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Chair

The Honourable Kevin Sorenson

Standing Committee on Public Accounts

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● (0845)

[*English*]

The Chair (Hon. Kevin Sorenson (Battle River—Crowfoot, CPC)): Good morning everyone. This is meeting number 19 of the Standing Committee on Public Accounts, Thursday, June 9, 2016.

Today we are conducting a hearing on "Report 4—Drug Benefits—Veterans Affairs Canada" from the spring 2016 reports of the Auditor General of Canada.

Appearing before us today from the Office of the Auditor General of Canada are Mr. Michael Ferguson, the Auditor General of Canada, and Casey Thomas, principal. From the Department of Veterans Affairs, we welcome Walter Natynczyk, deputy minister; Michel Doiron, assistant deputy minister, service delivery branch; and Cyd Courchesne, director general, health professionals, and chief medical officer.

We will have an opening statement from our Auditor General, and then a brief statement from Deputy Minister Natynczyk.

We welcome you again here today. Thank you for appearing.

Mr. Michael Ferguson (Auditor General of Canada, Office of the Auditor General of Canada): Mr. Chair, thank you for this opportunity to discuss our 2016 spring report on drug benefits for veterans. Joining me today is Casey Thomas, the principal responsible for the audit.

In our audit, we examined three areas. First, we examined the process that Veterans Affairs Canada used to add, remove, or limit access to drug benefits. Second, we looked at the department's cost-effectiveness strategies. And finally, we examined how the department monitored the utilization of drugs by veterans.

[*Translation*]

We found that decisions about which drugs to cover were poorly documented and not clearly based on evidence such as veterans' needs and clinical research. We also found that timelines had not been established for the implementation of decisions. In one case, a decision to limit access to a narcotic was still not implemented two years after the decision had been made.

We recommended that Veterans Affairs Canada implement a decision-making framework that specifies the type of evidence required and how the evidence should be considered. The department should use this framework in deciding which drugs to pay for and to what extent it would pay for them. We also recommended that the framework contain a requirement for the department to update the drug benefits list on a timely basis.

● (0850)

[*English*]

We found that Veterans Affairs Canada used some cost-effectiveness strategies, such as substituting generics for brand name drugs and negotiating reduced dispensing fees with pharmacies. However, the department did not assess whether these strategies achieved the expected results. The department had also not implemented strategies related to expensive new drugs entering the market.

We recommended that Veterans Affairs Canada periodically review its cost-effectiveness strategies to assess whether they were up to date and leading to reduced costs for drugs and pharmacy services. In addition, we recommended that the department identify other potential cost-effectiveness strategies to pursue on its own or in collaboration with other federal departments.

[*Translation*]

We found that although the department monitored some high-risk drugs, it had not adequately monitored drug use trends that were important to veterans' health and the management of its program.

We recommended that Veterans Affairs Canada develop a well-defined approach to monitoring drug utilization. This approach should serve the needs of veterans and help the department manage its drug benefits program.

[*English*]

With respect to marijuana for medical purposes, we found that the decision to cover marijuana for medical purposes was made at the senior management level rather than by the department's formulary review committee. We were unable to determine why this decision did not go through the committee's normal review process.

We also found that Veterans Affairs Canada had identified the need to contain the rising cost of marijuana for medical purposes and had therefore limited the coverage to 10 grams per day. This amount, however, was double what was identified as appropriate in the department's consultations with external health professionals and more than three times what Health Canada reported to be the amount most commonly utilized by individuals for medical purposes.

[*Translation*]

The veterans' primary care physician was not always the physician who authorized the veteran to utilize marijuana for medical purposes. Although the department had concerns about such situations, it had not systematically monitored authorization trends to determine whether they were of concern. In addition, the department had not monitored whether veterans using marijuana were also using drugs prescribed to treat conditions such as depression.

We note that Veterans Affairs Canada agreed with our recommendations and committed to taking corrective action.

[*English*]

Mr. Chair, this concludes my opening remarks. We would be pleased to answer any questions the committee may have. Thank you.

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

We'll now turn to Deputy Minister Natynczyk.

General (Retired) Walter Natynczyk (Deputy Minister, Department of Veterans Affairs): Mr. Chair, members of the committee, Auditor General, ladies and gentlemen, I'm pleased to be here today on behalf of Veterans Affairs Canada. Joining me today is Michel Doiron, the assistant deputy minister for our service delivery branch, and Retired Captain Dr. Cyd Courchesne, our chief medical officer.

I wish to thank the Auditor General and his staff for their ongoing contribution to assist the department in achieving effectiveness, efficiency, and accountability as we support the well-being of our veterans and their families.

As the Veterans Affairs Minister, the Honourable Kent Hehr, indicated, immediately following the tabling of the Auditor General's report, we accept all of the report's recommendations. We are taking immediate action to ensure the health care benefits program is efficient, valued, and supports the needs of our veterans.

To give you an idea of its size, in fiscal year 2014-15 the Veterans Affairs drug benefits program supported the costs for drugs for approximately 51,000 veterans in the order of $80 million. While the report found that most of the 2004 Auditor General recommendations related to the program were implemented, it did highlight areas for improvement with corresponding recommendations.

[*Translation*]

The media coverage is concentrated on the cost of marijuana for the Government of Canada and on maximum doses, which risks diverting attention from the fact that the report discusses all drug benefits.

[*English*]

We find as well that sometimes the department's role in the payment of drug benefits could be misunderstood. To clarify, it is Health Canada that is responsible for the regulation of medications for all Canadians, including our veterans. Veterans Affairs Canada does not prescribe medication; rather, it pays for medical treatments authorized by the veteran's physician or health professional.

To review, the Auditor General's report found the following key four points.

First, we do not have an adequate process in place to make evidence-based decisions related to our drug benefits list. Second, we should review our cost-effectiveness and program efficiency strategies. Third, we need to contain the rising costs of marijuana for medical purposes. Finally, we have not analyzed the use of drugs that are not on our drug list but are accessible, on a case-by-case basis, to eligible veterans.

● (0855)

[*Translation*]

Implementing the Auditor General's recommendations will help us to better achieve our goal of supporting the health and well-being of our veterans in an efficient and effective manner.

I will now briefly discuss VAC's current or planned activity in relation to each of these priority areas.

[*English*]

First and foremost, we need to ensure that systematic evidence-based reviews support our decisions with regard to the drug benefit list. To determine which drug should be included on our list, we look to the expertise of the Canadian Agency for Drugs and Technology for Health. Once Health Canada has approved a drug for use in Canada, this independent agency relies on an advisory body to review clinical cost-effectiveness and patient evidence, and makes recommendations about listing it on provincially-based, publicly-funded drug plans.

A Veterans Affairs national pharmacist was hired last year and is working now with public health plan counterparts to identify best practices in formulary management. An enhanced drug benefit management team is now reviewing the program and developing a strengthened decision-making framework which will identify the types of evidence to be considered, when to consider them, and how they will be assessed to make formulary decisions.

We're also improving timely access to a pharmaceutical support program for those men and women being released from the Canadian Armed Forces. For example, last year in April we implemented changes to ensure that retiring sailors, soldiers, airmen and women continue to receive the same drug benefits from Veterans Affairs that they were receiving from the military based upon drug history and their eligibility for Veterans Affairs programming.

[*Translation*]

Veterans Affairs Canada will examine and assess the cost effectiveness of its drug list with its federal partners and the Pan-Canadian Pharmaceutical Alliance in order to improve cost effectiveness by May 2017.

[*English*]

The department will leverage its partnerships with Health Canada and other federal drug plans and jurisdictions, and consult with private industry to identify opportunities to implement cost-effective strategies for our program.

Further, Veterans Affairs Canada will regularly assess and review its drug benefits list and claims data. This analysis will inform program changes to help reduce the administrative burden for veterans and lower the costs for delivering the program.

With regard to marijuana for medical purposes, it would be worthwhile to review the context of providing access for marijuana for medical purposes to our veterans.

In 2001, Health Canada began providing controlled access to marijuana for medical purposes to Canadians. It controlled the adjudication of requests, product distribution and costs, as well as setting consumption limits. Supporting regulations outlined which health conditions marijuana could be approved for and which specialists could prescribe marijuana for medical use.

In the Canadian health care system, as I mentioned, the veteran's primary care physician is responsible to determine the appropriate health care treatments to meet his or her patient's needs.

In 2007, based on the approval of a senior manager, the department approved the payment for marijuana for medical purposes on an exceptional basis for one client for compassionate reasons. Starting in 2008, Veterans Affairs allowed for coverage of costs related to marijuana for medical purposes for eligible veterans who were approved by Health Canada. In fiscal year 2008-09, five clients were reimbursed, with expenditures in the order of $19,000. By 2013, these numbers rose to 112 approved clients with expenditures in the order of $400,000.

In 2014, Health Canada introduced regulatory changes that reduced its role to regulate and licence private producers. Restrictions were removed on the quantity of marijuana that could be authorized by physicians and the price was established by private producers licensed by Health Canada.

Based on these changes, Veterans Affairs Canada instituted a practice to approve requests from eligible veterans for up to 10 grams per day if authorized by their physician or health care practitioner, and if they are registered with a Health Canada licensed producer. The Veterans Affairs director general of health professionals, who is also Dr. Courchesne, reviews any requests that exceed the 10 grams per day. While six such requests were approved previously and now grandfathered, no amounts greater than 10 grams per day have been approved under the current guidelines.

Since 2014, the number of veterans using marijuana for medical purposes and the associated expenditures have increased significantly.

Earlier this year, the Minister of Veterans Affairs, the Hon. Kent Hehr, requested a departmental review to assess how we provide marijuana for medical purposes as a benefit to veterans.

● (0900)

[*Translation*]

This departmental review, including various consultations, was launched in order to assess the current approach to providing marijuana for medical purposes to veterans as a medication. We will be able to take stock of the review in the coming months.

Departmental representatives are consulting medical specialists, suppliers and veterans who have been prescribed medical marijuana in order to learn more about the issue. These consultations are intended to help devise an effective monitoring approach to ensure veterans' well-being.

[*English*]

With respect to monitoring drug utilization, I wish to assure veterans and their families that there are existing alerts in our drug benefits system, as well as at the pharmacy and provincial health care system levels. Nevertheless, we absolutely agree that we need a clearer approach to monitoring drug utilization and detecting trends.

We will ensure that our monitoring practices are systematically reviewed to ensure optimal efficiency, while taking advantage of the best practices of other departments and jurisdictions. Strengthened processes will include regular and documented reporting to our formulary review committee.

[*Translation*]

All changes to monitoring by VAC of medication use will respect the fact that veterans' health care is mainly the responsibility of their physicians or the accredited health professionals and the health care system.

[*English*]

Mr. Chairman, ladies and gentlemen, I want to assure you that the work is under way now to address our shortcomings, and we will have completely addressed each of the recommendations in the Auditor General's report by the spring of 2017.

Again, I wish to thank the Auditor General and his staff for their work and assistance in supporting the well-being of our veterans, and I thank you for your attention.

Merci.

The Chair: Thank you very much, deputy minister. We want to thank you for coming today and for your testimony.

We'll now move to the first round of questioning. We will go to Ms. Shanahan, please, for seven minutes.

Mrs. Brenda Shanahan (Châteauguay—Lacolle, Lib.): My question is for the deputy minister. I thank you for clarifying the role of Veterans Affairs in the administration of the drug benefits. Of course, our concern here is to assess not only the use of public funds, but also how those funds are used for the health and well-being of our citizens, particularly those who have served our country.

What I'm concerned about is how this problem came to blossom to this extent before the Auditor General made his report.

I would like to understand much more the role of the new hire you have, the pharmacist who has come in and whether this person is enough to do the job that he or she faces. I would also like to understand the development of the decision-making framework, and in particular why in your action plan the target dates are simply Q1, Q2, Q3. For a problem that has reached this degree of urgency, I want to know why those target dates are, frankly, loosey-goosey.

Gen Walter Natynczyk: Madame, thanks very much for the question.

I guess I would say that over time, in the effort to find efficiencies throughout the department and to structure.... There used to be a pharmaceutical team. That team was decentralized throughout the department and involved a reduction overall in the number of folks with expertise in pharmaceuticals within the department.

That's why last year we recreated this team and brought aboard the expertise to address and really create the leadership, the management, and the structure for us to put together a decision-making framework and move forward with a very deliberate plan, while also recognizing as we move forward that we're working in partnership with our key partners, the Canadian Armed Forces, the Department of National Defence, and Health Canada to make sure we are moving forward in lockstep with them.

I'll just ask whether Dr. Courchesne could expand on parts of your question.

● (0905)

Dr. Cyd Courchesne (Director General, Health Professionals and Chief Medical Officer, Department of Veterans Affairs): Thank you, sir.

As was mentioned, when I arrived at the department 18 months ago, there was no pharmacist. I saw that as a gap to the good functioning of the formulary review committee.

We hired a very experienced pharmacist from the Canadian Forces and started right away to put in some procedures to tighten the decision-making that was identified by the Auditor General. We had identified that even before the report came out. Ms. Vesterfelt sits on the Canadian drug review committee of the Canadian Agency for Drugs and Technology in Health. She also sits on several other committees that are all pan-provincial and federal. Her role mainly is to provide analysis and advice to the department, but also to the formulary review committee.

Everything that is presented now needs to be analyzed before it's presented for consideration, and we've established guiding principles. Before, I would say the decisions that were made at the formulary review committee were not made willy-nilly, but the process could have been more rigorous. One of the recommendations from the OAG noted that there was a lack of documentation. Now we have written analysis of items that are presented to the committee for consideration, and they are part now of the records of decisions of the committee so that we have a trail showing how we came to consider this. Among the guiding principles is the principle of cost-effectiveness, so an economic analysis is done for every new item that's brought to committee.

Mrs. Brenda Shanahan: Thank you very much, Doctor.

I don't see this as a problem with data collection, because the applications have to be made for the drugs and the payments have to be made, but indeed one of analysis.

I'll get back to the deadlines that you have in your action plan, and I think my colleagues will have further questions on that as well.

Why do we not have tighter deadlines in achieving that decision-making framework? It's at a decision-making point, and frankly it's too far out, I would venture to say.

Dr. Cyd Courchesne: I think we gave those deadlines, because although we do have a new national pharmacist and we are hiring staff, implementing new procedures takes time.

I don't think we're going to wait until that date to get things done. Things are under way, and we've given ourselves until next May to complete them, knowing that implementing change can take time to organize, especially when I have just the one pharmacist working with new staff who have been hired to support the drug formulary.

Mr. Michel Doiron (Assistant Deputy Minister, Service Delivery Branch, Department of Veterans Affairs): Could I add something to that?

The point I would add is that we also want to make sure our decisions are based on evidence in some of these cases, and to actually do the analysis. It does take some time to get it right.

The procedure may not be that complex to write, but do we have the right evidence to make those decisions? As Dr. Courchesne said, we're working diligently to get there. We have to do that analysis and get the information from our partners, whether it is Medavie Blue Cross, who is our big supplier, or Health Canada or the various jurisdictions.

● (0910)

Gen Walter Natynczyk: I hear your impatience. I want it solved yesterday.

Again, the point that Dr. Courchesne mentioned in terms of no later than...really pushing on this team to get on with it. Again, it's getting the people into the position, setting up the overall doctrine to make these decisions, but then to get it done like tomorrow.

Mrs. Brenda Shanahan: Because this is blossoming.

Gen Walter Natynczyk: Absolutely, ma'am.

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

We'll now move over to the opposition side and to Monsieur Godin.

[*Translation*]

You have seven minutes.

Mr. Joël Godin (Portneuf—Jacques-Cartier, CPC): Thank you, Mr. Chair.

Ladies and gentlemen, I thank you for being here today and for participating in this exercise which we consider very important.

As parliamentarians, it is our responsibility to try to improve the efficiency of many practices in the different departments, and that is what we are trying to do this morning. I will not speak about the recommendations of the Auditor General nor of the replies that you have provided to them, as these are intentions.

To begin, I have a rather philosophical question for you. We are aware of the scope of the problem affecting the valiant and courageous military men and women who serve our nation, and then suffer from post-traumatic stress when they return from military activities. At the Department of Veterans Affairs, are you sure that the solutions you implement daily are the best?

I'm going to put my question differently. Would it not be relevant to revise the entire medical treatment system for veterans, setting aside the one that is in place and establishing a new one? Needs are growing exponentially. Sick people are consuming marijuana, the costs involved in reimbursing marijuana are exploding, and drugs are not monitored. Moreover, the decisions are taken by public servants without being validated by the committee. This concerns me.

Could you, this morning, give us a real picture of the current situation? Would it not be advisable to re-evaluate the whole situation?

Gen Walter Natynczyk: Thank you, Mr. Godin, for your question.

The ministers' priority is the well-being of veterans. Ministers define their mission as treating veterans and their families with empathy, compassion and respect. That is clear. We are the partners of the Canadian Forces, especially as concerns the transition of all soldiers, sailors and members of the Air Force. When these people leave the forces, we have to know what their needs are during the transition period, which is difficult for many of them. Approximately a quarter of them were injured and leave the forces for medical reasons. When they do so, it is important for us to work with their physician so that they and their family receive good care. We also work with the Canadian Forces to improve the transition and be aware of what health care services exist in the city or region where they reside.

It is important to remember that the veteran must recognize his needs and work with his doctor to receive the necessary support. Those who have asked for marijuana for medical purposes did so in order to manage their pain and even their injuries. It is the physician's responsibility to ensure the veteran's health. It's important to remember that.

[*English*]

I'll turn it over to Michel and Cyd.

● (0915)

[*Translation*]

Mr. Michel Doiron: Thank you.

As the deputy minister mentioned, the primary responsibility for the veteran's daily care belongs to his attending physician. Our role is to support the process and ensure that appropriate care is available. We try to be stakeholders, but the physician is responsible for the veteran's primary care. When the doctor prescribes medications, we reimburse them and we ensure that they are appropriate. We don't prescribe medication and we don't make diagnoses. That is the role of medical committees in Canada, in the provinces. It is certain that everything we do derives from the empathy, compassion and respect due to our veterans, whether they are grappling with mental health issues or other ones.

There is a lot of talk about post-traumatic stress but there are a lot of other mental health issues. A lot of veterans live in suffering and pain. Those are the two dominant elements. Following the recommendations of the Auditor General and other suggestions, we are modernizing our programs so as to ensure that the care will be given in a timely manner, whether veterans resort to an arbitration process or not.

Dr. Courchesne intervenes a great deal in communities, in the provinces, and with the medical community to ensure that veterans have access to a physician. We know that in certain provinces, it is not always easy to find one. Consequently, we ensure that the veterans are under a physician's care.

Dr. Cyd Courchesne: I don't want to give anyone any history lessons, but I want to remind you that the Canada Health Act excludes military persons from the Canadian health care system. When a member of the military leaves the Canadian Forces and returns to civilian life, at that point, the provinces are responsible for their health care.

As you mentioned, there is a problem with regard to operational stress injuries. The department has acknowledged that there are deficiencies in that regard in the health care system.

In 2001, we established a network of clinics specifically to treat these mental health issues. This network includes 10 clinics that work in partnership with the seven clinics of the Canadian Forces, so there are in total 17 clinics. The clinics have recognized that people who live in remote areas do not always have access to these services. Consequently, they set up remote service points away from the main clinics. So there is a network of 27 service points dedicated to responding to the needs of veterans, military members, and RCMP officers who are eligible for these services.

That is what the department has put in place. It reflects 15 years of expertise in mental health care for military members and veterans; this is not found at this time in the public health care system.

I simply wanted to remind the members of the committee that we have indeed taken steps to respond to the needs of this vulnerable population.

[*English*]

The Chair: We will now move to the opposition again, to Mr. Christopherson, please.

Mr. David Christopherson (Hamilton Centre, NDP): Thank you all for coming, Deputy and General—you have so many titles. It's good to see you again, sir.

It's fair to say that Canadians have been very unhappy with the way veterans have been treated in Canada. One of the things that the new government promised was that there would be a change. I'm hoping that the answers we hear today indicate that there's going to be a change. That it's not good enough anymore to just say nice things and platitudes about veterans and then ignore them once they come home, especially if they're broken and need help. I'm hoping that we begin to turn the corner, and we hear that today from the answers that we're getting. Because quite frankly, it's been disgraceful. That change needs to happen.

Chair, before I move to my detailed question, in looking at the action plan, which is a key part of what we do, I've already suggested that maybe we need to also look at this in terms of our own self improvement. I know you're interested in keeping us state of the art, pushing the envelope. We do as good a job as possible. We've already talked about having a little more analysis of the action plans, even asking the AG for comments around time frames and such.

May I also suggest to our analysts when we're looking at this, that maybe we need a template. It would be a lot easier and more efficient for us to focus on what we need if all the action plans were always laid out the same, rather than our having to go through each one to figure out how they have been laid out and having to do that work. These are small things or details that the public is not all that interested in, but they are important to us, and I would hope that at some point we can refine our efforts in this area.

The Auditor General would know, and Deputy, I think you would know from your past role, that one of the things this committee takes incredibly seriously is the recommendations in previous audits, especially when the ministry has said, “We agree with the findings” and then the Auditor General goes back and finds out that what had been suggested didn't get done. Let me say to you, Deputy, we've had occasions where there have been multiple audits and the department is still saying they agree and all of the nice flowery things that we want to hear, but then nothing happens. This really launches us. It certainly launches me when I see that.

We have some elements of that here again today. I reference page 14 in the English document, paragraph 4.59 on pharmacy alerts, which states:

> In response to observations from our 2004 audit, Veterans Affairs Canada strengthened its alerts for the potential overuse of narcotics and benzodiazepines, which are sedatives, so that alerts are issued regardless of where the veteran filled the prescription. The Department also partly addressed our recommendation to monitor instances in which pharmacists dispense drugs to veterans in spite of a pharmacy alert. These instances are monitored when they involve potential abuse or overuse of narcotics and benzodiazepines, or when a veteran tries to obtain the same prescription from the same pharmacy within a seven-day period. However, all other instances in which a pharmacist dispenses a drug in spite of an alert, such as those related to a potential drug interaction, were not monitored.

I can ask the AG to explain further, but it sounds relatively self-explanatory. Can you please give us an answer why something that was uncovered in 2004 and needed to be fixed was only partly fixed? There are some parts of that audit and the commitments this department made that have not been honoured. Please, it's time for accountability. Why is that?

● (0920)

Gen Walter Natynczyk: I'd like to say a couple of things right upfront, then ask Dr. Courchesne to pile on.

The first is the department's culture. You talked about the need for change in the department. I have to tell you, I speak to a lot of veterans. There are a lot of veterans who, unfortunately, don't come to us soon enough. We are changing our practices so they come to us as soon as they're ready—it's part of dealing with the stigma of mental health—so that those veterans feel safe coming forward, that their families and their battle buddies support them in coming forward, and that when they do come forward, the department then supports them. That's why we've put in place the idea of care, compassion, and respect and are empowering our employees so they have the opportunity and the authority to say yes when, indeed, a veteran needs support.

We're changing that culture. I just want to make sure you realize that. Part of that culture is also including support for the families, because again, without the support of families these veterans will not come forward.

With regard to the 2004 audit, I want to again say that we have made some progress in putting the right trip flares and indicators in place, but I'm going to ask Dr. Courchesne to pile on at this point and go into a bit more detail and better pronunciation of some of the drugs you were mentioning.

● (0925)

Mr. David Christopherson: Thank you, I appreciate that.

The Chair: Dr. Courchesne.

Dr. Cyd Courchesne: I want to say upfront, and I don't want this to sound like an excuse, but we are not a health care system. We don't prescribe. We don't provide the care directly. We manage a drug formulary. We make available and accessible the drugs that our population needs, and at the best price for the government.

There are alerts in the system. I don't want to leave the impression that everything is reimbursed and that there are no alerts. What was not happening in 2004 was that we were not asking for regular reports of Blue Cross Medavie, who administer the program for us, to give us those reports. But they do send us reports of people who are exceeding the limits, and we do scrutinize those send them back to their care providers. We send letters to their care providers saying, “Did you know that we've been asked for two prescriptions?”

But things have changed in Canada with pharmacy. Pharmacists and pharmacies in every province are all connected now. There used to be a time when you could go doctor shopping for prescriptions and to three different pharmacies and nobody would know. Well, now they know. Now these alerts for drug interactions and for shopping around are done at the point of service, so we don't need to monitor that because it happens right there. If a pharmacist sees that someone went around somewhere else, at another Shoppers Drug Mart, to ask for a prescription for benzodiazepines, they will contact that pharmacist and the prescriber and it will stop right there.

It's the same for drug interactions. Because we are not the care providers, we don't monitor those. The pharmacists will say right away, “This drug is not good to take with this drug. You're taking this for your hypertension and this drug should not be prescribed to you.” Then they contact the prescriber immediately.

There are redundancies in the system and we don't need to be monitoring that now.

The Chair: We'll now move to Mr. Arya, please, for seven minutes.

Mr. Chandra Arya (Nepean, Lib.): Doctor, you mentioned that there's no more doctor shopping, but please refer to paragraph 4.63 in the Auditor General's report, which says that 29% of approximately 600 veterans obtained authorization from one physician. Again, in the same paragraph, it says that 53% of veterans obtained that prescription from four physicians. Is that not doctor shopping?

Dr. Cyd Courchesne: With respect to marijuana and its authorization, I want to make the distinction that these are not prescriptions, but authorizations for access.

Mr. Chandra Arya: Okay, I'm sorry, it's authorization. Didn't it raise a red flag to see that one or four physicians were almost authorizing more than 50% of the marijuana?

Dr. Cyd Courchesne: Absolutely.

Mr. Chandra Arya: And what did you do?

Dr. Cyd Courchesne: And this is an issue, because most of the medical community did not want to be placed in the position—

Mr. Chandra Arya: I want to know what you did once this was identified.

Dr. Cyd Courchesne: In one case, we did file a complaint with the College of Physicians and Surgeons against the individual whom we thought was prescribing a lot. But the issue is that many doctors are not authorizing it. For people who want it, because the courts have said they must have reasonable access to marijuana, some doctors are more willing to provide the authorization forms than other doctors.

Mr. Chandra Arya: You talk about reasonable access, but 3% of veterans are using 30% of the budget, costing $9,200 each. When 36% of veterans are over 80 years of age, this distribution of spending does not smell good to me. Are you compromising the prescriptions required by other veterans for other illnesses, like kidney failure, because of the high expenditures on, or costs of, marijuana?

● (0930)

Gen Walter Natynczyk: To answer your question, sir, no, not at all. Again, we provide support to the attending physician so that the attending physician who is supporting the veteran can make whatever prescriptions or authorizations they require. With regard to your concern, it's precisely for this reason that our minister, Minister Kent Hehr, has directed the department to conduct a review to look at all of the information that is out there right now in order to determine what the most appropriate methodology is and best practice in support of the well-being of our veterans going forward.

Mr. Chandra Arya: I understand that, sir, but your own departmental data shows that 46% of the 600 veterans who are utilizing marijuana for medical purposes are are also utilizing anti-depressants. Have you looked into that?

Gen Walter Natynczyk: Again, sir, in every case, it is the attending physician who is working with the veterans—

Mr. Chandra Arya: When you identify it, what can be done by you, then?

Gen Walter Natynczyk: Again, the minister has met with medical experts, with the producers, with a group of veterans who are the beneficiaries of this program. We have met with a summit of almost 100 veterans' associations coming together to understand all the information out there. Again, a number of these veterans will lay out a number of bottles of medication in front of them. They have indicated that as a result of the medical use of marijuana, they are no longer having to take some of these other medications that affected their appetite, their sleep patterns and so on. But in each case, I just want to reinforce that our role is to support the attending physician to ensure that these veterans have the support that they need.

Mr. Chandra Arya: I understand.

Several times you indicated that your role is just to pay for the drugs. I think you mentioned this two or three times in your reports or in your statement. The federal government spends a total of $400 million on the prescriptions. Why until now have you not worked with other departments to find more cost-effective strategies here?

Gen Walter Natynczyk: Sir, we have continued to work with other departments. In this regard, we've been working very closely, as I mentioned in my opening statement, with Health Canada. We connect as well with the Canadian Armed Forces. There's co-operation and partnership not only with other federal departments, but other medical bodies as well.

Perhaps Dr. Courchesne could just expand on our partner—

Mr. Chandra Arya: Maybe the AG can explain it to us.

The AG very clearly says that “Veterans Affairs Canada should periodically review its cost-effectiveness strategies to assess whether they are up to date and are leading to reduced costs”. The AG recommends that cost-effectiveness strategies should be adopted.

Is that happening now, sir?

The Chair: Let me interrupt just for a moment.

Let's make sure that our questions come through the chair; that prevents the cut-off and everything else.

Mr. Chandra Arya: Sorry.

The Chair: We'll try to keep it a little more orderly.

To the Auditor General, please....

Mr. Michael Ferguson: I think the only thing I can say is that in the audit report, we identified the issue of cost-effectiveness strategies and that there were some things that the department should do to improve those.

I can't really speak to anything the department has done since then or what they have in their action plan, but certainly at the point in time that we completed the audit and reported on it, we identified some things they were doing in their cost-effectiveness strategies and some other places where they needed to improve.

Mr. Chandra Arya: You mentioned in your report that internal departmental briefing documents indicated the risk of having more than five grams of marijuana per day. The deputy minister mentioned that the restrictions were removed.

Does this internal document state that usage of more than five grams per day is not recommended, even though the deputy minister says there are no such restrictions?

The Chair: Please answer quickly.

The question is for our Auditor General.

● (0935)

Mr. Michael Ferguson: I'm not sure if I can give you an answer quickly. Certainly, what we identified was that the consultations the department had done indicated that the normal use of marijuana for medical purposes was at certain levels. I don't think there's really a difference between what I've said and what the deputy minister said. That was just the evidence. What we were pointing out is that the evidence at that point in time indicated that normal usage was five grams or less than that for medical purposes, but the limit was set at 10 grams. I'm not really sure I've heard that the deputy minister contradicted that. Perhaps they have collected more information since then, but that certainly was the information in the documentation that existed at the time we did the audit.

The Chair: We'll now move to the opposition with Mr. Poilievre.

Hon. Pierre Poilievre (Carleton, CPC): Paragraph 4.46 of the report indicates that shortly after the regulations were implemented the department once again identified the need to contain the rising costs of marijuana for medical purposes by imposing a dollar limit that would be paid per gram. It found that the per gram cost had increased.

What is the major driver for increased costs per gram of marijuana?

Gen Walter Natynczyk: My understanding is that it's dependent on the strain of the marijuana.

I'm going to turn this over to my specialists, Dr. Courchesne and Michel Doiron.

Mr. Michel Doiron: A couple of factors have influenced the cost per gram. Initially, Health Canada controlled the cost and they had capped it. When the regulations changed in 2014, the cap was no longer there and it turned into a free market. The cost per gram varies according to the strain of marijuana based on the percentage of THC or other products in the marijuana. It goes anywhere from $7 or $8 per gram up to $20 per gram depending on the strain you buy. The Auditor General in his report highlighted that we had not capped the price per gram. That was correct. It's something that we've been asked to look at as part of the research by Minister Hare. We want to look at the best strains and whether there is any cost-effectiveness when it comes to these strains.

Hon. Pierre Poilievre: It says here that the cap on quantity was set at 10 grams per day.

Is that a lot?

Mr. Michel Doiron: Yes.

Hon. Pierre Poilievre: Are a lot of veterans using that much?

Mr. Michel Doiron: A fair number of veterans are using up to 10 grams, but they're not necessarily using it all. In some cases, they're making sure they have it and use it when they need it.

Hon. Pierre Poilievre: On average, would they be using 10 grams per day?

Mr. Michel Doiron: They could be.

Hon. Pierre Poilievre: Has there been any consideration of the health impacts this might have?

Mr. Michel Doiron: There has been a lot of discussion on the impacts this may have on the health of our veterans. Notwithstanding cost-effectiveness and other issues raised by the OAG, one of the goals of the review that we are presently doing with health experts at Health Canada and with our beneficiaries is to try to determine what is and would be the optimal amount and its benefits and where it become dangerous for the health of the veteran.

Hon. Pierre Poilievre: It seems to me that 10 grams of consumption in a single day, on average every day, probably causes more health problems than it solves.

I also note the explosion in the budget for marijuana. Here it show that costs between 2013-14 and the first nine months of 2015 rose by 25 times. That's twice the rate at which the number of veterans consuming marijuana increased. We've increased the number of recipients by 13 times and the cost by 25 times, and that's only in a two-year period. Then I see that the cost is expected to double again next year. This is a phenomenal growth industry within Veterans Affairs.

My question is, are we prescribing medical marijuana for PTSD?

● (0940)

Gen Walter Natynczyk: Just to answer that, marijuana is not prescribed. It is being authorized for numerous medical issues.

Hon. Pierre Poilievre: Including PTSD?

Gen Walter Natynczyk: Including mental health and PTSD. But the most prevalent is actually musculoskeletal issues, significantly more than for those veterans who have a mental health injury. Perhaps Dr. Courchesne could just mention a little bit more.

Hon. Pierre Poilievre: How many veterans are being authorized to have marijuana reimbursed for the purpose of operational stress injuries?

Dr. Cyd Courchesne: I want to just clarify that we don't prescribe.

Hon. Pierre Poilievre: No, of course not.

Dr. Cyd Courchesne: We don't prescribe for any issue. That would be their attending doctor.

Hon. Pierre Poilievre: How many veterans are being prescribed or authorized reimbursement for medical marijuana for mental health issues?

Dr. Cyd Courchesne: I think it's in the order of 900. As the deputy said, most people report that it's mainly for musculoskeletal related pain.

Hon. Pierre Poilievre: You say there are roughly 900 who are using medical marijuana for treatment of mental health issues. Has the department studied whether the use of marijuana helps or exacerbates those mental health problems?

Dr. Cyd Courchesne: I have to say that this is in the realm of clinical research, and we don't do clinical research. It's a very good question and it's a question that is being looked at.

The Chair: We'll now move to Mr. Harvey, please, for five minutes.

Mr. T.J. Harvey (Tobique—Mactaquac, Lib.): I want to follow up on my colleague's comments about the 10 grams a day. I have a good friend who is paraplegic, and he takes medical marijuana for that exact use. In New Brunswick, until recently the musculoskeletal rate was 1.5 grams to 2.5 grams per day. It was increased in the last year to 3 grams per day, which is actually at the high end of the average doses. If you go to the Health Canada website and look at the recommendations on there, it says:

> For smoking and vaporizing, the median reported dose was 1.5-2.0 grams per day respectively.
>
> For edibles, the median reported dose was 1.5 grams per day.
>
> For teas, the median reported dose was 1.5 grams per day.

It's your department, and basically Veterans Affairs has identified that the need of a veteran is more than four times the amount of an average Canadian.

I'm not done yet, but when I'm done, you're more than welcome to speak.

I also know that the cost for medical marijuana is, at the low end, $6 on average, and at the high end it's $10. So it's an average of $8. I do understand there are strains that cost upwards of $20, but that's at the very high end, and it's for a very concentrated product.

If you have a veteran who is using 10 grams per day, which is more than 4 times the amount of the average user, at the high end of the dosage levels, to me, something in that just does not compute. Also, if you figure it out by average daily usage, in the medical marijuana study that was done of current medical usage across the country, the average usage was identified at around 90 grams per month total usage. For a veteran who is taking 10 grams per day, that would amount to over 300 grams per month. At an average cost of $10 a gram, that's $30,000 a year.

I question whether all of that usage is actually being done by the veteran. Maybe that's not a conversation that anybody wants to have, but I'm lobbing the question out here because it's right there.

I have a second question. What is the specific budgeted amount for medical marijuana forecast for 2016-17 and 2017-18?

I do believe those numbers should be available somewhere because Veterans Affairs' report on plans and priorities for 2016-17 does include budgetary numbers, so obviously there is a budgeted number.

● (0945)

The Chair: Mr. Natynczyk.

Gen Walter Natynczyk: I would just like to say that your concerns are well founded. It's precisely because of all that you've just layed out that the minister has launched this review. You're exactly spot on with your points. That's why the minister wanted to make sure that we actually get the best evidence we can from across all of the realms, from the medical experts and the producers, going into the price points and the strains that you've mentioned, as well as the beneficiaries. Obviously, we cannot meet with all the beneficiaries, but with a select group, to understand the various perspectives as we try to figure out how to move beyond this guideline that was put in place in 2014, and how to normalize this to ensure that there is not an unintended consequence of making the health worse for the veterans, and indeed supporting the physicians for the well being of those veterans.

This is precisely why we're working on this. We've been working, and as I mentioned before, we just had a summit of all the veterans associations here in Ottawa recently, to educate the community in terms of the kinds of points you just mentioned.

I will just ask Michel Doiron and Dr. Courchesne if they could wade in. I don't have the numbers on me with regard to 16, 17, or 18.

Over to you, Michel.

The Chair: Very quickly, please. Our time is pretty well up. I'll give you a little extra time.

Mr. Michel Doiron: If it's okay with the chair, I'll provide the exact numbers later. I have the numbers for the entire medication, but not for marijuana specifically. I can provide that to the committee after this meeting, if it's okay. I have the general number, but not the specifics.

As the deputy said, this is exactly why we're following up on the policy. We did put in place the limit of 10 grams, because once Health Canada changed, we were caught and we did cap the amount. We had started looking at what the optimal amount or right amount was. That is the work that we are doing in developing the policy, by talking to the experts, talking to other jurisdictions, and following up on the points you've raised. We were aware of those. These are all things that we have followed up on.

Even for the producers, what does an average Canadian take versus a veteran? They have different categories. I won't get into all of the details of who takes what, but some are at that level, some are a little higher, and some are over that.

We need to come up with a reasonable policy that will meet the needs of our veterans by ensuring their health, but also make sure that we're not causing a downstream effect with the marijuana.

The Chair: Dr. Courchesne, did you have a comment on that?

Dr. Cyd Courchesne: With respect to the amount, we can't assume they're smoking the entire 10 grams every day. When we talk to the veterans, some put it in their smoothies, some make brownies with it, and some extract oil, which requires higher quantities. We can't assume that all of our clients are at the high end of the 10 grams.

The Chair: Mr. Harvey is going to burst if I don't let him back in here.

Mr. T.J. Harvey: The only reason I made the point is that it's right on the Health Canada website and that—

Dr. Cyd Courchesne: Yes, I have it right here.

That's what they report. They're not recommending, but they're reporting that—

● (0950)

Mr. T.J. Harvey: What they're reporting is what their findings have been, and based on the evidence not only from here, but from a study that was based out of the Netherlands, that when marijuana is consumed in alternative forms besides inhalation, the amount that's consumed on a daily basis goes down.

To say that is a plausible reason why consumption levels could be so high is categorically false.

The Chair: Thank you, Mr. Harvey. Maybe we'll have a chance to come back to you on this.

We'll go to Mr. Godin.

[*Translation*]

Mr. Joël Godin: Thank you, Mr. Chair.

I appreciate my colleague's question. It is very relevant.

I don't want to demolish what is being done currently, but I think we have created a monster. Before marijuana was legal, what did we do? Did our military people receive poorer treatment, and were they in worse shape? How is it that marijuana has become the cure-all of the century and that it is being prescribed across the board? The 2013-2014 budget was multiplied by 25 in two and a half years. What did we do before?

For the moment, my question is limited to that point. I have other questions, but what used to be done to treat people suffering from post-traumatic stress syndrome? Did they prescribe alcohol?

Gen Walter Natynczyk: Gentlemen, I confirm that marijuana is not only used for psychological problems, but also for physical injuries. Our information indicates that many military people with musculoskeletal injuries use a lot more marijuana than those who suffer from psychological issues.

We have found that modern physicians authorize it in the form of various medications. From time to time, our veterans really have trouble, especially those who have complex pains.

[*English*]

I'll ask if Cyd could add a bit there.

[*Translation*]

Mr. Michel Doiron: Before 2014, veterans had to go to Health Canada and provide their information to that department. They were reimbursed, but the reimbursement process was more complex. That does not mean however that veterans did not use it. It means that we did not reimburse them for the reasons mentioned by the deputy minister.

Since 2014, the rules have changed. Doctors may authorize the use of marijuana and we reimburse the incurred costs. Before that, the person had to obtain authorization from Health Canada, and they had some very strict criteria. A court—I believe it was the Supreme Court—ruled in favour of amending the regulations. That change brought about a marked 25% difference.

I am not ready to say that before that date, our veterans did not use marijuana. The process to obtain it was however far more controlled and it was not prescribed by a physician. Now, physicians provide the authorizations.

Mr. Joël Godin: In fact, measures were put in place to facilitate access to marijuana. As legislators, we see that the budget for marijuana reimbursement has exploded and we don't know how this is going to end. Over the last nine months of 2015, the amount spent on this was 25 times greater than what it was two years ago.

We have to put in place some limits and controls. In the past, the quantity was 10 grams a day, but we also heard that that may or may not have been consumed. We have to be more rigorous with this. Personally, as a legislator, I am very uncomfortable to be discussing the possibility of a constantly growing budget for this, without adequate controls.

What measures are you going to put in place to control and monitor this expenditure better? I am not saying that the treatment isn't effective, but I think that things are too free and too accessible. We are trivializing the use of marijuana. Any soldier coming back from a mission can be advised to consume marijuana by his fellow soldiers, who assure him that this is going to do him good. At a certain point, I think we have to be more responsible.

What do you intend to do to introduce stricter controls over all of this?

● (0955)

Gen Walter Natynczyk: Mr. Chair, as I mentioned previously, physicians have the authority regarding marijuana, and are responsible for the overall health, both physical and mental, of our veterans who return to civilian life. It is important that we insist on that point.

That said, Mr. Godin, you are entitled to be concerned. That is why we are currently reviewing the policy using all available information and recommendations made to our minister in this regard. After that, we are going to consult experts everywhere in Canada, and veterans who use marijuana.

Mr. Michel Doiron: We understand your concerns. As the deputy minister was saying, that is why we are currently working with experts and the medical community in order to develop a policy we will submit to Minister Hehr, so as to ensure that rules involving marijuana are much clearer and more precise, whether we are talking about quantity, costs or other aspects.

You must understand that there is a difference between marijuana and the other medications. Generally, when medications are prescribed, prior analyses have been done. There are protocols; if you have a sore throat, penicillin must be prescribed three times a day over five days, for instance. I am not a doctor, and my colleague could tell you more about that.

However, when it comes to marijuana, we still don't have expertise like that either in Canada or elsewhere. We do however note trends and situations where it seems that marijuana gives people relief.

[*English*]

The Chair: Our time is up.

For those who may be watching this, we've heard part of the concern. In fact, in the deputy minister's opening statement, he showed the increases up to 2013. In 2013, $408,810 was budgeted for 112 recipients; in 2014, $5,160,747 was budgeted for 628 recipients; and in 2015, it was $12,156,000 for 1,320 recipients, with a forecast of that amount doubling again next year. That would be $25 million. When you go from $400,000 to $25 million over three years, if we don't ask questions about on that, people will be shaking their heads, I'm sure.

Mrs. Mendès.

Mrs. Alexandra Mendès (Brossard—Saint-Lambert, Lib.): I'd like to begin by saying that I'm perhaps going to seem the odd one out. I'd like to take away the value judgments and moral judgments that I'm hearing a lot of in regard to veterans' use of marijuana. I do not want to have our veterans seen as using this as a joyride, as some people are assuming. That is my first comment.

I want to ask about the costs and how we're using the budget for the authorization of marijuana use, not the prescriptions. Do you have any comparisons? You know how much you've spent on the marijuana. How much lower is it than for your other medications?

The deputy minister made a point of telling us that some veterans used the example of showing a full pack of medication they had stopped using once they started on marijuana.

Gen Walter Natynczyk: To the first part of your question, many of our veterans find marijuana for medical use to be beneficial to them. Again, it is very compelling, and the challenge is that it's very anecdotal. As Dr. Courchesne indicated, we don't have a medical research branch in Veterans Affairs, but with National Defence and Health Canada we partnered to create the the Canadian Institute for Military and Veteran Health Research. It's basically a system of systems of all of the medical schools across Canada with research branches in all of our universities who do research on both military and veteran health issues. It also links to our allies in the U.S., U.K., Australia, and the Netherlands so that we are aware of the best practices across the board. Dr. Courchesne is our link in that network of researchers, and this is clearly a significant body of research that challenges the evidence that, as has been mentioned, isn't there yet.

Yet, anecdotally, it is so compelling. When you meet our veterans, they will lay out all the bottles of various medications they no longer take because they are now able to take marijuana for medical use. They are able to sleep, they're able to eat, and they're able to undergo treatment at our operational stress injury clinics. They're able to undertake vocational rehab and education, whereas under all of these other various drugs whose names I can't pronounce, they were in a fog and could not function. We have that anecdotal information that, again, was an education to me, as it was to many in the department. Again, hearing from the medical experts from across the field, I think, is really important.

I think there was a media story about this recently, indicating that our spending on opioids and other pharmaceuticals had gone down, as has been mentioned, while that on marijuana for medical use has gone up significantly. While we recognize that those two numbers are correct, we do not have sufficient evidence to make a causal relationship.

● (1000)

Mrs. Alexandra Mendès: Would it be possible to have it eventually?

Gen Walter Natynczyk: We are certainly looking at all of this information. I'll just ask my colleague—

Mrs. Alexandra Mendès: I think it would be important, actually. It's part of the whole....

Gen Walter Natynczyk: Yes, I would ask my colleagues to chime in.

Michel.

Mr. Michel Doiron: As the deputy mentioned, we are seeing a decrease. Now, whether it's causal or not, it's very difficult at this point, because we've just started to see that decrease. We are following—

Mrs. Alexandra Mendès: But it's only since 2014 that it has been accepted.

Mr. Michel Doiron: Actually, it was more in the last year, I'll say, that we've seen it on the side of opioids and tranquillizers. But we always have to be careful not to jump to conclusions when we see a decrease somewhere. Anecdotally, as the deputy minister said, we've been told, and the veterans are actually showing us that “These are the medications I used to take, and now I smoke—whatever—a number of times a day, and here's what I can or cannot do.”

We have to be careful because sometimes they still take it, but it's a different dosage of medication. When you had certain strength—and I'm not a doctor—of medication, now their doctor is prescribing lower amounts of the drug for them to better handle whatever illness they may have, whether it's musculoskeletal, or mental health, or other issues, because marijuana can be used for various things.

But we are tracking this. We're starting to look at it to try to determine if there is a causal effect. Will that causal effect mean, going forward, that our forecasts have to change? At this point, I would not even dare to give an answer on that because I think it's way too early in the analysis, but we have seen a decrease in the use of opioids and tranquillizers.

Mrs. Alexandra Mendès: Thank you very much.

I think I'm done, no?

The Chair: You have 30 seconds. Will you give it to Mr. Christopherson?

Mrs. Alexandra Mendès: Yes, I will give it to Mr. Christopherson.

The Chair: Thank you very much, Mrs. Mendes.

We'll now move back to Mr. Christopherson, please.

Mr. David Christopherson: Very good.

Doctor, is it pronounced "benzodiazepine"—did I get it? Am I close?

We're getting there General, we're getting there.

All joking aside though, I wanted to complement Madame Mendès on her comments. I was having the same feeling, that we're starting to walk down a moralistic road in terms of evaluation, rather than a medical one.

Dammit, if that's what soldiers need when they come back after defending this country and they're in those kinds of war zones.... Nobody was being overly moralistic when we sent them over there; nobody was being overly moralistic with their families when there was the potential that they may not even come home alive.

Dammit, if this helps them, then it needs to be there. Nobody's talking like this about the cost of cancer drugs. We have to talk about them in terms of containing the cost, but not about whether or not morally we think such and such is an appropriate medicine to be giving to a fellow Canadian citizen who put on that uniform and went off into that war zone and got broken and came back and believed that the commitment this country made to them would be honoured.

I'm so glad you went down that road. I appreciate it and I support 100% what you said.

Having said that, though, we have an obligation involving our approach to drugs. I want to bring us back to the Auditor General's report, page 10, paragraph 4.42:

> We found, however, that over the following two years Department officials did not pursue Product Listing Agreements with pharmaceutical companies. We also found that not using them has limited what it can include on its drug benefits list because the costs of some drugs are too high.

When I look at the action plan, on page 2 I see under "Cost Effectiveness Strategies":

> Continue working with other federal drug partners and the Pan Canadian Pharmaceutical Alliance to explore opportunities to enter into Product Listing Agreements

What's the problem?

I would have thought the response to the recommendation would be that yes, we've done it, or it's on the brink of being done, or we're negotiating the actual final details.

Why is it so difficult to get into this agreement?

● (1005)

Gen Walter Natynczyk: Again from my previous life, if I can lead, I'll lead and I'll take the hill. In some cases I don't have the lead, and we have to work with other government departments.

We are working very closely with Health Canada in this regard. It has the lead for the PLAs. We are trying to move very quickly with them so that we can sign up with them and other government departments. National Defence, Indigenous Affairs, and other departments have significant pharmaceutical programs as well, so as a collective we can work with various companies to land a preferred pricing schedule for some of these pharmaceuticals.

I'll ask Dr. Courchesne or Michel to pile on.

Mr. David Christopherson: Before you go on to that, my next question is going to be why it wasn't a bigger priority sooner. This is not rocket science. We didn't need high-priced auditors to come in to tell us that when you join these bulk-buying agreement deals, you save money. Why has it taken so long, and why such a weak-kneed response?

I hear you saying there are complications, deputy. I accept that to a certain degree, but I'm not going to accept, as a reason we're not doing it, that it's complicated and it involves other ministries. I get that. It makes the challenge greater, but it doesn't mean you just walk away from it.

Help me understand why something so plainly obvious isn't already done.

The Chair: Thank you, Mr. Christopherson.

Gen Walter Natynczyk: Sir, we will move out with all dispatch to implement this as soon as possible.

The Chair: Thank you.

We'll now go to Mr. Lefebvre and then to Mr. Poilievre.

Mr. Paul Lefebvre (Sudbury, Lib.): Mr. Chair, before I start, my colleague Mr. Harvey wants to make a statement or ask a question.

Mr. T.J. Harvey: Thank you, Mr. Chair.

I have to leave and I don't have a question. I just want to state something for the record, since we're on the issue of the moral high ground here: my comments towards Veterans Affairs today and my questions weren't centred around the moral implications of this or in any reflect on my appreciation for those veterans, period. My comments are centred around my belief that Veterans Affairs has made a misdiagnosis of what the maximum levels should be, compared with the rest of the data from across the country indicates. The department is here today reflecting its belief that it's data on levels is correct, and I believe it's wrong.

It's not a judgment on veterans—period.

The Chair: Now to Mr. Lefebvre.

Mr. Paul Lefebvre: I want to ask a few questions about the formulary review committee and who sits on it, because from the Auditor General's report they are responsible for reviewing, maintaining, and revising its drug benefits program, as well as making recommendations and providing guidance to its senior management.

Who sits on this committee, and now that we're talking about evidence-based decisions, how is that a change from what was being doing before? I know that you guys are reviewing it, so what was occurring on this committee before, and how has that changed now that you guys are doing your review?

● (1010)

Gen Walter Natynczyk: I will start and then I'll ask Dr. Courchesne to wade in.

The formulary review committee comprises health professionals from our own department. It includes Dr. Courchesne and our national pharmaceutical advisor, as well as the pharmacists and the medical consultants from Medavie Blue Cross. In addition, we have our service delivery specialists from Michel Doiron's team, and we also have members of the Canadian Armed Forces on that team.

Mr. Paul Lefebvre: Has that always been the case, because Madame Courchesne stated at the beginning that there were no pharmacists involved? Can you expand on that?

Dr. Cyd Courchesne: When I arrived, there wasn't a pharmacist in the position—

Mr. Paul Lefebvre: Okay, so there—

Dr. Cyd Courchesne: —from the department, but there were pharmacists on the formulary review committee, from Blue Cross Medavie.

Mr. Paul Lefebvre: There were. Okay.

Now that we are looking at evidence-based decisions, how does that differ from before?

Gen Walter Natynczyk: Again, what we've done is to recreate leadership in pharmaceutical advice in the department that had been lacking for a few years. While we had pharmacists, they weren't Veterans Affairs pharmacists. They were from Blue Cross Medavie and others.

Now we actually have recreated the critical mass in the core of decision-making inside the department, so we now have some structure to develop a strategy, develop a plan, and capture it in a very rigorous way, so that we know how the decisions are made; when they are made; and again, going back to the Auditor General's point, when we're actually going to achieve these things to get it done in a timely fashion.

Cyd.

Mr. Paul Lefebvre: I guess I'm asking, why wasn't that done before, and why is it being done now? Do you have more resources now? Is it more best practices, that you guys have self-evaluated?

Dr. Cyd Courchesne: I can't really speculate on things before I got there. I can only say what I observed when I got there, and the way forward as the deputy has indicated.

Mr. Michel Doiron: If I may, Mr. Chair, I guess we were relying on our partners to make some of these decisions, and when Dr. Courchesne arrived we started looking at how we were documenting those decisions. The OAG did raise that in their audit, that we had not properly documented some of the decisions. I think there was a reliance on Medavie Blue Cross to provide us...and they're a great partner, they are incredible.

We decided that the department had to take that responsibility on, not a third party, to ensure that the decisions were correct, but more importantly, from a government perspective, that we were documenting those decisions and following through with them.

Mr. Paul Lefebvre: Has mental health now become more of a priority within the review committee? Or is it just one of the other—

Gen Walter Natynczyk: Sir, mental health exactly, along with physical health, is always a priority, so it is centre of mind constantly.

The Chair: We'll now go back to Monsieur Poilievre, please, for five minutes.

Hon. Pierre Poilievre: It says in paragraph 4.63 that 29% of the approximately 600 veterans authorized to utilize marijuana for medical purposes had obtained this authorization from one physician. Why is it that such an enormous number of veterans went through a single physician to obtain the authorization for marijuana use?

Gen Walter Natynczyk: Sir, we can only speculate that our veterans are networked with each other. Again, they have had a common experience in operations, be they in Afghanistan, in Bosnia, Rwanda, Somalia, or operations prior to that, so they are networked, and they are dispersed from coast to coast to coast in the country, some in remote areas, some in larger areas, and when a soldier, sailor, air man or woman hears that something is working for somebody else, they will share that.

Hon. Pierre Poilievre: The fact that they are dispersed would seem to be a reason why they wouldn't be going to the same doctor.

Gen Walter Natynczyk: But the other challenge that we have is that there are physicians in the country who will not prescribe—

● (1015)

Hon. Pierre Poilievre: That's the point.

Gen Walter Natynczyk: —and therefore that's one of the challenges. At the same time—

Hon. Pierre Poilievre: I'm sorry, I don't mean to interrupt you, but we're very tight on time.

Building on your point, we found that 53% of the approximately 1,400 authorized to use marijuana for medical purposes had obtained this authorization from four physicians. You've said that a lot of physicians won't prescribe it. There's probably a reason they won't prescribe, and I don't think it's because they're engaging in moralism, as some had suggested earlier. It's probably because they have some questions as to whether or not marijuana is the right treatment for the person who is sitting before them in the doctor's office.

I've been to the operational stress injury clinic here in Ottawa, and they specifically say that in order to treat post-traumatic stress, you have to confront the underlying trauma that caused it. This is very difficult and painful because people who come back from theatre are experiencing extraordinarily painful memories, and they have to relive those to treat the stress symptoms they are enduring.

My worry is that marijuana is being used as a numbing treatment rather than as a real treatment for the underlying cause of post-traumatic stress, which could be why so few doctors are prepared to prescribe it.

The other worry I have is that the quantities in question are a maximum of 10 grams a day. According to the Government of Canada, one gram produces two joints. So with 10 grams, that's 20 joints a day. That's like smoking a pack of cigarettes, with every single cigarette being filled 100% with marijuana. I have a hard time believing that this is medically sound, based on Health Canada's.... Mr. Harvey found earlier today that compared to Health Canada's observations on marijuana consumption, the amounts here are four, five, six times higher than those highlighted on the Health Canada website. Do you share any of these concerns about the possible excessive prescription of this solution for our veterans?

Gen Walter Natynczyk: Sir, you're absolutely correct in your concerns, and we share all of them, and this is the reason our minister has asked for this review: to try to get as much of the real information across the board from the best researchers in the country and to hear the perspectives from our veterans as well. The challenge for many of our physicians across the country is that there is a lack of evidence on the medical use of marijuana. It is still very much an experimental treatment, but some veterans find it to be very beneficial so they can undergo treatment, vocational rehabilitation, and so on. However, given all the concerns, it's precisely why we're doing this review: to provide recommendations to our minister on how to move forward on this important issue.

Hon. Pierre Poilievre: Will that review look into the psychological benefits versus the psychological drawbacks of abundant marijuana use among veterans suffering from post- traumatic stress?

Gen Walter Natynczyk: If I could ask Dr. Courchesne to just briefly mention her meeting with some of Canada's top medical experts on this topic.

Dr. Cyd Courchesne: Yes. The policy review is including an extensive literature review, and we're working with Health Canada. They've been very gracious in sharing the literature review that they're doing on that. Certainly that will be factored into our policy review.

The Chair: We'll now move to Ms. Zahid.

● (1020)

Mrs. Salma Zahid (Scarborough Centre, Lib.): We appreciate the department's progressive initiative on giving access to veterans who require marijuana for medical purposes, for their health issues. There are several concerns expressed in this report regarding the amount prescribed for the eligible veterans, including intervention during excessive drug usage, high-risk veterans, and containing the costs associated with it. It seems that this program was begun without a sound policy on how it should be implemented and administered. Can you discuss the department's policy with regard to medical marijuana? Why did you feel it should be created?

Gen Walter Natynczyk: In 2001, Health Canada indicated that marijuana for medical use should be accessible to all Canadians, and veterans are obviously are a part of our nation. In 2007, a senior official in the department approved, for compassionate reasons, marijuana for medical use by one individual who was in an end-of-life situation. We expanded it in 2008, and the department approved it for a small number of people. At the time, it was covered by Health Canada regulations that prescribed which physicians could authorize, under what circumstances, and to what limit. All of that changed in 2014, and at that point the department had to expand its guidelines.

I'm just going to ask Michel Doiron to elaborate on that.

Mr. Michel Doiron: The deputy's correct. At that point, we had a limited number of individuals coming to us. After the liberalization of the guidelines, a treating physician could authorize the use of marijuana, and we started getting a lot of demands. It's not a drug like other drugs. We had agreed to pay in 2008—though in 2007 there was one case we paid for. We were already paying.

Then we had to react to this growth. We looked at what the beneficiaries were asking for, what had been approved in that short period. We had put a cap on this in June 2014, because we wanted to make sure we understood what was going on. We capped it at 10 grams because 80% of our veterans were asking for that or less.

Mrs. Salma Zahid: You prescribed an amount of 10 grams per day, doubling the amount identified by external health professionals, and tripling the amount that Health Canada recommends. How was this amount of 10 grams determined?

Mr. Michel Doiron: We went to what was being requested and what we had been paying for since the act came into force. It was based on our going out and trying to assess the evidence. To be honest, for medical purposes, the evidence is clearer now, but at that point 2014, it was sketchy at best.

Mrs. Salma Zahid: Between 2014 and 2016, the evidence started coming in. Why did you not go back and do further research? Why did you not prescribe the amount based on the evidence available?

Gen Walter Natynczyk: I want to avoid the use of the word "prescribe". It's "authority". It's the authority a physician gives his or her patient to have access to an amount of marijuana. It has to do with the relationship between the physician and the patient. In 2014, the department, in trying to capture most of the authorities, set the limit at 10 grams. Clearly, that is higher than what Health Canada said. That's precisely why we're doing this review now, in order to provide advice to the minister on how to move forward on this very important issue.

● (1025)

The Chair: Mr. Godin.

[*Translation*]

Mr. Joël Godin: Thank you, Mr. Chair.

I would like to clarify my position in this debate.

As a parliamentarian, my purpose is to find potential solutions to see to it that our veterans are treated well. The fact that I am questioning the costs should not be interpreted as a minimization of their situation. The costs are one element, but it is very important for me that we find the best solution for veterans.

I want to know today if the whole exercise is aimed at finding the best solution. If marijuana is the solution, we have to know whether we are dealing with communicating vessels, as Ms. Mendes mentioned earlier, and if it means that another category of medication and its costs will be reduced and be transferred there. I think you don't have the answer, but that you will provide it later. Those are my thoughts.

My question is for the Auditor General.

Based on your audit, can you reassure us by telling us that the Department of Veterans Affairs is in control of the situation and will take the necessary means to ensure the effectiveness of its programs, while also ensuring that the budgets are not a money pit in the ground?

Mr. Michael Ferguson: As we noted in the audit, there were a number of issues with the program. Obviously, in order for the program to work effectively, certain problems need to be ironed out. That was the case for all aspects of the program that we looked at. The department will have to make a few improvements for the program to be effective.

Mr. Joël Godin: My next question is for the department representatives.

You have accepted the recommendations and stated that your intentions are good, but are you able to say to us today, June 9, 2016, whether you have the necessary means to achieve your ends?

I don't want you to take this the wrong way, but would just like to ask you, in my own words, whether you have enough staff and data available to you to better manage public funds within your department. The goal is to make the most of those taxpayer dollars so that veterans can enjoy a good quality of life and the best medicines available on the market, while at the same time living within our means.

Gen Walter Natynczyk: Thank you very much for your question.

The well-being of our veterans is also our goal. It is truly a priority for us. To answer your question, I'm confident that our managers and our department's leadership and planning will be able to remedy the shortcomings identified in the audit report. As I've said before, I greatly appreciate the Auditor General's help and have noted the issues he pointed out. With the support of our doctors, our pharmacists, and our measures, we will make sure those weaknesses are corrected.

Mr. Joël Godin: Thank you very much, Mr. Chair. That brings me to the end of my questions. I have a bit of time left, but I am offering it to my colleague.

[*English*]

The Chair: You do have a couple more minutes, but I want to get something here.

As you know, we'll be issuing a report on the study we're doing. Just so I understand this correctly, although we've seen this explosion in the use and quantity of medical marijuana, we have anecdotal evidence that the use of other pain relief, other medication, has diminished. That's all anecdotal.

There is no evidence, as far as data are concerned, that says, yes, the number of medications has diminished, the number of those using these medications has diminished and so has the cost. There's no evidence for that. It's more anecdotal. You have the veterans saying that they have all this medicine they don't have to take anymore. Is that correct?

● (1030)

Gen Walter Natynczyk: Mr. Chair, we actually do have evidence, as you indicated, that the use and cost of marijuana for medical purposes has increased exponentially. We also have evidence that the use of opioids and other antidepressants has gone down.

The Chair: Proportionally?

Gen Walter Natynczyk: What we are lacking is the causal relationship. We are lacking causal evidence that one went up and the other went down.

The Chair: Given the excessive jump in the use of medical marijuana, doubling in cost over the next year to $25 million, how much of a decrease has there been in the use of other medications? Is it just miniscule? It may not be exactly proportional, but is it close, or what type of evidence do you have there?

Mr. Michel Doiron: It is not one for one, and that's in regard to a causal effect. We've seen a very big increase in marijuana usage and cost, but the relationship is not one for one. We have seen a decrease in the use of other medications. We're trying to analyze that decrease, and why, but it is not directly proportional—far from it actually. That's what we're trying to analyze.

The Chair: So, it's far from proportional.

Mr. Michel Doiron: Yes. Now, we've only started to see that decrease. That's why we are studying it to see what will materialize, what will it look like. We are tracking that and working with our partners at Medavie Blue Cross in tracking the use of opioids, tranquillizers, antidepressants, and some of the pain medications. At present, it is not directly proportional.

The Chair: Mrs. Mendès.

[*Translation*]

Mrs. Alexandra Mendès: Thank you very much, Mr. Chair.

I would like to thank the witnesses for the clarifications they provided.

It's important to continue with this study and to later confirm the benefits of using marijuana to treat certain illnesses and chronic pain —as that's what it's often used for—our veterans have to deal with.

I would like us to return to the title of the Auditor General's report. It alludes not only to marijuana as a treatment, but also to all of the other medications veterans need.

Will the study or research being carried out on the program in its entirety be able to show whether there is a difference in terms of savings between the use of marijuana for medical purposes and the use of other medications? Could this be included as part of the study as a whole?

Mr. Michel Doiron: Thank you very much for your question.

That's what we are planning to do. I can't predict what the results of our studies will be. The further these studies progress, the more evidence we'll have on the cost of the marijuana and on the increase or decrease in the cost of other medications. In addition to developing a clear policy on marijuana, we want to know what is being used. Some veterans have told us they no longer need to use medication *x*, *y* or *z*. And others tell us their doctors are prescribing lower doses than they used to.

It's the causal link that we're trying to analyze.

Mrs. Alexandra Mendès: From what I know about the issue, it would apply more to pain medication.

Mr. Michel Doiron: Yes, to a large extent, but it also applies to antidepressants, tranquillizers, and opioids. This is what we are in the process of analyzing. It's too early in the study to draw any conclusions. We are going to develop a policy on marijuana. We will be conducting public research, in addition to our research with the Canadian Institute for Military and Veteran Health Research and other organizations. We want the policy to be flexible enough to meet the needs of our veterans. Our core mandate is to ensure the well-being of our veterans, and I am pleased that the committee mentioned that.

There will be further studies; more people will start using marijuana for *x*, *y* or *z* reason, and the information will be made available. We will review our results on a regular basis with those aspects in mind, in order to make sure that our policy continues to meet the needs of our veterans, not only in terms of effectiveness and efficiency, but also in terms of their health and well-being.

● (1035)

Mrs. Alexandra Mendès: Right now, our objective for the medium and long term is for your department to know that we will be following your progress in the next few years with interest. We will come back to review it, but always keeping the best interests of our veterans in mind.

I find it extremely difficult to assess your estimates. It might strike you as odd that I would make such a remark, but I look at your estimates and see that you are anticipating a few increases, but nothing major from one fiscal year to the next.

How can you predict what the medical needs will be? I imagine you would rely on data from previous years, but aren't future needs very difficult to predict?

Mr. Michel Doiron: I will give a general answer and leave it to Dr. Courchesne to get into the technical specifics.

It is difficult to make predictions, but I believe that it is critical to understand that, for us, whether it's one veteran or a thousand veterans who come to us in need, our mandate is to ensure that they receive the care they require.

Mrs. Alexandra Mendès: Exactly—and that's why I'm asking you the question. You don't know exactly what the needs will be, but in principle, you don't have the right to refuse to respond to those needs.

Mr. Michel Doiron: That's right.

Our budgets are based on yearly estimates from past years and from a consistent military tempo. If Canada decides to deploy troops in a conflict, we will have to review our estimates.

We must have realistic estimates. We base our forecasts on previous years, on the community of serving members, on the veterans' community, and on the number of members who leave the Canadian Armed Forces each year. There is a very well-established percentage of those members who become our clients. It's part of our data. We regularly work with Treasury Board and the finance department, and we will make adjustments in a given year and at year's end, as needed.

[*English*]

Mrs. Alexandra Mendès: Thank you so much.

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

Thank you to our guests for appearing before our committee today. I think you've attracted a lot of interesting questions. Above all else, I think we want accountability and transparency, and we want to know that one department, say Veterans Affairs, isn't working against the best recommendations of Health Canada. When we have an Auditor General's report, our job is to go through it.

Let me just say that because of the number of questions that we've fielded today, if you leave here and all of a sudden think that something was missed or maybe that you didn't have enough time to complete an answer or to provide a little more information, please submit that answer to our clerk, who will see that each one of us is copied on some of that.

We're going to suspend. I'll ask the committee to stick around for a moment. We have one small item of committee business. It wasn't on the agenda, but I think we have agreement to go to it briefly.

We will suspend and come back here in about two minutes, because our time has almost run out.

We thank the individuals who appeared today. Thank you.

[*Proceedings continue in camera*]