consider the collective or cumulative financial risk posed by new and expensive medicines relative to the overall cost drivers in the health system.

Let us say here that we are not suggesting that drug prices are appropriate in many or even most cases. We share the widespread concern of governments and others that drug prices seem to be inordinately high and difficult to justify in some cases. Our only comment is that all interested parties must continue to challenge manufacturers to provide an adequate rationale for a drug price and to be open to negotiation on prices in a number of areas.

Some governments provide access to drugs that are not recommended for funding by CDR, such as Ontario, whose legislation allows the minister to pay for drugs not on the provincial formulary. As a result, some drugs with no recommendations are being reimbursed in a few programs but not in others, thus creating further inequities in access to treatments for Canadians. Drug plan decisions give rise to a number of questions. Is the Ontario process or that used by the federal drug plan to provide case-by-case coverage a reasonable approach as a form of appeal to a CEDAC recommendation, or should CEDAC identify criteria for patient access to some drugs, resulting in a qualified or a partial yes recommendation?

● (1550)

Conditional recommendations may provide an opportunity to broaden the scope of decision-making while further evidence is gathered. If drug development is viewed as a continuum, real-world use may be the only way in which answers are obtained to some of the questions posed by CDR, such as the need for long-term safety and effectiveness data. An effective Canadian model for drug review and evaluation for coverage under public drug programs in Canada needs to provide access where the evidence is relatively weak owing to the difficulty in conducting broad-based trials in certain disease groups, while at the same time ensuring that data are collected and that outcomes are measured to confirm the benefits as well as the risks.

The reality is that for some new drugs the scientific evidence that demonstrates value isn't available for various reasons, such as the small number of patients in the case of rare diseases or the lack of evidence of long-term safety and effectiveness. Individual manufacturers have a role to play in working with governments to support access to products so that governments are not alone in assuming responsibility for meeting patient needs. Partnerships based on improving patient outcomes may offer options to the current all-or-none approach.

Mr. Chairman, I'd like to refer—

The Chair: We're having a bit of a problem because we had allowed 10 minutes for both of you and you're considerably over time. So if we could just be very tight on the second presentation, we'll allow that, but I won't let you go more than five minutes.

Mr. David Bougher: We just have a few more minutes, Mr. Chairman.

The Chair: Okay, go ahead.

Ms. Linda Tennant (Former Member of the Federal, Provincial and Territorial Pharmaceutical Issues Committee, As an Individual): What I'll do then is jump to some recommendations that we prepared, and I'll try to speak fairly quickly.

As CDR expands its mandate, role, and operations, everything should be subject to regular independent review to ensure that it remains efficient, effective, and relevant to all interested parties. In other words, we're saying CDR shouldn't rest on its laurels. It should continue to be subject to review, and by the way, by independent parties.

The Chair: Madame Gagnon.

Ms. Christiane Gagnon (Québec, BQ): You are going too fast. You have a translator and he can't follow you. It's okay if you want to talk fast, but he won't follow you.

The Chair: Okay, Madame Gagnon.

● (1555)

Ms. Linda Tennant: A wee bit more slowly?

The Chair: If you could just decelerate a fraction, we'll continue. Go ahead.

Ms. Linda Tennant: My apologies.

In addition, then, to a regular review of CDR and its activities, we would also suggest that individual direct programs, expert advisory committees, should be the subject of regular review to make sure that, on an ongoing basis, individual drug programs are not duplicating or overlapping the CDR process but rather they are complementing each other.

CDR should be encouraged to expedite and expand its plans to increase transparency. The success of these measures should be evaluated after six to 12 months. Transparency is always a major public concern today, as we know, on all fronts. CDR should also evaluate the experience of the addition of two public members to CEDAC. CDR should examine the roles and experience of the citizens' councils in the United Kingdom and Ontario, where in fact they have provided an additional mechanism for public input to the expert advisory process.

CDR should incorporate processes for qualified or conditional recommendations by CEDAC. Such recommendations could take into account the challenges that some drugs present in meeting standards of evidence and the potential for benefiting a patient population with limited or no other treatment options.

CDR should consider the use of subcommittees in certain specialty fields in order to broaden the expertise applied in certain drug reviews.

Our last point is that all governments should work together to expedite the implementation of studies that present real-world evidence and answer key questions that may be raised in the evaluations by CDR. In other words, we shouldn't just look at the evaluation before the drug is implemented for funding purposes, but rather after the drug has been on the market for some time.

Thank you for our opportunity. May I make one more comment, please? We just want to say that as former drug plan managers, we have the highest respect for the staff and expert advisers of CDR, CEDAC, and other expert advisory committees in this field. We know first hand their commitment and the difficulties they face in trying to bring forward recommendations that promote the best possible care for Canadians in this highly complex and very controversial field.

Thank you very much.

The Chair: We want to thank you very much.

We'll now move on to the University of Toronto. We have with us, by video conference, Dr. Janis Miyasaki, associate clinical director and the of the technology and therapeutics assessment subcommittee of the American Academy of Neurology.

The floor is yours and you have ten minutes. We look forward to your presentation.

Dr. Janis Miyasaki: Thank you, Mr. Chairman and the committee, for the opportunity to speak to you regarding my experiences both with CDR and the Ontario drug benefits program and in my role as a clinician-investigator, a clinician of patients with serious neurodegenerative diseases and an investigator in evidence-based medicine.

I'd like to disclose that I did apply for a position as a standing member of CEDAC. They didn't accept me, but I bear no hard feelings about that.

I have acted as a consultant to the Ontario drug benefits program as well as a consultant to the common drug review.

I have found that the process is very rigorous; they provide rigorous evidence-based reviews of drugs. However, I also feel there could be some improvements made to the process.

Also, I want to state that participating in drug and technology development is crucial to maintaining quality in Canadian health care and that evidence-based medicine and pragmatism are both needed in drug funding decisions.

First, my experience with the CDR is as a medical expert, not as what is known as a methodology expert. A methodology expert would be someone, typically with a PhD, who has expertise in guideline- or evidence-based medicine.

In my role, because I do have a background in writing guidelines for the American Academy of Neurology, I have been able to meet some concerns about what the appropriate designs and outcome measures of studies should be. However, I would also state that the American Academy of Neurology is very advanced in the development of critical appraisal, and other such specialties may not have experts who are similarly equipped to deal with the CDR's concerns. Therefore, studies that may have good evidence to show efficacy might be otherwise discounted.

I feel that there is a need for the CDR to take this clinical relevance into account and also to admit that often we do not know the value of quality-of-life outcomes or the appropriate outcome for studies. I think we all have to be honest and admit that even in evidence-based reviews there is some consensus contained in deciding how we are going to phrase the questions and gather the evidence, in grading the evidence, and then in interpreting the evidence.

Participation in drug and technology development is crucial in terms of maintaining and retaining the best academic physicians and scientists in medicine and science. If they are not able to participate in these activities, we will lose that great resource. In particular, I am aware that one company has closed down its neuroscience division and has stated it will not market any further neuroscience drugs in Canada. This concerns me as an investigator as well as a physician. I want to be able to provide my patients with the best possible care for a very serious illness.

Finally, there's the question of pragmatism in evidence-based medicine. Certainly, in our process at the American Academy of Neurology we have taken a strictly evidence-based approach to our guidelines. What we have heard from our members is that they would like to know, what is the clinical relevance, and what doesn't the research show? That speaks to the fact that even clinicians need to know the context they're making these decisions in. What are the potential factors that should change your interpretation of the evidence? That is something that any drug policy agency needs to take into account as well.

Because my experiences have allowed me to look at both sides of the coin, I still have a lot of faith in the common drug review. I think they do a wonderful job of evaluating the evidence, but I also feel that pragmatism needs to enter more into their decisions.

Thank you.

● (1600)

The Chair: Thank you very much.

We will now move on to the Best Medicines Coalition. Louise Binder is chair and Linda Wilhelm is an operations committee member.

The floor is yours.

Ms. Louise Binder (Chair, Best Medicines Coalition): Thank you to the committee for inviting me to speak today on the topic of the common drug review.

I'm presenting on behalf of the Best Medicines Coalition. There is a description of the organization in our submission.

I'm also HIV-positive, and I have been working in public health policy in this area for many years.

The coalition and the HIV community have been following the common drug review since its inception. We have concluded that the common drug review is a good idea gone very wrong. We have also concluded that the common drug review, in its present configuration, cannot be fixed.

I submit that the common drug review has failed in fundamental ways to meet its stated goals or to carry out its mandate with a process that meets even the most rudimentary rules of natural justice. In general, it is not providing cost-effective decision-making to the participating provinces. It does poor, shortsighted pharmaco-economic analyses. It unnecessarily duplicates the work of many provincial review processes. It duplicates costs. It has processes that are not transparent, inclusive, or patient-friendly, thus missing much relevant data in making its decisions. And it has no appeals process.

Instead of providing you with a barrage of facts and figures and charts to back this up, I'm going to take my time to tell you the story of one drug—a drug I know very well—and its journey from clinical trial through reimbursement coverage. I believe it will graphically prove my claims about CDR.

The drug is tenofovir, or Viread. It's a non-nucleoside reverse transcriptase drug, called NNRTI, used in combination therapy with other antiretroviral drugs in HIV to keep the virus from proliferating. Research has shown that a combination of this class of drugs and two other classes of drugs will actually work to lower the amount of virus that can be created. It's not a cure, but it definitely has kept many people alive and well for much longer than before these drugs came along.

There are three main problems, though, with the drugs. They are generally toxic to the system—being lifelong chemotherapy—and they have very nasty side effects. One result is that people often have organ failure or other serious diseases because of the drugs. Another result is that some people can tolerate certain drugs and not others, and therefore can't take these drugs. They must find others that they can tolerate better instead of creating all these secondary problems. There's no such thing as one size fits all in this drug system.

These drugs also do not work forever. The virus, over time, changes or mutates so that the drugs no longer work. This is called drug resistance.

The last problem is that for reasons about which we can only speculate, some people respond to some drugs and not to others. This may be genetic makeup. It may be the type of virus they have. It's different in each person.

Thus, as I say, we need all the drugs we can get in our armamentarium at any one time.

I've actually made three drug switches myself, all due to liver toxicity, not failing treatments. The last drug switch left me so ill that I actually slept for nearly three months. I had to tough it through, though, because I had no other choices.

Enter tenofovir, or Viread, a drug that in trials worked well and appeared to have few side effects or toxicities.

Tenofovir is excreted through the kidneys rather than the liver, which is unusual. This means it takes pressure off the liver in some cases. In some cases, in only 1% to 3% of people, it is not tolerated. Otherwise it is well tolerated.

So tenofovir entered the nucleoside class of drugs, and it was compared against AZT in trials. AZT is a potent and effective drug, but it causes a lot of side effects and toxicities, including severe anemia, fatigue, nausea, and headaches. It also gives complicated lipid problems, high cholesterol and triglycerides, which can lead to heart attacks, strokes, and changes in body distribution that are quite disfiguring. Suffice it to say, it is not for everyone.

● (1605)

The clinical trials showed that tenofovir was every bit as effective as AZT, with far fewer side effects. In August of 2004, the therapeutic products branch approved it, asking only for further trials in naive patients. They approved it totally in patients who had already taken therapies.

Then it went to the common drug review and to the Quebec Conseil du médicament, and I want to quote the Quebec Conseil du médicament, because it made the right decision. It says:

> The data show that combinations of antiretrovirals that include tenofovir demonstrate efficacy that is at least equivalent to other first line combination therapies for people with HIV who have never received antivirals. This combination also appears to have a safety profile that leads to fewer patients abandoning treatment. This is in addition to the known benefits of tenofovir: a single dose, which reduces the problems caused by forgetting a dose and improves treatment compliance; low potential for drug interactions due to the elimination pathway of tenofovir; and improved safety in regard to the lipid profile and lipodystrophy. In addition, United States guidelines recommend tenofovir as a first line treatment.
>
> However, although this agent does offer benefits, it is currently the most expensive agent in its class. The Conseil...believes that the higher cost of Viread [tenofovir] is justified by its additional benefits. For this reason, it recommends Viread be transferred to the regular section of the...[list of medications].

Now, how did it fare at the CDR? Not so well.

CDR gave its decision in March 2006 after taking 210 days to review it.

By the way, the Conseil approved this drug in 161 days.

CDR didn't recommend tenofovir as a first-line therapy. It couldn't see any difference between the efficacy of AZT and tenofovir. It recognized that there were fewer withdrawals due to adverse events and recognized the convenience of a once-a-day regimen; however, it said it wasn't cost effective because it cost more money than AZT did.

Fortunately, many provinces didn't follow this advice. Ontario and British Columbia gave it “no conditions” for reimbursement, and Alberta said it was up to the physician to decide. Other provinces followed CDR.

So returning to my assertion that CDR has failed, why do I say it? Well, there's a poor understanding at the CDR, in my submission, of cost effectiveness, even at the most rudimentary levels. If the CDR had looked at toxicity and the side effects profile of AZT and had spoken to clinicians and patients knowledgeable in this area, they would have learned a lot more about the side effects and toxicity profiles that add to the actual cost picture. They would have learned that patients take many additional drugs to counteract the effects of AZT toxicities and side effects.

Ten per cent of people on AZT get anemia; six per cent have to go off the drug. That means they go on to tenofovir anyway. Actually, many have failed AZT because of drug resistance, because they can't adhere to the drug. Many people who stay on AZT have to take a drug called EPO to counteract the anemia. That's expensive and was not taken into account.

People with lipid problems will either quit the drug, going on to tenofovir, or they will have to have surgery for “buffalo hump”, or fat distribution, which is paid for in the system. They also may get high cholesterol and triglycerides and often do, and they have to buy statins to deal with that.

They often have to take antidepressants, antianxiolytics, and psychotherapy as a result of being on this drug. Also, it disrupts sleep patterns, so many people on AZT take sleeping pills. Anti-nausea pills are also often required.

In addition to all those extra costs, there are more doctor's visits and, in extreme cases, hospital and emergency room visits.

None of these pharmaco-economic factors was taken into account by CDR, though they obviously were by Quebec. Thus, they are not actually giving good cost containment advice to the provinces. It is also out of step with the decisions in most developed countries and with published treatment guidelines for first-line treatments.

● (1610)

As I say, fortunately, some provinces have seen this. However, this begs the question about the value of CDR. It appears to be nothing more than unnecessary duplication, since all provinces with drug review committees have kept them going, notwithstanding CDR. They cost money to run, as does the running of CDR, at an amount which is not inconsequential—$5.1 million a year.

CDR has added an average of 26 weeks to the overall time it takes to get badly needed drugs to people. In the case of Viread, CDR took 210 days. So the total time it took for Ontario to get that drug on the formulary was 456 days; in Saskatchewan, 330; in Newfoundland, 330; on the federal formulary for Aboriginal people, 350; and in Quebec, 161.

Ontario has already recognized that CDR is very limited in its usefulness and has actually promised that all drugs for life-threatening conditions will be reviewed once TPD approves them, within three to four months, notwithstanding what CDR does.

It's true also that CDR was to create consistency of coverage for patients across the country, but that's pure pie in the sky. The province continues to do their own reviews, make their own decisions based on their analysis of the data and their drug budgets. CDR's opaque, non-inclusive process has led to its failure to some degree. If it would allow clinicians with knowledge about the disease area and patients to come in to give evidence and be part of their committees, they might learn something about the drugs they're reviewing.

Even an appeal process would be an improvement. Trying to get them to talk to you about drugs is like pulling teeth. You write and you write, and maybe if you write long enough, you might get a meeting with them. That certainly was my experience.

We make the following recommendations.

In the short term, we recommend that any further expansion of the mandate of CDR be halted. It should be frozen where it is.

A working group should be struck to develop and implement a plan to dismantle CDR and return to the previous system of provincial decision-making.

It must, of necessity, be an FPT group, obviously, but we would want other stakeholders, including patients and patient-driven community group representation, included. It has to have as its mandate a process to provide review committees in provinces that do not have them presently, and also a review of all the provincial review systems to ensure they're effective, efficient, transparent, and stakeholder-inclusive, so that we really do get the opportunity for some consistent analysis.

If this is outside the scope of the committee to recommend—and I hope it isn't—then at the very least it must recommend a working group of the type I've mentioned above to completely overhaul the CDR, top to bottom. The reporting relationship for CDR should be at arm's length from ministries of health.

It should include researchers, clinicians, and patients on its decision-making body, who are knowledgeable about the disease involved. It should allow all relevant stakeholders to have access to those bodies, and it should ensure that the time taken for review, including the decision by the provinces, should be no more than the time the provinces were taking for decisions before CDR.

The status quo or minor tinkering, in our view, is simply doing a disservice to Canadians and to the provinces that deserve the best pharmaco-economic advice available.

Thank you.

● (1615)

The Chair: Thank you very much.

We'll now move on to Elisabeth Fowler, the vice-president of health policy from Ward Health Strategies.

The floor is yours.

Ms. Elisabeth Fowler (Vice-President, Health Policy, Ward Health Strategies): That's me. Thanks.

Is Linda going to speak?

The Chair: No.

Ms. Elisabeth Fowler: Okay.

Thank you for inviting us. I am here from Ward Health Strategies, and I want to send my apologies from Chris Ward. He had every intention of coming, but there was a death in his family, so he couldn't attend. So you are stuck with me instead.

Ward Health Strategies is a health policy communications consultancy, with offices in both Canada and the U.S. Our clients include pharmaceutical and medical device companies, as well as government and health-related non-profit organizations.

I'd like to thank you for inviting us to present today on some of the major issues of drug policy that are impacting the quality and the sustainability of Canada's health care system. It is our perspective that the common drug review, or the CDR, can be viewed as a marker or an instructive example of how and why Canada is falling behind other countries in providing access to health care innovations that both save lives and improve the quality of care by producing better health outcomes.

In Canada, spending on health care consumes more than 10% of gross domestic product and represents the major share of total public sector expenditures. Managing that spending is critically important, putting issues of health care affordability and sustainability at the very top of Canada's public policy agendas.

Canada's population is aging, and as we age we use our health care system more. Today, 62% of Canadians are living with a chronic condition, and 75% of Canadians die from the side effects of these chronic conditions. These figures will rise as more of the baby boom generation reaches retirement age and become seniors.

Most health spending today is on chronic disease and the complications associated with these diseases. According to the Canadian Centre for Chronic Disease Prevention and Control, chronic disease is estimated to account for a full 87% of disability in Canada and two-thirds of all direct health care costs.

Many seniors rely on provincial drug plans for the drugs they need. The provinces and our national government came together to establish a common drug review with the stated goal of reducing duplication and making recommendations about what drugs will be covered by the publicly funded drug benefit plans in Canada.

There has also been some thought that the process of a common drug review can lead to better consistency and drug access in Canada and help form the basis of a future national formulary. From a public policy perspective, these may seem to be reasonable goals. However, from the perspective of Canadian patients, the CDR has been a monumental failure.

In the few short years of its existence, the CDR has already helped put Canada farther behind other countries in terms of health outcomes. Nowhere is this more evident than in the area of cancer. In its annual report card on cancer care in Canada, the Cancer Advocacy Coalition of Canada has clearly demonstrated on a province-by-province basis the association of reduced cancer mortality with increased access to treatment. The CDR has repeatedly recommended against listing of new and innovative cancer treatments. The case of Nexavar and Sutent, the first new hope for kidney cancer patients in over 10 years, is the most recent example. But when you compare the cancer outcomes between the United States and Canada over the last four years, the effective restricting of access to new treatments in Canada is even more alarming.

Between 2000 and 2004, the number of people dying from cancer in the United States has increased by little more than one-tenth of one per cent. In Canada the cancer deaths are up a full 7% for the same period. The American health care system has its share of deficiencies, of course, not the least of which are the more than 40 million people without health insurance. However, Canadians, I'm sure, will be shocked to learn that seniors and individuals living on low incomes in the United States have better access to drugs through publicly funded programs like Medicare Part D and Medicaid than similar populations in Canada who rely on our publicly funded drug programs.

Last year we did an analysis of drug access for American seniors under the U.S. Medicare drug plan and concluded that seniors living in Michigan would have access to 82% of the drugs that had been reviewed by the CDR by the beginning of 2006. In contrast, a senior living in Ontario would have access to only 15% of these drugs.

We believe this disparity has grown, and will continue to grow, unless government drug plans ignore the CDR recommendations that act as a barrier to new drug access in Canada. Medical innovation has had a profound effect and a profound impact on the prevention, treatment, and management of chronic disease. Let's take another example. Although it is still the number one cause of death in Canada, the death rate from heart disease and stroke has been cut in half over the last 30 years. In fact this year it is likely that cancer will replace heart disease as the number one cause of death in Canada.

Better knowledge about the risk factors associated with cardio-vascular disease has led to a number of interventions that have had a profound impact on health outcomes. New medicines help people control their blood pressure and cholesterol. New medical devices and surgical interventions also play a part. The challenge for health policy-makers in funding medical innovation is to ensure that decisions are not based solely on cost containment—in other words, simply managing the supply side of drugs, devices, and procedures. The focus instead needs to be, must be, on improving outcomes through early detection and screening, preventing chronic disease, managing the risk factors associated with chronic disease, and reducing complications. Of course, access to drugs is not the only thing that will make a difference in an aging population. In order to increase health outcomes for individuals living with chronic diseases, health promotion and detection programs are important, as are screening programs and access to the physicians who treat the patients.

One has only to look at the difference in drug coverage between public and private sector employer-sponsored drug plans and government-sponsored drug plans for seniors and other vulnerable populations to realize that employers understand far better than governments the importance of improving health outcomes by providing better access to medical innovation. Employers fully understand the importance of maintaining the health of employees so that they can remain productive, so that they can remain out of hospitals and out of long-term care facilities and therefore avoid the costs associated with both long- and short-term disability. This approach would be equally advantageous if applied to those who rely on the publicly funded drug benefit programs.

Ultimately, oversight of the common drug review is from its board of directors, which consists of federal, provincial, and territorial deputy ministers of health, who in turn are appointed by the premiers and the Prime Minister. Those making decisions for the CDR have clearly demonstrated that their primary interest is to contain costs, and they have responded to the issues of health system sustainability by making it increasingly difficult for those using public drug plans to get access to the drugs they need to maintain their health.

● (1620)

Chronic conditions are costly. The Canadian Coalition for Public Health estimates that chronic conditions cost our economy over $77 billion in 2005 and that two-thirds of direct health costs and 60% of indirect health costs result from chronic disease. If a chronic condition is maintained and treated, however, many of these more costly complications can be avoided.

The Canadian Institutes for Health Research have indicated that prescribed and non-prescribed drugs are among the fastest growing components of our health care system, that they now consume over 17% of our health care budget. This is seen by most to be a cause of great alarm and an indication that our health care budgets are spiralling out of control. However, we believe that a perfect health care system is one in which an even greater proportion of health spending is consumed by drugs and vaccines that manage or prevent disease and its complications.

It is unlikely that the outcomes I mentioned earlier in the U.S. are related to overall quality of their health care system alone, as Canadians do have better access to acute care than their counterparts in the U.S. Canada also has fewer uninsured residents than the U.S., but there is no doubt that access to treatments is making a difference in the health of populations as well as in terms of health care spending.

Putting more money into giving Canadians access to drugs will improve health outcomes. Allowing Canadians to have access to vaccines, to drugs to manage chronic conditions, coupled with patient education on compliance and adherence programs and monitoring for adverse events, can help ensure that Canadians are among the healthiest in the world.

In conclusion, we believe the CDR needs a major shift in order to properly serve the needs of Canadians and their health care system. The CDR needs to broaden its perspective and begin truly looking at the advantages of incorporating new health technologies into our system.

The CDR must allow physicians to care for their patients with the best tools available, and the CDR needs to allow more patients to be involved in the decisions it makes.

Thank you.

● (1625)

The Chair: Thank you very much.

Thank you to the entire panel for your presentations.

Now we'll move to the questioning and answering part of our meeting, which I'm sure promises to be interesting. We have some interesting and different opinions at the table.

Hon. Carolyn Bennett (St. Paul's, Lib.): Maybe they should just talk amongst themselves. We'll just chair it, Mr. Chair.

Voices: Oh, oh!

The Chair: Yes, we'll just referee it.

Nonetheless, we'll start with Ms. Carolyn Bennett, and she's going to be sharing her time with Ms. Fry.

You have five minutes. Go ahead.

Hon. Carolyn Bennett: Obviously, it's interesting, in that there are two different ways of going about it. It seems that almost the more specific the drug.... The cancer people didn't seem very happy with having their drug declined, in terms of kidney cancer, and, Louise, we're hearing from you that you have also had a similar experience.

It sounds like people feel that if practitioners and citizens and patients were more involved in the decisions, maybe you would get a better outcome. I'm worried that I'm hearing that the only answer is to just abandon it, when at the same time I understand from the national pharmaceuticals strategy that we would like one day to end up with a national formulary.

If that's the case, and the EU can do that, and we've got five formularies for the federal government alone, how do we move to this goal of a national formulary? What would that look like? If you were writing the recommendations for this committee, how do we use the problems and some successes with the CDR to get us to what we really want, which would be that regardless of where you live in this country, you get the drugs you need?

The Chair: Who would like to start?

Go ahead, Joel.

Dr. Joel Lexchin: There is no easy answer, obviously, to your question, but certainly there are a number of factors that you need to consider. First of all, there is the difference in the financial ability of provinces. As long as your drug programs are province-based, you have to deal with the reality that different provinces have different levels of financial resources. In fact, if you look at the—

Hon. Carolyn Bennett: If you don't mind, Joel, just to stop you there, I think on expensive drugs for rare diseases, we, as a country, have decided that's not right. For Fabry's disease, where most of the patients live in Nova Scotia and Alberta, we've decided we want to share that risk. So if what we do in this country is share risk on those kinds of things, then that's not an assumption that all of us would accept.

Dr. Joel Lexchin: We're not sharing risk, though, for all the rest of the drugs. If you look at public spending per capita on drugs, it's very closely related to provincial GDP per capita. The more money the provinces have, the more money they have to spend on drugs.

So unless you're looking at a national drug plan whereby the federal government assumes the responsibility, you have to look at mechanisms of equalizing the resources the different provinces have. Some provinces will reject drugs that are either expensive for small numbers of people or expensive overall because large numbers of people are going to be taking them for long periods of time; other provinces won't. There's no getting around that. P.E.I. cannot afford the same level of drug costs as Alberta can.

The federal government is either going to have to take over the whole shot, or the federal government is going to have to work out some kind of a cost-sharing agreement with the provinces so that the provinces can do better.

● (1630)

The Chair: Anybody?

Janis Miyasaki, the floor is yours.

Dr. Janis Miyasaki: I don't think I can come up with a solution for the honourable member, but I'd like to address her concerns about how we can make the reviews more reflective of Canadian values.

For the non-physicians in the group, I think it's important to understand what we mean by evidence-based medicine and what we mean by levels of evidence.

I've provided some information to Carmen DePape, which she will have translated for you, and I believe you'll be able to have it for your review later this evening.

If you look at the level of evidence required to be what is called “class one evidence”, which is the highest level of evidence, you have to have a prospective, which means a study in the future; randomized, which means patients have equal chance of being on a placebo or the active drug; controlled clinical trials—and they have four other criteria for them. That is an awfully high bar to meet, and the conduct of the trial has to be absolutely perfect, with not an excessive amount of dropouts for the patients. But this is the bar that seems to be used with the common drug review, at least in my experience.

We do deal with patients in the real world. It is impossible, generally, to have a perfect trial. It is impossible to satisfy what every policy group will want as the most important outcome. And as we've heard from the patient group, other factors may not be taken into account, even in a pharmo-economic analysis performed by interested parties. They may not take into account things that she mentioned, such as the quality of life issues.

The fix to that is not really just abandoning the whole process, nor is it opening it up so that it becomes really a clash of advocacy groups and who has the loudest voice, because we are interested in distributive justice when we provide funding for treatments. It is looking at the evidence and acknowledging that we can't always have a perfect study.

The Chair: Thank you very much.

We'll move on to Ms. Hedy Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you.

Actually, Dr. Miyasaki answered a lot of the questions I was going to ask, but I've heard very many people say that the CDR should be abandoned because it's not doing a good job, and we should go back to the provincial groups because our provincial pals are already doing the same thing and it's a duplication of effort.

I disagree with that because I agree with what Carolyn Bennett was saying. If we're looking at distributive justice, we want to make sure that everyone across the country has access to certain drugs. At the same time, I hear from Mr. Lexchin how we have too many people with clinical backgrounds, because they bring a bias. I don't know if that's what he intended to say, but that's what I heard him say. I also heard Dr. Miyasaki saying we need to have more people with clinical expertise and knowledge of evidence-based medicine to be on this, because if you're going to have cost effectiveness, cost effectiveness is about cost and outcome and quality of life.

I believe we need to look at how the CDR is constituted and whether we're getting the best answers to the question. Distributive justice means that it doesn't really matter if P.E.I. cannot afford it. We need to be able to find some formula that would allow us to expand what Prince Edward Islands needs if they cannot afford it. Otherwise we have walked away from the whole concept of access in this country. If all you can do is have access to investigation and access to hospitals but you don't have access to treatment, what is the point? You tell me nicely that I can get all kinds of tests, but when it comes to getting better, unless I have money, I can't. The federal government does have to assume some cost-sharing role, I believe, if this is going to work.

I think Dr. Miyasaki has an important point to make on why we need to expand this, not only to bureaucracies that decide only on cost, but to people who understand evidence-based care and who understand the clinical care of the patient to bring about that side of the effect. If we're going to bring about patients, we need to bring about people who will represent patients, in large, in general. Otherwise, we're going to have advocacy groups all fighting over what should be acceptable and not, and we will miss the whole result.

● (1635)

The Chair: Do you have a question?

Hon. Hedy Fry: My question actually is for Mr. Lexchin.

Do you not agree that the concept of distributive justice is important in this, that the values of Canada with regard to access to treatment is an important one, and that we should expand the CDR?

Dr. Joel Lexchin: First of all, it's Dr. Lexchin.

Hon. Hedy Fry: I'm sorry, Dr. Lexchin.

Dr. Joel Lexchin: Second, I never said anything about whether or not there should be more or less clinical expertise on CDR. All I was doing was pointing out that the CDR decisions are broadly in line with decisions made by similar groups that use similar levels of evidence.

I do agree that we need to provide resources. That was my point. Either the federal government takes over the entire plan and runs it so that it's equal across the country, or, if you leave it as a provincially based program, you have to be able to work out a federal cost-sharing arrangement so that the provinces that are poorer are able to access the same level of resources as provinces that are richer.

The Chair: We have a bit of a problem. We have Linda Tennant—I'll allow a quick answer there—and then Dr. Janis Miyasaki.

Ms. Linda Tennant: I just want to say that David and I had proposed that in fact CDR be increased in terms of the clinical expertise that was used at the table for certain drug discussions, and it's very much in line with what Dr. Miyasaki said.

The Chair: Okay.

Dr. Miyasaki.

Dr. Janis Miyasaki: I would like to address the issue of what comparators we use. Various panellists have mentioned comparing to Australia or Scotland or comparing to Medicare in the United States. I would say that I definitely know comparing to Medicare in the United States is not an appropriate measure, since the majority of people are not covered by Medicare and Medicaid. In fact, they are covered more likely by UnitedHealthcare, and the UnitedHealthcare has a very different drug formulary than Medicare does. When we're comparing formularies, we need to look at what countries have the models we want, not just what is close or what highlights the disparities.

I think it is an issue of looking appropriately at what countries' values are and whether we share those values. That's the best way to look at how we should craft our drug review process.

The Chair: Thank you very much.

Madame Gagnon, please go ahead.

[*Translation*]

Ms. Christiane Gagnon: Mr. Lexchin, you conducted a study that gave you some results. The CDR process did not seem satisfactory to you. You made comparisons with Australia, among other countries, and you are coming to the conclusion that the CDR is effective or adequate in terms of evaluation time and program efficiency. You also came to the conclusion that it was comparable to other countries' processes, that the same results were obtained, and that we have no more or no fewer products.

I would like to bring you back here, to Canada. You did not conduct a comparison with Quebec. In Quebec, more products are on the market and less time is taken. Perhaps it is because of financial or human resources, but I would like to know why Quebec works better. It is held up as a model. You went all the way to Australia to find out that the evaluation processes are similar.

I am anxious to read your evaluation to understand your approach, because there are some holes in what you said.

● (1640)

[*English*]

Dr. Joel Lexchin: We used a set of criteria to decide which agencies to compare to.

First of all, they had to use the same kind of evidence that the CDR uses, which is a combination of pharmaco-economic analysis and clinical evidence. They had to have evaluated at least half of the CDR drugs. They had to publish their material on the web. They had to make more decisions than just yes or no, so they had to have at least a third category of decision—in other words, fund with restrictions. All of those things were the bases on which we chose the comparisons.

Quebec didn't fit that, so we didn't use Quebec. That doesn't mean Quebec decisions are right or wrong; it just means that Quebec didn't turn up in the bases on which we chose the countries.

Why does Quebec fund more drugs than other provinces? There are a variety of reasons. It could be that the social priorities of Quebec are such that you are willing to put more money into drugs than other provinces are. It could be that Quebec feels that by listing more drugs, they will get more economic activity out of the drug companies, since a large number of them are located in the Montreal area, and sometimes drug companies make implicit promises that if drugs are funded, they will increase investment. There are a variety of reasons Quebec may choose to put more drugs on its formulary than other places, but we didn't explore that.

[*Translation*]

Ms. Christiane Gagnon: Did you do any comparative studies with the rest of Canada on the quality of life or the health of patients who are taking the medications? Have you evaluated the effectiveness of these medications? This is what we are being asked.

Some witnesses have come to tell us that access to new medications was difficult, because many were rejected, especially medications for rare diseases. Some would even like to see different processes for different diseases, because the sample is too small and too many products are rejected. In Quebec, the process is different. Does that have a more positive impact on the patients' quality of life?

[*English*]

Dr. Joel Lexchin: I think it would be a good idea to compare quality of life in a different group of patients with the same disease in different provinces, where access to care is different, but those kinds of studies haven't been done. If CIHR wants to fund those, I'd be happy to put in an application for money, but nobody has looked at that. It's a valid point, and something worth pursuing.

The Chair: Thank you very much.

Mr. Fletcher, you have five minutes.

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

Mr. Chair, I notice that the idea of an independent review has come up again at this meeting. Perhaps that is something this committee should consider when we come out with our final report.

As in every other committee, in this committee there doesn't seem to be enough time to ask all the questions I would like, so I'll focus on the Best Medicines Coalition. I'm just reading about your group. You say you're a national group of organizations representing millions of Canadians. What types of organizations make up your coalition? Please give a quick answer.

Ms. Louise Binder: They're all disease and disability groups. I won't remember them all, but Linda is representing the arthritis community here. There's hepatitis C and HIV. The cancer advocacy group and the breast cancer group are represented. I actually have a list. It's a broad-based group. There's a diabetes representative and others for a number of different diseases and disabilities.

● (1645)

Mr. Steven Fletcher: What is your annual operating budget?

Ms. Linda Wilhelm: It's $250,000.

Mr. Steven Fletcher: How much money have you received in recent years from pharmaceutical companies?

Ms. Linda Wilhelm (Operations Committee Member, Best Medicines Coalition): We got about $100,000 from Health Canada for the research project, and then probably the other half was from the pharmaceutical industry.

Ms. Louise Binder: I think we got about half from Health Canada and half from the pharmaceutical industry to do our work.

Mr. Steven Fletcher: So half of the money you receive is from pharmaceutical industries. Are these unrestricted educational grants?

Ms. Louise Binder: Totally.

Mr. Steven Fletcher: I think this is an important point. It's very interesting that the point of view your coalition has advocated for is virtually identical to Rx&D's point of view.

Ms. Louise Binder: I'm not surprised about that.

Mr. Steven Fletcher: That may be a coincidence, but I think it would be helpful, when NGOs ask for CDR to be transparent, that the NGOs are transparent as well.

Ms. Louise Binder: We're totally transparent about our funding.

Mr. Steven Fletcher: In the material that was provided to this committee there was no indication that any moneys were received from pharmaceutical companies. That would help put the point of view you are presenting in context.

Ms. Louise Binder: With all due respect, I wouldn't care where the money came from. What I want to see is access to treatment for people in this country. Do pharmaceutical industries want to sell drugs? Sure they do. Does that mean on this issue we have a commonality of interest? Sure we do, but for completely different reasons.

Mr. Steven Fletcher: Or there's a conflict of interest, depending on your point of view.

Ms. Louise Binder: That's not fair. I don't think any—

Mr. Steven Fletcher: I'm just pointing out the reality of the situation. But having said that, I think there is a fair degree of sympathy for the point of view that CDR should be reviewed.

Ms. Louise Binder: You know, I've won awards from the Province of Ontario and from the law school I attended. I don't want to be disrespectful.

Mr. Steven Fletcher: The fact is that you brought forward a point of view and you received money from large organizations that would benefit significantly from your point of view, and that should have been disclosed. That is my point.

The Chair: Do you have another question?

Mr. Steven Fletcher: It's also interesting to note that the point of view that has been expressed often leads to the most expensive drugs, and they're also the most risky. I wonder if another member of the committee could explain what evidence there is to support the benefit-risk ratio in regard to some of these newer drugs versus the cost.

The Chair: Anybody?

Ms. Linda Wilhelm: Can I respond to that?

I was going to begin by giving my own personal history. I have rheumatoid arthritis. I was diagnosed in 1983 at the age of 23. My first prescribed treatment was 16 Aspirins a day, until there was nothing left of my stomach.

Mr. Steven Fletcher: Mr. Chair—

The Chair: I'm sorry, Mr. Fletcher.

Mr. Steven Fletcher: My question was directed at the coalition, not the individual.

The Chair: Mr. Fletcher, no.

I'm sorry about that. Go ahead, Ms. Wilhelm. You can answer. The question was asked. How you answer is up to you. You go ahead and answer, but you're going to have to do it very quickly.

Ms. Linda Wilhelm: Yes, I will do it very quickly.

It just goes to why the expensive drugs are needed, which is what he referred to. I started with the cheapest drug that you could ever imagine, aspirin. I then went to another cheap drug called Plaquenil, then to another cheap drug called Cupramine, and then to another. And I didn't care about the cost of the drug. I wanted a drug that would work.

Twenty years later, 13 joint replacements later, a wheelchair, and a year in bed, I got access to a breakthrough called Enbrel, a biologic, at that time probably one of the most expensive drugs on the market at almost $20,000 a year. Within six weeks I walked out of the hospital after being in there for three months. I now walk three kilometres every single day. That's why we need expensive drugs.

Some hon. members: Hear, hear!

● (1650)

The Chair: Okay. Thank you very much.

Mr. Marston, you have five minutes.

Mr. Wayne Marston (Hamilton East—Stoney Creek, NDP): Thank you, Mr. Chair.

Being new to this committee, I certainly find it very interesting. But something has percolated to the surface here and I can certainly understand that.

I want to thank Ms. Binder for her directness on the question in regard to funding. Some may have felt it should have been disclosed beforehand. I didn't see any reservation on your part in responding, and I appreciate that. And I can understand that a person who has difficulties in their life would feel an alignment to some extent with pharmaceutical companies who supply the benefits to them. I think that's perfectly reasonable.

I would be curious, though, if any of the presenters have any association or receive funding from the pharmaceutical companies, just in fairness.

Ms. Fowler.

Ms. Elisabeth Fowler: Yes. I mentioned in my presentation that our funding is one-third basically: one-third pharmaceutical company, one-third government, and one-third not-for-profit health charities.

Mr. Wayne Marston: Great. Thank you for that.

I appreciate the directness because—

The Chair: We have another answer here.

Ms. Linda Tennant: I'm completely retired and don't receive any money from any company at all.

Mr. David Bougher: And I'm in a similar position.

Dr. Joel Lexchin: I had a piece of cold pizza at a drug lunch 10 years ago.

Voices: Oh, oh!

The Chair: So what you're saying is you're on the take.

Mr. Wayne Marston: I think it's important and fair to the process to have that out there, and I want to thank everybody for that.

The Chair: Dr. Miyasaki.

Dr. Janis Miyasaki: I did mention I'm a clinical investigator, so my research unit has received money to conduct clinical trials. I have also received consultancy fees from the Ontario drug benefit program, the CDR, as well as having consulted to various American government agencies for free.

The Chair: Thank you very much.

Mr. Wayne Marston: I appreciate that now we've got all the cards on the table, because one of the previous speakers was speaking to Quebec, the efficiency that's seen down there and the number of drugs that are available. And it jumped out at me when I heard the comment that this was also a province where a good number of pharmaceutical companies are located.

I'm just concerned that there's an underlying current here that could be interpreted as pharmaceutical influence in both of those cases. So I'm the type who likes to see things on the table, so to speak.

Dr. Lexchin, would you like to respond further, or do you feel you've completed that?

Dr. Joel Lexchin: There are anecdotes from various places that suggest that drug companies sometimes try to use their economic power to influence decisions. For instance, back in 1971, when Manitoba set up its public drug plan and its formulary, the reaction from the pharmaceutical industry was that if Manitoba went ahead and did that, the industry would have to think again about investment in Manitoba.

When British Columbia set up its reference-based drug system, regardless of whether or not you think it's a good or a bad idea, the industry again made economic threats with respect to setting that up.

There were anecdotal reports when I was on the drug quality and therapeutics committee in Ontario that economic benefits were being promised should certain drugs be listed on the formulary.

I don't have any direct evidence of what goes on in Quebec or what doesn't go on in Quebec, but I believe that the enhancement or the development of the pharmaceutical industry in that province is a key aspect of its industrial strategy. So the province may feel that by listing more products it will get more economic benefit.

The Chair: Okay. We'll go to Janis and then Linda.

Dr. Janis Miyasaki: With respect to conflict of interest, it's certainly an issue that's foremost in my mind, because we are producing important guidelines for our members.

You've touched on financial conflict of interest. What's perhaps even more compelling is intellectual conflict of interest, when someone is intellectually vested in a certain point of view. We can talk about all kinds of conflicts of interest.

I think that disclosing and being open is important, and it's why I provided my CV to the members. They can look to see how much money I'm making from these studies that go on for years.

I think acknowledging it up front doesn't mean you might be any less biased, but it acknowledges that you are aware you could be influenced. I think not acknowledging that all of us have some interest around this table is the really difficult thing.

● (1655)

The Chair: Thank you.

We'll have one quick answer from Linda.

Ms. Linda Tennant: On David's and my behalf, I would like to again emphasize the need for increased transparency in whatever we do, whether it's through CDR, CEDAC, or anyone around this table.

The Chair: Thank you.

Mr. Patrick Brown, you have five minutes.

Mr. Patrick Brown (Barrie, CPC): I think Steven wanted to say one thing.

Mr. Steven Fletcher: I think Patrick is splitting his time.

To follow up on the previous comment, my injury is probably the most expensive injury society can incur. It'll cost tens of millions of dollars if I live to a normal life expectancy. I don't think costs should be the mitigating factor. I would ask that there be transparency.

Could the individual who advocated for the independent commission or review explain how that independent review can be done in a transparent and fair manner?

The Chair: Does anybody want to respond?

Yes, go ahead, Linda.

Ms. Linda Tennant: I think David and I mentioned an independent review. We were again thinking along the lines of transparency and the fact that CEDAC and CDR must remain relevant to all stakeholders. You only maintain your relevancy if people in fact understand what you do and you're open about it.

It was our thinking that if an agency evaluates or reviews itself, it doesn't look very good to the outside world. If you bring a degree of independence to the review, you will hopefully satisfy the stakeholders to a greater extent.

The Chair: Thank you.

Mr. Brown.

Mr. Patrick Brown: Thank you, Chairman.

I'm very interested in the comments we've heard today, and I've heard many similar comments from my constituents. It's why I'm looking at this from the issue of patient access.

It always breaks your heart when constituents come into your office to tell you that government has been a hurdle to get the drugs they believe are absolutely necessary for their families. I heard the Best Medicines Coalition and the Ward Health Strategies say that.

Elisabeth Fowler, you made a few comments in terms of kidney cancer and in terms of cancer drugs. It's one of the themes I've heard again and again when I've heard concerns about this. You mentioned the most blatant one as being drugs that would be helpful for kidney cancer.

Are there a few other examples you can share with us in terms of cancer drugs that struggle to get to the market where the CDR has potentially been a barrier? We've heard before there are some differences among the drugs that British Columbia viewed as being approved, which the CDR turned down. Maybe there are a few other examples you can give us.

The other comment I wanted to hear is this. Mr. Bougher, you mentioned there were differences in drugs. It's why this has created differences in the provincial plans and it's why it was initially created. But aren't we still at the point today where we have wide differences across the country? If that was the reason for the creation of the CDR and it's still occurring, why would it be necessary now?

My third question for the guests today is this. Mr. Lexchin said the CDR was specific to Canada. But aren't the provincial plans specific to Canada too? Wouldn't health services in each province and drug plans in each province also have that Canadian sense to them?

Could I first hear from Ms. Fowler, and then Mr. Bougher, and then Mr. Lexchin, if there's time?

● (1700)

Ms. Elisabeth Fowler: Thanks for the question. I have to admit that I don't know specifics of other cancer drugs, because Nexavar and Sutent are the ones I know most and I've talked to the patients about. I know the struggles they've had in getting access to it and what the alternatives would be. If they didn't have access to this drug, they would be subjected to numerous invasive massive surgeries and that's it. So this drug is pretty key for them.

But I can say that the Cancer Advocacy Coalition of Canada has done an extensive report. They have looked at disparities between provinces—as you said, B.C. has great access—and they have found that in the provinces that have chosen to give access to more drugs to their patients, deaths from cancer have gone down. Mortality is much less—it has not gone down—than what it is in other provinces.

Mr. Patrick Brown: And the differences in the provincial plans?

Mr. David Bougher: I think the point was that members of the committees bring their own biases and professional knowledge to the table and the discussions. In fact, for the provinces, it's an area of our concern with respect to decisions that are contradictory. Cancer was one in relation to CEDAC recommendations. Introducing conditional listings or more flexibility in terms of providing patients with access to new drugs would assist in giving that flexibility. We've heard about Quebec. There are perhaps social considerations and economic considerations, and those aren't brought into the picture.

Mr. Patrick Brown: But if one of the original reasons for creating CDR was differences in the plans, aren't the differences still there today?

Mr. David Bougher: Yes, the differences are.

Mr. Patrick Brown: So what was the point of that being one of the reasons for the creation of CDR? Clearly if it was to eliminate differences in the provincial drug plans, that hasn't been achieved.

Mr. David Bougher: There are a lot of consistencies in the acceptance of the “no” recommendations.

Mr. Patrick Brown: Are there more than there were four years ago?

Mr. David Bougher: I haven't studied that. I don't know if anybody else can speak to that.

The Chair: Thank you, Mr. Brown.

We'll go to Luc Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Mr. Chair.

Dr. Lexchin, when you were having the discussion with my NDP colleague just now, you seemed to be of the opinion that one of the reasons why there are more medications in Quebec was that there are a number of pharmaceutical companies in the province. I would just like you to clarify one thing. Was that a personal opinion, or was it based on any fact analyses and studies that you have conducted?

[*English*]

Dr. Joel Lexchin: The fact that the pharmaceutical industry is heavily concentrated in the Montreal area is well known. The rest of it is speculation, based on the fact that, as I said, the Quebec provincial government has made the development of the pharmaceutical industry one of its key pieces of industrial strategy for obvious reasons. You've got a lot of people there. It generates a lot of economic activity. Quebec wants to build up on that. The relation between economic activity and listing is speculation. I don't have any firm evidence on that, and I said that.

[*Translation*]

Mr. Luc Malo: So anyone could conclude that it is also because the Quebec government wants to offer the greatest possible range of medications to everyone with diseases, rare or not.

Ms. Fowler wants to speak on the matter.

[*English*]

The Chair: Okay, we have two other answers there, and I don't want you to cut those off because it's probably very valuable stuff for you.

So, Elisabeth, go ahead, and then Linda.

Ms. Linda Tennant: I would just mention that as of five years ago—and I am a bit out of date, because that's when I retired from government—there was actually more industry in Ontario. If you look at the brand names and the generics, I think in Ontario we had maybe about 60%. I just want to point out that there's also a large industry presence in Ontario.

The Chair: Okay, that's fine.

Now, Elisabeth, go ahead.

Ms. Elisabeth Fowler: I just wanted to speculate perhaps a bit myself. Is it not possible that Quebec has realized that giving access to medications that will help maintain someone's health, that will help improve their quality of life, that will help to keep them working and being productive members of society will have far more benefits than maybe those for the few companies that are there?

If you look at the silos, if you see how much Quebec pays for drugs per capita, it is greater than what other parts of Canada pay, but what they pay for physicians and hospitalizations per capita is less.

● (1705)

The Chair: We have one more answer.

Dr. Janis Miyasaki, go ahead.

Dr. Janis Miyasaki: I'm not sure what the values are behind the judgments that lead to the Quebec formulary, but I think there's another possible explanation, and that is how they interpret the evidence. They are presented, really, with the same evidence. Those same binders go to every drug formulary, but it means they may be interpreting it in a very different way. They may put different values on different aspects of that submission.

It does speak, again, to the fact that every committee is going to have some hidden values that they bring to the table. They may not be able to articulate them all. So I don't think we have to invoke a nefarious plot or that they have consciously decided that more drugs mean more health. People look at the evidence differently and they value different things.

The Chair: Go ahead, Louise.

Ms. Louise Binder: It's not even that you don't know what they looked at. I quoted you, in the case of the drug that I provided, exactly what they looked at. They looked at all the quality of life things, such as side effects, toxicities, other medications, the fact that people are more likely to remain on a drug when it's a once-a-day medication. There's no secret about what the differences were.

The CDR discounted all of that, and Quebec took those things into account. There are no secrets, in my opinion, certainly about that medication and what the differences in the thinking were.

The Chair: Thank you very much.

We will now move on to Mrs. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Mr. Chairman.

Thanks very much to our presenters.

We've been hearing a fair amount of testimony on this topic for quite a few meetings now, and there seems to be a common theme coming through, whether or not you agree that the CDR is doing a good job or not, and there's certainly two points of view on that. There is a common theme that a review is necessary.

I have a couple of very basic questions that I want to throw out here. I don't know who wants to answer them.

Do you think governments have a duty to look at the prices for drugs that we're considering paying for? If we do, how would we approach that? What would be the best way to approach it? If the CDR isn't working, what would be the way to do it? Does anybody have any suggestions on how and who should determine which drugs government should be reimbursing?

Does anybody want to try to answer those basic questions? Louise?

The Chair: Go ahead.

Ms. Louise Binder: Certainly I do think we should be looking at the costs of drugs. The idea is to do the best we can with the drug budgets we have, for sure. So the answer to that is yes.

How do we do that? I think we need to take a look. There are a number of different pharmaco-economic formulae that can be used. We need to determine the one that most appropriately fits with Canadian values, and I think you'll find it is not the one that's presently being undertaken by CDR. A one drug to one drug comparison, with cost being the only factor, as long as they both appear to be the same in efficacy.... If it costs more, that's the end of the analysis. I don't think that is part of Canadian values at all.

I think we need to be looking at the impact of factors that affect not only the drug budget but other health care budgets, such as Elisabeth mentioned: doctors' visits. We need to look at the whole impact on the health care budget when we look at pharmaco-economics.

The earlier question was put, how do we get some consistency across this country? And I think that actually should be the bottom line. It should be consistency based on the best practice in this country, not the lowest common denominator, which is what is actually happening under CDR, except in those provinces that don't listen to CDR. They don't follow the “no” rule all the time either, because the provinces didn't follow the “no” rule from CDR in the case I presented. So I don't think that's quite accurate that they always follow the “no” rule.

What I would like to see is that each province does the best it can with its present budget, with a common pharmaco-economic analysis that makes sense for Canada and is duly determined by Canadians. We've never been asked if that made any sense to us, and it doesn't. Where provinces can't bring themselves up to the best practice, if you like, in the country, then I completely agree with Joel. The federal government should then come in and help them to bridge the gap so that there is really good access to treatments for Canadians across the country.

● (1710)

Mrs. Patricia Davidson: Would this still be—

The Chair: I'm just going to try something out.

Dr. Janis Miyasaki, are you there?

Dr. Janis Miyasaki: Yes, I am. Isn't my picture there?

The Chair: Your picture is gone, but nonetheless you're looking fine. I just wanted to check.

We'll continue. Just speak up if you'd like to speak, because I won't be able to see you.

Dr. Janis Miyasaki: Okay, then I do want to speak.

The Chair: I was guessing that.

Dr. Janis Miyasaki: Part of the problem with the economic analysis of values is what the appropriate measure is. What's typically used is the quality adjusted life year. And we're not even sure that that's the most appropriate measure. It becomes difficult. How are you going to put a value on being able to dress yourself, on being able to feed yourself? These are very complex issues that can't be settled by a single equation or a single approach. It does speak to the need, again, to be transparent in how you make your decisions and how you value these things and to have input from the people who can give you the best information.

The Chair: Thank you very much.

Go ahead, Pat.

Mrs. Patricia Davidson: I'll put this back to Louise. Do you envision this, then, to be a provincial-territorial-federal group, similar to what CDR is? Or how do you envision it being done?

Ms. Louise Binder: I do see it as having to have the buy-in of the provinces, the territories, and the federal government, because all their budgets are impacted. So of course it has to work that way. I think, administratively, if we can keep it with the provinces administering it, it would be great. They already have the processes in place for doing that. Where I see the federal government coming in is in this sort of top-up area in those provinces where that's required.

I want to make another point, too. If we're talking about really doing the best we can with our budgets, how about looking at the generic drug prices in this country as well as at the brand-name drug prices in this country. You know, we pay the highest prices in the developed world for generic drugs in this country. If we want to talk about where they're located and why they get such good treatment in the provinces where they're located, we could do a lot of speculating. I won't. My organization has actually done a paper on this, and it's going to be presented shortly. It's something else we ought to be looking at.

Mrs. Patricia Davidson: I think you'll see that there has been movement on the generic pricing. I think you'll see that in Ontario, specifically.

Ms. Louise Binder: Yes, we've been talking to the government there about this problem for a long time.

Mrs. Patricia Davidson: Thank you.

The Chair: Thank you very much.

We'll go to Ms. Brown.

Ms. Bonnie Brown (Oakville, Lib.): Thank you very much, Mr. Chair, and thanks to everybody who came.

Those of you who are participating in this meeting are witnessing the conflict we have been listening to now for several meetings. I'm wondering if you think that some of that conflict came about with the birth of the CDR, because the provinces and territories that came together had different reasons for wanting to have this body. That is, the poorer provinces now benefit from the quality of work and the scientific expertise of the CDR that is paid for as a group. The richer provinces also benefit, because they have another body that says no, sometimes, which they can blame for saying no. It seems to me that when two groups come together with totally different agendas and give birth to something for totally different purposes, there's bound to be some conflict.

I know that Mr. Bougher and Ms. Tennant blame that on the different decisions by the provinces that reflect the beliefs, experiences, and even biases of the decision-makers. But when you add to that the different motivations of the provinces for wanting to have this particular body, is it ever going to be possible to resolve it when these conflicting purposes are at work in one particular agency?

● (1715)

The Chair: Go ahead.

Ms. Linda Tennant: In the six years that I managed the Ontario drug benefit program, I heard every single argument that's been made around this table. These programs have been controversial for decades, and they will continue to be controversial. The fact that we have different ways of making decisions, different opinions, will always lead to a very lively debate on who's right and who's wrong.

I think what some of us are trying to suggest...and in fact at the provincial level I have to say that the provinces, in the drug review area, have been trying to work together for over a decade to streamline their processes so that they would match more closely. The common drug review was meant to be another step in that progress, if you will, and a first step towards even further consolidation of what we did.

Given that this is controversial and that it's very much open to conflict, we're suggesting greater transparency. What we're not suggesting is.... And I will give a personal opinion here. I don't see that having 12 committees versus one committee resolves conflict or makes it any easier; rather, one committee looking at what that committee does and trying to improve its processes would seem to me to be a better way to go. But I think the controversy will continue.

Ms. Bonnie Brown: I'd be interested in what Dr. Lexchin thinks.

Dr. Joel Lexchin: I agree. You're never going to agree with all the decisions that are made, and there is certainly a wide variety of different values that people are going to bring to issues around pharmaceutical policy and what drugs should be covered and what drugs shouldn't.

But I think the more transparency there is and the more you can see how decisions were being made...you may not like them, but you're more likely to accept them. So transparency goes on a number of levels. For instance, I think the CDR should be more open to really seeing the evidence basis for its decisions. I wouldn't have any problem if they had open hearings, the way the FDA does, to allow different groups to make presentations before they make their decision.

I would also like to see some transparency from the pharmaceutical industry around why it's charging the prices it is for the drugs. Why are some things worth $20,000 or $50,000? If they can prove that it's the real value of these things, that's fine. So far, we don't see that either.

Ms. Bonnie Brown: I think we're going to get to that, Dr. Lexchin, in our study, probably in the fall, the business about pricing.

The other thing I'm questioning—

The Chair: Louise Binder wanted to answer.

Ms. Louise Binder: Sorry, I was just going to comment.

First of all, I completely agree with Joel. I think the pharmaceutical industry does a very bad job at proving its prices. I've actually, notwithstanding the funding we get from the pharmaceutical industry, written a formal complaint to the Patented Medicine Prices Review Board, about every AIDS drug that they have ever reviewed. That's an area where my colleagues and I and the pharmaceutical industry strongly diverge, as we do about direct-to-consumer advertising, which I think also raises the price of drugs —

Ms. Bonnie Brown: You're not answering my question.

Ms. Louise Binder: —and a number of other problems we have, such as cross-border Internet pharmacies, etc.

So I'm pretty clear about where we diverge and where we converge.

To your point—

● (1720)

Ms. Bonnie Brown: Thank you.

Ms. Louise Binder: —you're right. I think that's exactly what happened. The irony is neither side is getting what it wanted.

The "smaller provinces" with smaller budgets wanted to get good-quality pharmaco-economics, and I would submit to you that they aren't.

The larger provinces were hoping that no would be no. The fact of the matter is, it isn't that no is no and yes is maybe; they are in fact providing many of the drugs that this group recommends not to provide, because they see in their own provinces that those decisions aren't withstandable from a scientific perspective and a pharmaco-economic perspective.

Yes, I think everybody wanted something, and nobody's getting what they wanted out of it, which is why the Atlantic provinces continue to have an Atlantic common drug review. They've actually come together to meet themselves, and the provinces have continued to keep their own processes going.

I don't think we're any farther ahead with CDR than we were before, and I don't think continuing to keep something going that nobody likes and nobody is getting what they want from is a good spending of $5.1 million. I would rather see—

Ms. Bonnie Brown: That leads to my second question.

The Chair: Go ahead, but make it very tight.

Ms. Bonnie Brown: It's about the accountability of this body created by the provinces and the federal government with a decent budget that is growing as they expand their role. It's really more our business, but are you satisfied that they are accountable to somebody?

I have this idea that if 13 people are in charge, nobody is in charge. I'm not sure the taxpayers are well-served. The federal government isn't even the biggest payer, but there's only one taxpayer and they're paying through their provincial taxes and their federal taxes for something. I'm not saying it's not a good thing—we haven't decided that yet—but I think there is a problem with accountability for the money spent.

Does anybody want to comment?

Ms. Louise Binder: I couldn't agree more. I completely agree with you. They report to—

Ms. Bonnie Brown: Each other.

Ms. Louise Binder: They report to the deputy ministers of health who are their bosses and to whom they are also making reports. If we want to get into some conflict of interest questions, I think that's a fascinating one. They should be an independent body. Their bosses shouldn't be the same people they're making their reports and recommendations to.

The Chair: Does anyone else want to try that one?

Go ahead.

Mr. David Bougher: On the accountability question, obviously accountability flows through the deputy ministers to ministers. Ministers agreed originally, in fact supported CDR and agreed to a "no means no" recommendation. I would disagree with Louise about many drugs for which no recommendations are being accepted; I think there are some.

In terms of accountability, that's a question that goes to deputies and to ministers. You probably heard from the conference of deputy ministers about that. I can't answer that question.

The Chair: Thank you very much.

We're going to call this part of the meeting over. We have some business that we'll deal with for the committee.

I want to thank all the presenters for their presentations.

Mr. Steven Fletcher: Mr. Chair, I believe the government has one more round.

The Chair: No, I'm sorry, Mr. Fletcher, you don't.

I want to say thank you, Janis Miyasaki, for your presentation as well. I'm sorry about losing your video, but thank you very much.

We'll call this part of the meeting over and then we have some business to discuss.

Dr. Janis Miyasaki: Thank you.

The Chair: We have a notice of motion from Ms. Brown that we'll talk about.

[*Translation*]

Ms. Christiane Gagnon: Mr. Chair, perhaps it is important for us to keep 15 minutes aside when we have other work to do. Luc has left because he thought the meeting was over.

● (1725)

[*English*]

The Chair: On the agenda.

[*Translation*]

Ms. Christiane Gagnon: I am going to find him in case there is a vote. Are we going to vote on what we have to do?

[*English*]

The Chair: I'm not wanting to vote, and that's why I didn't call it in camera. You're absolutely right, we don't have time to talk about some of the things, like the third report of the subcommittee. I want to bring you up to speed on a couple of issues.

We have tried to incorporate as many witnesses as we could. As we said at the steering committee, we wanted to get this completed by the 16th. We have accomplished almost everything, except for the group from the United Kingdom, which can potentially do a video conference Monday morning at 11:30. Is it acceptable to have a video conference on Monday morning at 11:30 with the United Kingdom? Will we have enough here to hear the witnesses?

Mr. Steven Fletcher: I think we should stick with our regular time, Mr. Chair.

The Chair: They can't make that, and those are our options.

The other thing is that we wanted to have the department back again. That could be accomplished on the 30th.

Ms. Bonnie Brown: The department or the common drug review?

The Chair: The common drug review officials, as that was the consensus I heard the last time. We wanted to have them back, and we could do that on the 30th, as we would complete most of the witnesses by the 16th.

Hon. Carolyn Bennett: What happened to Vancouver?

The Chair: Vancouver?

Hon. Carolyn Bennett: The IUHPE conference.

The Chair: Oh, we didn't get into that. I don't have any information on it. There's no decision on that, but we can bring that up perhaps at the next meeting.

That was a conference, right?

Hon. Carolyn Bennett: It's the international health promotion conference. Canada is the host. The WHO Commission on Social Determinants of Health....

I think the committee would learn a lot on health promotion, and we could even, as we've done at other international conferences, have a small meeting with some of the keynote speakers so that you get one-stop shopping.

The Chair: Yes, so what you're suggesting is to travel to that. That's on June 10 to 15, in Vancouver, B.C., which will be very, very tight to do.

Hon. Carolyn Bennett: Yes, well, even two days or something.

The Chair: It's going to be quite expensive to travel, because we need interpreters if we travel as a committee—all those things.

Hon. Carolyn Bennett: But informally, on our points....

Hon. Hedy Fry: I live in Vancouver.

The Chair: Well, you certainly can do that anyway.

Hon. Hedy Fry: You can come and stay at my house.

You can't all stay at my house. That's carrying it a bit too far.

Mr. Steven Fletcher: Is your house wheelchair accessible?

The Chair: Okay, but we could travel there with points, at any rate, right? So the registration fee is all there would be, I suppose, but I don't know what that would be.

This is something I didn't know anything about.

I'm told it's a $1,200 registration fee.

Hon. Carolyn Bennett: They won't charge us.

The Chair: They won't charge us?

Hon. Carolyn Bennett: No. Absolutely.

The Chair: Well, then, just go ahead and do it.

Hon. Carolyn Bennett: We should just all go.

The Chair: Well, anybody who wants to should.

Mrs. Patricia Davidson: When is it?

The Chair: Why don't we copy this information and give it around to everybody? Is that fair?

Hon. Carolyn Bennett: It's June 11 to 13. It's fantastic. It's the one that was in Bangkok two years ago.

Mr. Steven Fletcher: Are we in session then?

The Chair: Yes, we're still in session, and I want to just talk about those things, because I want to get the United Kingdom one.

On this one, we can get the information around to everybody. I guess we have it already. Fair enough.

That's about all we really need to talk about at this part of the meeting. There's no point in going in camera and actually doing the steering committee report, because we're going to be following it generally anyway.

Mr. Steven Fletcher: I can save my comments for the next time.

Ms. Bonnie Brown: Can I just verbally tell them?

The Chair: Yes, okay.

Ms. Bonnie Brown: I'm putting a notice of motion—Carmen will get it translated—the idea being that there are two health threats that keep being brought up on TV. One is the Pesticide Management Regulatory Agency changing its rules and lowering its standards, according to a report yesterday. The other one is the Hazardous Materials Information Review Commission apparently talking about lowering some standards in its regulations. In my view, this ties in with what we are finding out about the Quarantine Act. So I'm putting a notice of motion that we have one extra meeting and call those two agencies in to explain to us if indeed they are changing regulations or not.

● (1730)

The Chair: And we'll debate that at the next meeting. Fair enough?

Ms. Bonnie Brown: Yes.

The Chair: There's one other thing here. There's a budget that we could approve if it's unanimous. I know we didn't give notice for it, but it's a budget to pay for the witnesses: $29,000.

Ms. Bonnie Brown: So moved, Mr. Chair.

(Motion agreed to)

The Chair: Thank you.

Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon: Do we have a meeting on Monday morning?

[*English*]

The Chair: *Lundi?* Yes, we have a meeting. We wanted to have the United Kingdom one, but I got a consensus that it wasn't going to be there.

[*Translation*]

Ms. Christiane Gagnon: That does not work.

I will not be here on Monday. We will be in Geneva with the minister. So I will not be here next week. If you change the program, you have to tell Luc Malo.

[*English*]

The Chair: Okay, fair enough.

The meeting is adjourned.

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