HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

COMMUNITY SERVICES

Thursday, October 9, 2008

Committee Room 1

Department of Health
Re: Seniors' Pharmacare Program

Printed and Published by Nova Scotia Hansard Reporting Services

COMMUNITY SERVICES COMMITTEE

Ms. Marilyn More (Chairman)
Hon. Ronald Chisholm
Hon. Leonard Goucher
Mr. Patrick Dunn
Mr. Gordon Gosse
Mr. Trevor Zinck
Mr. Keith Colwell
Mr. Leo Glavine
Mr. Manning MacDonald

[Mr. Manning MacDonald was replaced by Mr. Wayne Gaudet.]

In Attendance:
Ms. Kim Leadley
Legislative Committee Clerk

WITNESSES

Department of Health

Ms. Cheryl Doiron
Deputy Minister

Ms. Judy McPhee
Acting Director - Pharmaceutical Services

HALIFAX, THURSDAY, OCTOBER 9, 2008

STANDING COMMITTEE ON COMMUNITY SERVICES

1:00 P.M.

CHAIRMAN
Ms. Marilyn More

MADAM CHAIRMAN: I'll now call to order the Standing Committee on Community Services. We're very pleased to have officials from the Department of Health with us today to discuss the Seniors' Pharmacare Program and we'll let them introduce themselves in a minute.

There's one item I'd like to add to the agenda under Committee Business. Possibly we'll finish with our witnesses around quarter to three, to give us time to discuss any follow-up from the Forum on Disabilities. At that time I'd also like to bring to your attention a letter from the Chair of the Public Accounts Committee that has just been distributed to you.

So perhaps we'll start with the introductions from the committee members, Keith.

[The committee members introduced themselves.]

MADAM CHAIRMAN: So we're very pleased to have the Deputy Minister of Health, Cheryl Doiron, join us and perhaps you'd like to introduce Judy.

MS. CHERYL DOIRON: Thank you, Madam Chair. With me today I have Judith McPhee, beside me, who is the Acting Director of the Pharmacare Program, all aspects of Pharmacare. Over on the sidelines I have Pamela Hafey, who is one of our communications support people who works with this program. Beside her is Karen McDuff who is with our financial services and works with this program and a whole bunch of other things, including the big world of continuing care. They're here to basically be on the sidelines but if they could be helpful with any questions we may, if you would agree, refer to them. Basically we'll try to address most of your questions.

MADAM CHAIRMAN: Agreed. So we'll open with perhaps a short presentation and then the committee members can ask questions. If your other staff actually come over to answer a question, just remind them to use one of the microphones.

MS. DOIRON: I'll just give a very, very brief statement and then ask Judith to do a short presentation. What we decided to do, understanding that you had asked for us to be here in relation to the Seniors' Pharmacare Program specifically - Judith's presentation will just give a very short piece around what are all of the programs that are delivered through the Pharmacare branch and basically just set that context. Then we'll go specifically to a few facts around the Seniors Pharmacare Program and then basically send it back to you, Madam Chairman.

So with that little brief statement from me, I'll ask Judith to run through the presentation.

MS. JUDITH MCPHEE: Will you hear me if I stand up?

MADAM CHAIRMAN: No, it's not a matter of us hearing you, we need it for recording purposes.

MS. MCPHEE: Okay, so I'll have to sit. I'm not used to sitting when I'm presenting. What I'm going to do is just very briefly, for the next few minutes, talk about the Seniors' Pharmacare Program and lay some groundwork for our discussion this afternoon.

As you know, Seniors' Pharmacare Program is just one of a number of Pharmacare programs that we deliver and special drug funding that we deliver in the province. Seniors' Pharmacare Program, of course, is our largest. We also have Family Pharmacare, which was implemented approximately six months ago, on March 1, 2008. We have the Nova Scotia Diabetes Assistance Program. The next two Community Services Pharmacare and Low Income Pharmacare for Children are two programs that are owned by the Department of Community Services. They set the policy and they set eligibility criteria. We, at the Department of Health, do manage the formulary and the benefit list for them, as well as the day to day operations of the claims adjudication. The Community Services Pharmacare is for income assistance clients.

Then we also fund a number of specific disease states; things like cystic fibrosis, diabetes insipidus, multiple sclerosis. We also have funding for some specific drugs; for example, the anti-rejection drugs for transplant patients, HIV drugs, there's a drug for anemia of renal failure that is provincially funded, as well as a drug for drug-resistant schizophrenia, which is funded. So for all of these programs, including Seniors' Pharmacare Program, the benefit list or the drugs that are covered under these programs are managed by expert drug advisory committees. There are two main ones - there's a national committee, called the Common Drug Review; and there is a regional one, called the Atlantic Common Drug Review, which make recommendations on what drugs we should cover as benefits, what drugs we should take off, and how we should cover some drugs, with what criteria.

They make the recommendations to government. The recommendations generally are supported by evidence of efficacy and cost-effectiveness, to make sure that the money we are spending on drugs is increasing health outcomes and that we are getting value for dollars spent.

These groups of experts are a mixture of physicians, practising physicians, both GPs and specialists, as well as pharmacists. They all have an expertise in critical appraisal of the literature and of scientific studies. Many of them also have an interest in pharmaco-economics, or health economics and epidemiology, so they are quite a skilled group.

Getting down into the Nova Scotia Seniors' Pharmacare Program, the mandate of the program is to assist seniors with their prescription drug costs. Participation is optional and it is offered to residents who are 65 years of age or older and don't have drug coverage, either personal drug coverage or private drug coverage or are not covered through a federal plan, such as Veterans Affairs Canada or Indian and Inuit Health Services.

This is the setup of the Seniors' Pharmacare Program. It has a premium and co-payment structure, so there is an annual premium of $424. So that is, in effect, your cost to join. So it is $424 - there are a number of exemptions to that. Any senior who is receiving the GIS is exempt from that $424, as well as low-income seniors, single seniors with an income of less than $18,000 a year or married seniors with a combined income of less than $21,000 a year. So they would not pay the premium of $424. There's also a category in there where their incomes are not as low but they are still low; those are single seniors with an income of less than $24,000 a year or married seniors with a combined income of less than $28,000 a year. They still will pay some premium but it will be a lesser amount, so it will be reduced.

All seniors, though, do pay an annual co-payment, to a maximum of $382. The co-payment is set at 33 per cent of the total drug cost, until you reach your maximum of $382 and then for the rest of the year they would no longer pay anything at the counter.

Just some statistics of our last full fiscal year, which was 2007-08; seniors enrolled - and this is fairly consistent over the last number of years - seniors enrolled at any one

point in time is around 100,000. The number of prescriptions filled in this year was slightly over 3 million - 3.25 million. Total program costs were approximately $171 million. Cost to government was right around $126 million and cost to seniors was slightly under $45 million.

[1:15 p.m.]

These are our projected costs for the current year that we're in: $178.75 million; cost to government, $132.5 million and cost to seniors $46 million, or slightly over $46 million, and this is the 75/25 per cent split.

Just to touch very briefly on some of the challenges that we face; of course sustainability of the program is always front and foremost. There is increasing cost of drugs, particularly new drugs that are just entering the market are coming on at very high prices. There is an increasing demand from the public for new drugs that sometimes offer little benefit. We're seeing an increasing demand for this, with the public being more informed with the Internet and U.S. advertising and whatnot. There is an increased demand and often people or the public think that because it is more expensive and it's new that it's better, which is not always the case. So one of our challenges is always ensuring appropriate use.

Another challenge that we have is determining the program costs and we do have in regulations the 75/25 split. That can be impacted by any number of things; the number of prescriptions, the number of seniors that we have paying premiums, that kind of thing. So every year we project and we use historical data, we do a lot of trending, we do a lot of projections and a lot of fairly sophisticated analysis to try and come up with a number that is going to give us the 75/25 split and we have been fairly successful in the past number of years.

One thing to mention, to take away, is that if there is - and as I say, we do a lot of trending - if there is something unexpected that we hadn't thought about or something happened that we had not anticipated and threw off one of these numbers, that's when we get into maybe not making the 75/25 split.

Another challenge that we have, of course, is the resources to manage, and we're seeing more and more pricing agreements coming from industry to offset the high costs of drugs and, as well, managing our expert drug advisory committees.

So I'll just leave it there.

MADAM CHAIRMAN: Thank you very much. So who would like to start with a question or comment?

HON. LEN GOUCHER: Just so I understand it - and thank you very much for being here by the way today, it's great - the $424 which is the registration, plus the $382, is it $806 a year capped or is it $424? In other words, you have your $424 . . .

MS. DOIRON: Plus, it's . . .

MS. MCPHEE: It's plus, yes.

MR. GOUCHER: Plus your co-pay, plus the third. So it would be a maximum of $806 for the average person, is that correct?

MS. MCPHEE: Right. So if you break it down by month, it's about - at the worst-case scenario - $67 per month and for seniors who are GIS-exempt, it would be about $32 per month. Just to say that we have about 50 per cent of our seniors are exempt from the premium.

MR. GOUCHER: Just to clarify something for me because I know I've had a couple of calls in the office about it and we've tried to help them and we do appreciate, by the way, the response and the support that we've had from the department, it has been great. If somebody in a lower income group - and I think you stated it earlier - the maximum for many of them is just $382, they don't pay the $424, is that correct?

MS. MCPHEE: That's right.

MR. GOUCHER: The $382 is the minimum that's paid by everybody?

MS. DOIRON: That's the maximum they would pay depending on the amount of their drug, so yes if they have . . .

MR. GOUCHER: That's right, that's a better way to look at it because it may be nothing. Thank you very much, Madam Chairman.

MADAM CHAIRMAN: Thank you. Leonard.

MR. LEONARD PREYRA: Thank you very much for coming. This is my first meeting of this committee, so you'll have to forgive me if I'm a little bit out of touch with some of the issues. This is quite an important issue in my constituency and my questions really originate in the kinds of casework we're dealing with.

My first question is really about the navigation of this system itself. Most of the cases that we deal with involve a lot of confusion about how one goes about getting into the system - the paperwork, the kinds of things that are covered, or not covered, or how you assess income. Now I've looked at what was distributed earlier and it seems relatively straightforward, but it still takes a bit of work. I'm wondering, do you have anything in

place now or are you going to have something in place that would help seniors and their families navigate their way through the system?

MS. DOIRON: We do. I'm going to get Judy to answer this but also just to add to your comment and perhaps to public confusion, with the advent of the Family Pharmacare Program, again, it adds another layer of complexity because seniors can choose if they want to go into the seniors' program or if they'd rather be in the Family Pharmacare Program. Once they make that choice they need to stay with it, but nevertheless, they have a choice. If they are quite healthy and they really aren't on many drugs, then sometimes they will choose to go with the Family Pharmacare Program because they're only paying, in a sense, as they go.

I think it is for the average person, somebody who's not involved in this field at all and sometimes for some of our seniors who may have not dealt with a lot of this kind of benefit thing in their lives before and often you're getting seniors who are now single in the sense that they've lost their partner and taking on these things, so it is understandable, I think, that there's some confusion there.

We have been making an effort to try to bring more information forward to assist people and I'll get Judy to describe exactly how that's handled.

MS. MCPHEE: When a senior approaches their 65th birthday, they do get a package outlining how to join and enrolment pamphlets and booklets. Currently what we are doing is we're going through all of those - we have a major project on right now - trying to make those communications less confusing, especially now that we do have the Family Pharmacare Program up and running. We do have as well a 1-800 number and a Web site that seniors can go to that has all of the information posted. I know that a number of seniors do not have access to the Internet, but we do have a 1-800 number as well as our office. We're more than happy to walk everybody through the process and help them choose which plan is best for them, either Seniors' Pharmacare or Family Pharmacare.

MS. DOIRON: I find if somebody needs help, that the 1-800 number is really one of the best for them because they get individual, personal attention and response. If they have any tendency to be a bit confused with it, then somebody can actually kind of gently walk them through it at the speed at which they can deal with it. On the other hand, a surprising number of seniors are actually going on computer, so sometimes that is helpful. Often, I think, people like to get a person on the other end of the line and to have a person to speak with and, of course, the 1-800 number offers them that.

MR. PREYRA: I have a question as well about follow-up on medication. I was talking with a pharmacist recently and he said they used to have a program where if they were concerned about a senior they would give them the medication, but they would also follow up on it to make sure the medication was being taken or that if the prescription wasn't being refilled they'd do some follow-up, but they don't have the capacity for it now and it's not being reimbursed. Is there a way for the department to monitor the intake and

output of drugs, just to track, not problem cases, but where there might be concerns or if there's over-medication, is there something in place to check that?

MS. DOIRON: We don't have a general information system yet, but we will have that. We are in the process now of the first phase of design work for a pharmaceutical information system. Once that system is in place, then we'll be able to track a lot more and have an option to do so, and so will some of the pharmacists and so on throughout the province be able to track an individual's medical history, in terms of whether they're getting multiple prescriptions from multiple physicians or emergencies or wherever, so that's coming.

We do at this point have the system that tracks narcotics, so there's some oversight in that regard that is working quite well since that system has been up and running. But basically at this point, from the department's perspective, we have not been into trying to deal with individual cases in terms of how their medication is going. Judy may have something to add to that.

MS. MCPHEE: Yes, I will add that we are collaborating with the Pharmaceutical Association of Nova Scotia (PANS) and doing a medication review for seniors. It is limited to seniors and we are paying pharmacists a cognitive fee of $150 to do a medication review. If a senior is on - I don't have the eligibility criteria with me here - more than four chronic medications then they would fit the criteria to have a review done by their pharmacist and the pharmacist can bill us this fee of $150 to do that, so they will go do that review.

There are a number of pharmacies doing that and some of the difficulties are at the store level in the shortage of pharmacists and having the time to do that, but that is an initiative that we began.

MR. PREYRA: Thank you.

MADAM CHAIRMAN: Thank you. Leo.

MR. LEO GLAVINE: Thank you very much, deputy minister and Judy for being here today - a very important topic for especially our senior population which is continuing to grow, of course. That probably leads me to the first question. As you project out the kind of cost here to government and knowing the kind of cohort that is going to be coming through in the next two decades, do you see this process we currently have as sustainable or is there going to be the potential for a bigger transfer back to the senior to look after their own medications? How are projections being looked at in that regard?

MS. DOIRON: I'll start with that one. We basically believe that by putting in the 75-25 split that we defined it in a manner in which it should be more sustainable. I found it was rather difficult every year to have to decide or to negotiate - we did a lot of consultation around it with the various seniors' groups, the Group of IX that the Senior Citizens' Secretariat supports. It was very difficult for them and for the department to be

constantly into dialogue and debate on how things should be covered, how costs should be shared, and now I think that is predictable.

We have been working very hard, as have our colleagues across the country, at trying to also better manage the overall costs and increases in drugs with some success and we continue to pursue that. With the pharmaceutical strategy that was started several years ago on a national basis - a federal-provincial basis actually - while we have not at this point had agreement from the federal government to participate financially, they are at the table with us. There have been a lot of learning and improvements as a result of being able to kind of have that dialogue across the country, and I think there's still room there - regardless of who covers costs, there is still room, I think, for us to continue to manage the whole drug system in a manner that will help to at least contain it.

[1:30 p.m.]

Basically, we are also through that strategy, certainly all of the provincial and territorial jurisdictions, still very much at the table, at senior levels, at the ministerial level, talking about these issues, particularly as it applies to catastrophic drug coverage and the sharing at a federal-provincial level of the costs around expensive drugs for rare diseases. Again, with approaches there that we have not abandoned in terms of saying we have to make pharmaceuticals manageable, we have to make them sustainable, and there's a whole variety of approaches in that sense being taken to try to get there.

We have seen in the last couple of years a little bit more benefit to several drugs actually coming on the market at the generic level. Once we are able to get drugs converting from the protected to the generic levels, then usually we see some substantive drop in price for the drug, and we've benefited from that across the country in the last couple of years. It's a little bit unpredictable as to when that's going to occur, but I think that we will continue to see some of that occurring into the future as well. So there are a lot of variables and factors that are at play right now, recognizing the extreme growth that we saw for a number of years in terms of drug growth costs and trying to bring that back into more manageable levels.

We think that with a number of those factors in place we will be able to somewhat contain the growth for our seniors in this province and they now have that guarantee that they're never going to be asked, unless some government again changes legislation, they're not going to be asked to pay more than 25 per cent of what they're taking.

MR. GLAVINE: Thank you. In terms of being sustainable and manageable, we probably - and I'm sure Judy could give us this - there are probably four or five drugs that have a greater predominance in terms of their use. Is it too simplified to think in terms that we could have a win-win in the province in that when they are moved from the Bayer Corporations of the world to generic that, in fact, we could engage in generic production of these in the province, again, reducing the cost, plus the employability - and that's why I

say win-win. Is it too simplified for us to think in those terms or do you think, deputy minister, that's something realistic to possibly move toward?

MS. DOIRON: I don't think that we should ever just discard potential benefits from innovation. We did have, a couple of years ago, basically an individual or a group of individuals who thought they might want to get into production of specific drugs. In that particular case, at that point in time, we couldn't see that there was a strong business case for it, but I don't think we should be discouraging any potential - I mean we know that there are basically huge companies out there with which people would have to compete so I'm not sure how realistic it is. But I think that we've seen in any variety of fields in more recent times, whether it be with issues in regard to the environment and fuel and things of that nature, that sometimes innovation can occur. Basically I think we have some very, very capable people in this province who would have the ability to take a look at that kind of market.

MR. GLAVINE: Thank you.

MADAM CHAIRMAN: Thank you. Wayne.

MR. WAYNE GAUDET: Thank you, Madam Chairman. Thanks again for your presentation. I want to begin with the participation in the program. Judy, you indicated there are about 100,000 seniors participating in the program. I'm just curious, how many don't participate - do we have a number?

MS. MCPHEE: No. I think in the province there are approximately 150,000 seniors and at any one time we have around 100,000 seniors, so that's at a point in time. If we look at how many participated in the program, for example, last year it was around 116,000. Now, some of those may have been in for only a couple of months and then either moved away or came out of the program or passed away, those kinds of things, so that's the number. So there is a large majority of them.

MR. GAUDET: So looking at the so-called 50,000 or so who don't participate, most of them would have their own private drug plan of some type, is that it - insurance coverage of some type?

MS. MCPHEE: Yes.

MR. GAUDET: That leads me to this question of, are there seniors in this province - and the reason I'm asking that, I have some individuals at home who can't read, who are French, and unfortunately when they have correspondence from anyone, sometimes it just gets lost. So my question is, do we have some kind of tracking to assure us there are maybe individuals out there, seniors, who may quality who aren't registered in the program? Do we have some kind of system to verify that?

MS. DOIRON: We don't try to track who is not in the program but what we do have is an effort to have all of the brochures and things that we provide translated, and French is the first language into which we currently translate. So if people needed the availability of information in a different language, we would try to satisfy that.

For example, we know that the second most frequently spoken language in Halifax right now is Arabic, but we have a program in the department that basically looks at health services to the French-language residents. So if, in fact, for example, if you or some other representative of a particular area were able to bring something to our attention that would be helpful at a community level, we would be able to respond to that but we don't make an attempt to track who is not in the program.

MR. GAUDET: No, I was just curious if you had a tracking system to identify an individual that we don't know why they're not on the program. I was just trying to find out if there was some kind of tracking done.

MS. DOIRON: We do to the extent that we actually do access individuals who are going to be turning 65 and they all get the information sent out to them. So we, at one point in time, would have each year the number of people in the province who would be 65. Now, not all of them come back and enrol, but we would have had a list, in other words, to send information to and by virtue of that, I guess we could go back and track some of that information if we wanted to learn something from it.

MR. GAUDET: I guess I was looking at individuals who are probably in their 80's, not the ones who are turning 65 that your department are communicating with. Basically people who may have been left out or - I was just trying to find out if that occasion doesn't present itself. Just wondering.

Anyway, I'll move to the next one - Judy, you talked about reduced rates. I'm just curious if a senior was making $19,000 - so I understand, $18,000 you don't pay - what would be the reduced rate that a single senior at $19,000 would have to pay?

MS. MCPHEE: It's based on income and that's done with our provider, so I don't have an answer for that but I can get that for you.

MR. GAUDET: I was just curious. Deputy, looking at the cost of the program - I look at 2007 and 2008, the cost was $126 million to government, this year it's $132 million. Does the department have a magic number of how much the department will contribute toward the seniors' program? I know there are lots of variables, how many more drugs are brought into the program and then the program is - but I'm just looking at, let's say, the last five years. Do we have a sense of how much the department is looking at budgeting for next year, for example?

MS. DOIRON: We do that year by year in terms of trending, and basically with the circumstances we've had in the past number of years, not just the past year. So looking at

the past and understanding what we may know about what's coming up in the coming year, we would do that projection.

We had previously been in the area of 10 to 12 per cent or more per year and with the number of activities and initiatives that have been taken in the last couple of years, we're seeing somewhat less of an increase year over year, which is good for the individuals, good for the seniors, it's good for the government as well. So I think there's a pretty comprehensive number of variables that are put into that consideration in doing that trending and projection.

It is basically a methodology and we could - at some point, for anybody who is interested - actually kind of break it out and display more of that methodology. We don't have a cap on it, so that basically what we're doing is trying to predict reality in terms of the number of users, our experience, the number of prescriptions with the variation in drug costs and all those things that occur, with the changes in the rates for pharmacists, for filling prescriptions, et cetera, many, many things factored in. So I think that the methodology so far has been pretty sound.

When we make our projections they have been very close, for most years. Then if we're not quite on, if we're slightly under or slightly over, then, of course, that gets consideration; if we go back and do a five-year trend, then that factor would be put into that trend. For example, if we did not spend all of the dollars in this year's budget, then that would influence next year's costs and cause somewhat of a reduction for both the senior and for the department. So it does get carried forward in terms of the actual experience.

We don't track it for this year and then if we weren't spot-on, kind of start going around with all kinds of refunds, but the benefit of any amount that we have in surplus is factored into the following year's cost.

The same would hold true, however, if we went over the budget, if some things came on the market and we had not expected something and we went over, then the total cost for the following year would probably reflect that, but we would never be picking up the impact of one year to the next because it's always done with some trending over a period of years, not just the one-year factor.

MR. GAUDET: I have one final question, very quick. I'm just wondering, how does Nova Scotia compare with the rest of the country with our Seniors' Pharmacare Program? Are we somewhere in the middle of the pack? Are we low, high?

MS. MCPHEE: We're actually one of the more generous ones for our seniors. For example, if you look at Atlantic Canada, most of the provinces in Atlantic Canada do have a seniors' drug program, but it is for low-income seniors only. For seniors who are moderate to higher income, the program is not accessible.

MADAM CHAIRMAN: Trevor.

MR. TREVOR ZINCK: Thank you, Madam Chairman. Thank you, deputy, Judy. As we've all said before, it's an important subject, especially since we're all aging. (Laughter) Including myself. I still feel young - I'm sure we all feel young. (Laughter) Okay, I'm red in the face, if you want to record that in Hansard.

I want to go back to when the Family Pharmacare Program was first announced and we know the backlog that it caused because many of the calls that came in were, which program is best suited for me? Have we come to the point that we can tell, as of now, how many seniors have actually opted out of the seniors' program and taken on the Family Pharmacare Program?

MS. MCPHEE: In terms of the number of seniors?

MR. ZINCK: Yes.

MS. MCPHEE: The majority of seniors have stayed in the Seniors' Pharmacare Program. I don't have exact numbers but I can get them for you, but the majority of seniors have stayed in the Seniors' Pharmacare Program.

MS. DOIRON: If, in fact, you required several medications, then you're probably going to be better off in the seniors' program and most seniors, I think, have opted to stay there even if they're not using a high amount today, being concerned about where they might be tomorrow or next year.

[1:45 p.m.]

In our case, we have a large number of seniors in this province who are living with three or four chronic diseases. Generally when you see that kind of statistic you're probably also looking at seniors who are living with multiple medications. Given the incidence of disease and disability and so on in our province, most seniors are probably going to be better off staying in the seniors' program, and that's what most of them have chosen to do.

MR. ZINCK: So if a senior did make the decision to jump, are they obligated to continuously use the Pharmacare Program? Let's say they switched, is there a certain time frame where once they realized the difference that they can come back to the original program? Would that be without any penalty?

MS. MCPHEE: Yes, at renewal time, so they would be obligated to stay in that program for that fiscal year and then they could move back.

MR. ZINCK: Without penalty?

MS. MCPHEE: Yes.

MR. ZINCK: Okay, I'll have one more question. Generic drugs - they definitely have been increasing. It was also mentioned that it saves the government money. So when we have a situation where we're switching to the generic drugs and we actually end up saving money, where does that excess money go and how does it get determined? Does it stay in the Department of Health? Does it get moved around? Can you explain that?

MS. DOIRON: If we are in a position where we don't use all of the dollars that are in that part of the budget in a particular given year - we haven't had many years like that but we have had one or two - but if that's the case, then basically as we do across all programs of the Department of Health, we are constantly monitoring our financials. Coming up, I think, next week our senior team again is going to be sitting down, taking a look at our budget status across all programs and, basically, if we have pressures that are arising in one area and we either know we're going to have a surplus in another area, or we can somehow facilitate it and try to cover off something that's in another part of the budget that we maybe don't have a choice about, then we will try to work our budget in a sense as a global budget, so we can try to bring the department to a balanced position.

We have had a balanced Health budget for the last several years, which is a little bit unique in the country, I guess, but we've been working very hard to get there. We give, for example, the district health authorities a budget, we also allow them to approach it on a global basis so that they can move their funding as they need to in order to deliver the services they need to deliver, but have some flexibility with how they can get themselves into a balanced position, which they also have been doing pretty well over the last number of years. So there has been a rare time - once or twice that I can remember - where the Pharmacare Program has been able to assist in that sense. Most years we're looking for money from elsewhere to cover what might be overages that we have with the drug growth. So it balances out, I think, or it has in the last several years, over time.

Basically we try to be in a position where we're delivering services as much as we can and we're not really looking to try to have a surplus but more to be balanced.

MADAM CHAIRMAN: Thank you. Keith.

MR. KEITH BAIN: Thank you, Madam Chairman. and thank you very much. I guess I'm going to follow up on the question Trevor asked. It is concerning a person opting out of Seniors' Pharmacare Program and going into Family Pharmacare; they can renew on the anniversary date, they can go back, they can switch over to Seniors' Pharmacare again.

I guess everyone around this table gets a lot of questions and there's a lot of confusion, as Leonard has referenced. You say there's no penalty, but in our book it says there is.

MS. MCPHEE: There is for going back from one program to another. There is a late entry penalty for if you have not joined Seniors' Pharmacare Program when you turned

65. So you come from a private insurer or no insurance and you don't join Seniors' Pharmacare Program at 65, but not a penalty going from one program to another.

MR. BAIN: There wouldn't be a penalty from Family Pharmacare, it seems.

MS. MCPHEE: Right.

MR. BAIN: Okay, the only reason I asked that, if I could, just one of the things that's here, if you do not apply for Seniors' Pharmacare Program within 90 days, or if you decide to leave the Seniors' Pharmacare Program but then want to join again later, you may - and I guess "may" is the operative word here - have to pay a late entry penalty, which means you must wait 90 days for your coverage and pay one and a half times.

I guess that's the confusion that's out there when we're trying to answer some of those questions.

MS. MCPHEE: Yes, and that was written before Family Pharmacare was in existence and that is the kind of thing we're doing right now with our project, is going through all these communication materials to ensure that they are reflective of now Family Pharmacare being up and running.

MR. BAIN: I'm just speaking from one instance that I had. When I looked at that, I advised the person that it would be better for him to go with the Seniors' Pharmacare Program in case - he was not on a lot of medication at that time but if the time ever came that he was, and then when I read that, that you're going to have to pay one and a half times, you hope you didn't give the wrong information, but he did enroll in the Seniors' Pharmacare Program anyway.

MS. MCPHEE: Yes, that is confusing. I'm just going to write that down, to make sure that . . .

MR. BAIN: I think it's number five.

MS. DOIRON: I think it's a good point, though. We've had a few people - not lots and lots, but a few people - who have debated that, individuals or seniors. In a sense, we tried to explain it by referencing it the same way you would with any insurance program; you turn 65 and you're not on medications, you think I don't want to be paying a premium, it's just lost money, but in a sense what you're doing is paying insurance. If we had every senior who was in a position of paying less than that premium say that I'm not going in until I need it, then basically you're introducing a penalty cost to those people who have to be in the program that's over and above what you would have if most seniors opted to come in it as a form of insurance.

So it was a method of trying to say well, how do we moderate that so that we keep the price down as low as we can but, on the other hand, if you're not on many medications,

you know you may be taking a bit of a risk. If you don't go in and then, all of a sudden, something happens to you next year, you're in a very different circumstance. Then you want to be able to claim the benefits. So it has basically been that kind of an attempt to say, how can this insurance program work best for everybody?

MR. BAIN: That's good. I just - even myself, I was very confused over that whole issue so thank you for that.

MADAM CHAIRMAN: Thank you. Pat.

MR. PATRICK DUNN: Thank you, Madam Chairman, and thank you for coming today and some of the questions that I was going to attempt to ask have been answered. One in particular is the sustainability of the program with the high percentage of our population going into their senior years - with perhaps the odd exception around the table - with regard to the current model, as far as the sustainability of the program. But I think my colleague asked that question and you certainly gave a good answer.

Another question was dealing with the age 65 - do most seniors apply for this at 65?

MS. DOIRON: Well, based on the numbers we have, probably two-thirds or more do, so there's maybe 25 or 30 per cent who don't. That can be, as we said, although we don't have that tracking, you can get a number of seniors in the province who may qualify at 65 who may have a spouse who is not yet 65 or is still employed, has coverage, any variety of reasons why they would choose not to apply.

We have not had a lot of cases where somebody has selected not to apply and then comes back basically saying that they now need to come into the program. Occasionally we'll have somebody who enters with that penalty clause but it certainly isn't equal to anywhere near the number of people who have elected not to come into the program. So obviously people may have other arrangements or are not getting their drugs through our program.

On the question of sustainability, I don't want to minimize the impact of the growing cost of drugs or the growing incidence of the use of drugs because it's a very important factor, obviously, on our system and there's so much more that we do now with medication - in many cases good things that we're doing with medication that previously used to lead to either disease conditions that can be delayed or avoided or situations where basically people would end up having to have procedures which now can be dealt with through medication, so there has been a lot of progress in that regard.

We all know that in terms of dollars that are spent, medications is one of the highest amounts now, having surpassed even what we're paying for physicians. So it's something we need to be working with all the time.

In that context of sustainability, I think what we're trying to say is that we want to be able to support people with medications when they're necessary but we also have to look at what that means, relative to transformation of the the entire system. From two perspectives I would mention, one is we are, as is the Department of Health Promotion and Protection and many government departments and other organizations today, aware that we need to deal with promotion and prevention. We need to prevent people from getting into the illness states which requires all kinds of things, including medication.

We also need to make sure that we are addressing all the other components of the system so that people, when they are needing care or assistance, that they get it at the right places, that we're not ending up driving people to emergency departments in order to be able to access the medication, for example. So there are a lot of things, when we talk about sustainability, that start to find their way back to what happens across the entire continuum of how the system works, that will have an impact, I think, on our ability to sustain medication costs where we will need them, but to minimize them where we can.

MR. DUNN: I've talked to two or three constituents where they, for whatever reason, neglected to sign up when they should have. They had that time frame, and I know there's lots of reasons - we'll call it mail overload or something, for the sake of a reason. Okay, let's say that they do sign up eventually, how long does that penalty stay there?

MS. MCPHEE: It used to be a lifetime penalty, that you paid one and a half times the premium for a lifetime; it's now five years. It's a five-year penalty.

MS. DOIRON: But I would also add that that notice goes out quite well in advance - I think it's about six months in advance - and there is more than one notice. So it's not losing one mailing that would put them in that situation.

MR. DUNN: And I agree with that. It's not that they didn't have notice - they just didn't, for whatever reason, apply.

In the future with this program, will this program eventually get to the point where there is no penalty? Or why is there a penalty for someone who is 67 and they decided, well, I think I will apply now? It's something that people have been asking me and I really don't have an answer.

MS. DOIRON: I guess that goes to the question of sustainability, the program in general. If we only ensure people who need to spend more than the premium and co-pays, then the program continuously gets more expensive. So if nobody joins the program until they're going to be over that threshold, then like any other insurance program, it's probably going to be less and less manageable and require more and more of the taxpayers' dollars.

I think what we're saying is, we have a pretty good program, it's not everything and it doesn't pay for all of the costs, but it's fairly generous when you compare it to other programs and we want to be able to sustain it. If we have participants in the program, some

of whom are not over that threshold or cap, then it's going to moderate the costs for everybody. So it's like an insurance program when we decide, I guess, if you like, as a public in Nova Scotia, to what extent can we provide that kind of coverage for seniors or for anybody in the province? So it's a little bit stressful.

[2:00 p.m.]

Where I have most concern is when you get seniors who may not think all that through or have the opportunity to talk to somebody who can help them think it through and maybe end up in that position through, in a sense, no fault of their own. I think we also need to be considerate of the fact that some of the seniors are quite capable of thinking it through and basically do not want to pay out more than they would be required to do, even if they were paying for their own drugs.

Again, I go back to saying it's around the kind of mentality of how you participate in an insurance and it's a generous insurance when you have need. But we are not at the point where we're saying that you don't need to take any responsibility and we're not at the point of saying that the public will pick up every cent of your drug costs when you decide you want them to do it.

MR. DUNN: Perhaps one last question and you may not have this information at this particular date. Proportionally when we look across the province, are there any areas, for example, urban as opposed to other areas, where there are a lot of participants in the Seniors' Pharmacare Program? Does anything jump out at you as far as . . .

MS. MCPHEE: For seniors specifically?

MR. DUNN: Yes.

MS. MCPHEE: No, we haven't really looked at it. We are going to be looking at Family Pharmacare geographically, but we have not looked at seniors.

MS. DOIRON: We do have information in terms of geographic areas, in terms of the burden of disease in the province. Just given that fact, you would almost expect that you would see higher drug costs in some areas than others, but it's an interesting question. We don't have that answer but we probably could look at it that way.

MR. DUNN: Thank you.

MADAM CHAIRMAN: I'm going to ask a couple of questions from the Chair. I'll grant that the Seniors' Pharmacare Program is probably the most generous in Atlantic Canada, but every time the costs go up to seniors we hear stories from low-income seniors who are struggling now and so any additional costs really create problems, a challenge for them. As expensive as Pharmacare Programs are, it's even more expensive not to provide

appropriate medications because then the acute care system comes into play and the costs are possibly two, three times what it would be for a prescription, if not many more.

I don't remember the name of the review, but I remember hearing about a review done on the impact of changes to the Seniors' Pharmacare Program in Quebec. They found that there were seniors who did not get their prescriptions filled because they couldn't pay the co-payment and there were actually seniors who died as the result of that. I'm just wondering, as the Health Department, do you ever put a Health lens on any changes that are recommended to the Seniors' Pharmacare Program to foresee what the results of your proposed changes are going to be?

MS. DOIRON: Basically we do look at those factors in looking at aspects of policy analysis. I think considerations like that are taken into place. It becomes a very difficult issue of choice at the end of the day, about where any additional dollars are going to go. I'll give an example, which is extreme, to illustrate the point.

When we get into a position, as we do here in Nova Scotia, for example, we have the highest incidence in the country of Fabry's disease. We have drugs and enzyme replacement therapy for some of those individuals who meet the criteria established by physicians who might benefit from the drugs. Those drugs cost about $300,000 per person, per year. So if, in fact, we were going to - and basically these people are currently getting them under a research project, so it's not a case right now that they're not receiving them. But in a case like that, if the province were going to pay for the entire cost on an ongoing basis, we would be talking somewhere in the order of a minimum of $10 million a year for 30 or so people. Then you take a look at, okay, if we don't provide those drugs, look at the impact on the quality of life of these individuals, on the length of life of these individuals, and try to both economically and ethically assess that.

On the other side of the equation, you will have other choices like, do we spend $10 million to take care of these 30 people, or do we spend $10 million to address things that could be done in early childhood development? Essentially, every time we look at those kinds of situations we are into those kinds of considerations at some level. So while we can put the impact analysis, including health status, the economy that's behind keeping people well and participating in the workforce and so on, and we do look at those factors, there are competing issues against which the choices will have to be made.

If you look at one in isolation, you're quite likely going to come to a decision to say, it probably makes sense to do this. If you look at it across the spectrum of issues, you are always going to be in a position then to have to make a choice and that, I think, is some of the struggle that not only we're in when we're trying to make recommendations, but, of course, our elected decision makers are in when they then have to decide what programs or policy changes they're going to go with.

MADAM CHAIRMAN: I can understand the broad spectrum of Pharmacare, but I guess I'm focusing right now on the Seniors' Pharmacare Program. I'd have no way of

guessing how many seniors have not either taken out their prescriptions or don't take their medication every day as prescribed. I'm just wondering - it may be that there would be a cost savings in actually changing some of the baseline eligibility for seniors, to allow them to get appropriate medications at the right time. I just throw it out as something that needs to be looked at a little more carefully.

The other thing I wanted to just quickly mention is, obviously we want the best use of public money from this program and it seems to me there are two areas that should be looked at. One is, are seniors getting appropriate prescriptions or medications and are they using it appropriately? I know the pharmaceuticals do a very good job of so-called educating the family physicians as to the benefits of certain drugs. I'm just wondering whether the department and the Seniors' Pharmacare Program have either looked at doing their own education of family doctors, or initiating again some of the senior medication review programs like the prudent use of medications?

It's scary to see a senior walk into one of those medication review sessions with a bagful of medications that they're taking and you can just imagine how they're acting against one another and creating side effects that require more medications that require more medications. I think those are two areas we could save money and make sure the money we have for the program is being used to its best effect. Has there been any consideration of drug education for both physicians and seniors?

MS. DOIRON: Yes, there has been and I'll let Judy answer that.

MS. MCPHEE: As I mentioned before, we do have the medication review for seniors that we fund, the cognitive fee, which is $150 for pharmacists to review seniors' medications. As to your other point about detailing physicians, we do and we've had for a number of years a detailing service. It's run through Dalhousie - the Department of Medicine, Continuing Medical Education Program - so it's at arm's length from us, however, it is funded by us. There are three and a half people employed to go to doctors' offices and to detail them on the appropriate use of drugs.

It is, if you will, almost a counter-detailing from industry or is viewed by industry as almost counter-detailing, but it is scientifically based, there is a lot of review done for each disease state that these detailers go out. It is voluntary for physicians to sign up, but there is well over half of the GPs in the province who have signed on to this and do have detailers see them with each project that we do. As well, nurse practitioners are part of this and part of the detailers and we're moving into pharmacists and specialists as well.

MADAM CHAIRMAN: Thank you very much. Leo.

MR. GLAVINE: Thank you very much, Madam Chairman. One of the discoveries a couple of years ago now, were seniors receiving GIS and who were paying the premium. I'm just wondering if there has still been a trickle of that type of senior either self discovery or perhaps through some other means? Is there still that taking place?

MS. MCPHEE: No, I think all of those seniors have been reimbursed. We now have a memorandum of understanding with Revenue Canada, we will be very shortly getting feeds in so that will solve that problem.

MR. GLAVINE: We talked about whether a senior enters the Seniors' Pharmacare Program or decides that perhaps the Family Pharmacare Program may in the long run be more beneficial to them. What about the Diabetes Assistance Program? Is that stand-alone for seniors or is it working in conjunction with the Seniors' Pharmacare and Family Pharmacare Programs?

MS. MCPHEE: The Diabetes Assistance Program is a program just to assist non seniors, diabetics under the age of 65 and it only covers their diabetes medications. All of those diabetes medications are also covered under Seniors' Pharmacare, so it would be of no benefit for a senior to join the Diabetes Assistance Program, unless that's all the drug coverage that they wanted. The Diabetes Assistance Program is still up and running. We are looking at whether to roll that into Family Pharmacare now that we have it. It may die a natural death as well because it is just confined to diabetes drugs.

MR. GLAVINE: One of the situations that I've come across this late summer, early Fall - actually two cases - where a senior whom both members of the family being illiterate received notification that they needed to re-enlist in the program. In other words, they had been on Seniors' Pharmacare but each year you get notification and they didn't realize that that had to be sent back. In both situations they were 66, in other words they were going through this for the first time. Why would somebody who is confirmed to have done all of the necessary backgrounding and have reached 65 and in the program, why is that procedure there required on an annual basis?

MS. MCPHEE: To annually renew?

MR. GLAVINE: Yes.

MS. MCPHEE: Because the premium is paid on an annual basis and it's based on your annual income from the following year whether you are GIS exempt or not. As well, circumstances change, it's a way to know if seniors are now deceased or have moved out of the province and that kind of thing. It is an annual process.

MR. GLAVINE: You have said that you were getting information from Revenue Canada . . .

MS. MCPHEE: To verify.

[2:15 p.m.]

MR. GLAVINE: So in other words, if nothing has changed from that Revenue Canada solid information then why would it be necessary? I guess I'm trying to get around

the call from the pharmacy that this person was in the program, they're not in the program, we can't give them the medications that they need. I've run into two of these situations in the last two months.

MS. DOIRON: At minimum, they would need to re-enroll or pay their premium in order to go into the following year. One way or the other they would probably get some notice in that regard. Whether we call it a re-enrolment or whether we basically say, we'll bill you for your premium, there would have to be some action on the part of the individuals to continue their coverage. How we could make that easier, I don't know, it's something maybe we should think about.

MR. GLAVINE: It's probably just one of these exceptions that's going to be there from time to time.

MS. DOIRON: Maybe. One of the things that, as we get into some of the initiatives that are unfolding under our transformation agenda, next year we will be looking at the whole issue of pharmaceuticals in the province. I don't know what will result from that because in all likelihood, as we look at how that area could be transformed to better serve the public to be safer and all those factors, we think there probably may be a way to partner differently with local pharmacists, to have them play maybe a different or more enhanced role in some of the things that need to happen across the life of an individual and their medication. What that means and where it will go at this point I'm not quite sure, but I think it's important that we know and understand the issue that people are facing and when we do set that work off that we can look at how we can make that whole system work better around the individuals and families in their communities and who is it that we engage in that to allow that to occur differently? Those kinds of considerations maybe can come to the table and those dialogues to see what kind of design is going to be better for the future.

MR. GLAVINE: Thank you very much.

MADAM CHAIRMAN: We have at least five more questions, so I'd like to suggest for the rest of the second round that we limit it to one question per member. We should finish around 2:40 p.m., to allow the deputy to have some closing remarks and then we'll get into the rest of our agenda. Leonard, you're next.

MR. PREYRA: Before I ask my question I did want to compliment you, Madam Deputy Minister, on your comments on youth mental health over the summer. I think a number of people in my constituency appreciated it very much, the acknowledgment that there are challenges there, thank you.

I did have a question about a community centre, Spencer House, in my constituency. Both the Minister of Community Services and the Minister of Health have been there over the last year and complimented the administrators for running a really good program. But I'm wondering whether or not there's any effort to use a place like Spencer House for earlier identification, detection, prevention of health care issues? It seems to be

a wonderful gathering place - today, for example, there are about 100 people there and they come in for their Thankgiving meal and they often do have a nurse who's called in from time to time. I'm wondering if there's any way of making it a regular event where the Department of Health is there to identify, you know promote services and things like that.

MS. DOIRON: I think those are some of the kinds of initiatives as we get more and more involved in connects with the communities through both public health, primary health care and the kind of promotion prevention kind of side of how we all work that there's potential there. That's why when we're talking about health transformation, we talking about it really being a very primary health care focus kind of approach that we take.

That means, I think, that there will have to be resources moved from some areas to others, that additional resources will be driven more to those areas so that we can have people in place who could connect individuals at those really very appropriate times, to other things across - not just to the health system but across other services systems that are going to be able to kind of support them and get them to a point where they are feeling like they're a well-contributing member of society.

I think we have much to do in that regard and I know that certainly the leaders of the health care system right now are very given to that kind of thinking but there's a lot we need to do to actually actualize more of it on the ground. So I think you bring up an excellent example of where something like that could occur more effectively.

MADAM CHAIRMAN: Thank you. Wayne.

MR. GAUDET: Thank you. I want to go back, deputy, to speaking of the penalties. You made a comment earlier about individuals, through no fault of their own, for whatever reason, maybe it was a mail overload or what have you, decided to come back and tried to get in the program but are faced with a five-year penalty. Don't you think that's a heck of a lot - you know, way too much? We're not talking about someone who is very dependent on drugs, that was an oversight for whatever reason, but yet they're being penalized for five years.

MS. DOIRON: I guess that's certainly an opinion to have. I guess it's a matter of what is an appropriate penalty and not necessarily isolated to individuals. Again, I think mostly a few individuals who, through no fault of their own, don't end up continuing their enrolment or coming into the program in the first place. I think basically the penalty is there predominantly for the individuals who I guess want to take a risk, saying I'm not going into the program until I'm going to spend the money that the program is going to require.

So I think it's unfortunate that occasionally people get caught within that when maybe we need to understand their circumstances better and where that occurs we can certainly look on a case-by-case basis, I think, that if there's rationale that would be legitimate to kind of consider, but we also will have to have some approaches that are going

to, I think, protect the integrity of the program, in terms of it being a reasonable coverage and insurance plan for the majority.

MR. GAUDET: I appreciate your comment. You know case-by-case, there's always exceptions to whatever rules we may have. I appreciate that.

MADAM CHAIRMAN: Thank you. Trevor.

MR. ZINCK: Not that I would want to see an increase in premiums but two of the issues that have come up over the last six months in my community, particularly with seniors, has been dental care, oral care and vision care. A lot of times - well, either one will tell you - the optometrist will tell you your vision is a direct reflection of your overall health, the dentist will tell you the same thing. What I'm seeing is people leaving their oral care and their vision care go.

Have we, as a government, considered implementing some sort of plan that would allow seniors to take advantage of a program like that? I say that because if it would be a small cost, I think it would be something that seniors would recognize the benefit of.

MS. DOIRON: I think that's a very good area that you identify where I think the right kind of approach can lead to avoidance of some other major issues. Basically starting with the oral care, because I think there's enough evidence today to say that if you're not providing appropriate oral care it can lead to all kinds of other diseases.

We are working on that, in fact, in a couple of areas; one is to basically put physicians back in the system and particularly through the Department of Health Promotion and Protection, in the public health side, to be able to put people back in that system who actually can provide oral care at home or in groupings where seniors are gathered and so on, and also to make sure that oral care is a subject that's looked at and provided in our long-term care facilities, for example.

So work is progressing in that area to kind of reintroduce that because it used to be part of Public Health and over the years has somewhat been way cut back, I guess, somewhat cut back. Some of those services really did not continue. Well, I think we see the merits of reintroducing them.

In addition to that, you're probably aware of the bill that went through in the last session around allowing hygienists, a dental hygienist, to be able to provide independent practice. One of the biggest drivers of that was the ability of the hygienist to be able to provide reasonably low-cost care, on an independent basis, for seniors again wherever they may be, either on an individual basis, on an institutional basis and so on. So from the oral dental point of view, we've been taking a very serious look at how we can continue to improve that situation.

On the side with vision, we haven't made as much progress but I think again, it's an area that we need to explore and see how we can assist people in that regard as well. So I will make note of that one and take it back but on the oral hygienist and dental side, we are taking some steps forward.

MADAM CHAIRMAN: Len.

MR. GOUCHER: Thank you, Madam Chairman. No question but I think sometimes in our lives when you can try to add something, just from life experience, it's probably not a bad thing to do. I've been living with a situation with my mom and dad now for about three years, I imagine probably a lot of people know it. My dad has prostate cancer, diabetes, kidney problems, macular - he's blind - dementia, skin cancer, blood clots, it goes on and on, so he's taking a lot of pills. The one thing that I will say is that through his battle, the health care system has been wonderful to him. It doesn't matter whether he's in the emergency department, whether he's in a hospital, whether he's in the room, whether he's in the veterans' hospital, and that's something I'll bring up in just a second.

The system is not broken; as a matter of fact, it's working pretty well, I think, and that's just a personal comment. That's not a government or a political comment - I think it works well, for most people. I'm sure there's the odd person where some things do happen.

We're talking about communication between hospitals, doctors, pharmacies; we're talking about prescription accountability to ensure that patients are taking it. My dad gets a raft of pills that he has to take every day but they're in pillow packs. Well, guess who provides the pillow packs - it's the pharmacist. Guess who suggested it - the pharmacist. That's not uncommon. It's a very common thing and it keeps him straight as to what he has to do because he has to take pills at three or four different times during the day, and a fair number of pills.

The interesting thing is the communication that exists between the doctors, between the pharmacists, between the hospitals - and Dad sees David Bell, a wonderful doctor, he sees Dr. Wood, he sees Dr. Kelly for skin problems, several other doctors for other issues - they all communicate and everything seems to feed back through to the family doctor and information funnels back. The interesting thing is that between the family doctor and the pharmacy there have been a couple of occasions where prescriptions have ended up in a recommendation for either a change, or just don't take it because of an interaction, as you were talking about.

I just wanted to add those comments, Madam Chairman, because I think we can sit here and we can talk about this and we can try to fix something, but I think sometimes it doesn't hurt to add a little real life as to what people go through, with what I'm going through now, what my dad is going through, what my mom is going through. The only other comment I would make is that there is a - I just can't remember which pill it is that my mom takes for bone density, it's a very expensive one . . .

MS. MCPHEE: Alendronate? Fosamax?

MR. GOUCHER: It was a questionable one, anyway, where I think the government was looking at using a new generic that was coming on the market. I can't remember what it was, there are so many of them. But there was a problem there where she still has to stay because the generic does not act the same as the more expensive drug, unfortunately, and she has to stay on the other one. I hope sometime when we're talking about generic drugs that we also understand that the generics don't sometimes always act the same way and that some people do have reactions to them. I think you probably know that and I hope that's always taken into consideration with a lot of these programs.

[2:30 p.m.]

The one final comment is, I wonder how many of the 30,000 or 40,000 people who are not on the program are covered by an absolutely wonderful organization that my dad is now, called DVA. When DVA comes in behind you, I'll say they're an absolutely incredible organization and it relieves a lot of expenditures from the province and puts it on the federal neck. I would suggest there are probably a fair number of people in this province who come under the umbrella of DVA. I just add that as a comment, Madam Chairman, and thank you very much, I appreciate it.

MADAM CHAIRMAN: I just want to ask one question, we may have a chance for a round three for a couple of people. My question is around the formulary. Increasingly as people get older they're having more and more sensitivities to certain medications, or fillers, or whatever. I've had a couple of constituents who questioned the red tape around getting exception drug status for specific drugs that over the years, it's the only medication that they can actually tolerate. They suddenly turn 65, it's not on the formulary and they start this sometimes very complicated process of getting exception status. The doctor applies to Pharmacare, they might get approval for eight weeks and then they revert back to something else, they have a side effect so the doctor reapplies for exception status.

It just seems strange that the family physician can be trusted to make the right decisions for most of the person's life and then at 65 has this restricted list of medications that they're then able to prescribe for the senior. So is there anything being done to streamline the sort of bureaucratic red tape process around the whole Seniors' Pharmacare Program?

MS. MCPHEE: Well, the exception status process is not just for Seniors' Pharmacare, it's in all our Pharmacare Programs. Different jurisdictions, different provinces call it something different, they might call it restricted drugs. They are restricted or exception status for a number of reasons. Sometimes it's because there is an equally as good or even better option that is less expensive that's on the formulary. These drugs are on the formulary, it's just that you have to meet certain criteria to get them, so that's one reason.

One reason is that oftentimes with a number of these drugs they're second line, they're not the preferred drug for that, it's not appropriate to use them as the first drug in the treatment of an illness. The exception status or restricted drug process is in there for a couple of reasons. One is to encourage appropriate prescribing and not all physicians - I don't want to say that they don't prescribe appropriately, but they may not use a medication that another one would be as good or better at the time - and as well, to encourage the use of less expensive medications if they are as good or better. So those are the two reasons why we have the exception drug process and it's not only in seniors it's in all our Pharmacare Programs. It is this committee of experts, these physicians, GPs, specialists and pharmacists that determine the criteria for these drugs.

MADAM CHAIRMAN: Thank you. Third round. Trevor.

MR. ZINCK: The only question I had was in regard to the Dental Hygienists Bill. Maybe I'm pleading ignorance but has it been proclaimed yet, do we know?

MS. DOIRON: I'd have to double-check that.

MR. ZINCK: That's an important factor because when I mentioned oral care I was thinking exactly that bill because many hygienists had approached all MLAs, I believe, and that was one of the key factors they stressed, the importance of having the ability to visit with seniors. A dentist won't see you if you haven't had an appointment within a certain amount of time and having the ability to go in and actually prep a patient with some preventive stuff and basic oral care was going to be key to getting that person back into the system.

MS. DOIRON: We will send that information back to the committee, just to make sure that you know if it's proclaimed or not.

MR. ZINCK: Great, thank you.

MADAM CHAIRMAN: Leo.

MR. GLAVINE: One of the developments that has occurred in recent times - and I'm sure the deputy is well aware of this - is where a nurse practitioner has gone into a senior's home or even working in collaborative practice, as they have lots of time to do very thorough physicals, they have been able to eliminate some medications for seniors that just seem to kind of get built up over time. Are there any programs in other provinces or do you see any practical way an enhancement could take place there? Again, it would be another saving area, plus probably benefits to health as well. I'd just like a comment from you in that regard.

MS. DOIRON: There are a couple of programs in other provinces that have progressed to be more inclusive in terms of their ability to assess those situations. Most of the ones that I'm aware of - Judy may be able to speak to this better - they tend to want the

seniors to come to a centre or come to the provider, I guess. I think the idea of, particularly those seniors who are alone at home, is important in terms of having a way in which we can have people go into the home.

We are looking at a variety of ways, the nurse practitioner being one, but other modes of collaborative practice as well that we've been talking about expanding more. For example, the fact that we have a very nice demonstration project down along Brier Island, with more extended use of paramedics who have a lot of downtime. There are a number of other areas in the province where that is also true and we feel that we should be making more progress and certainly our contractor, EMC, very much supports this, where through a variety of practitioners we might be able to provide more support, even in the home, with people who are capable of taking a look at a situation and/or calling other collaborative practitioners into the situation with them.

Some work is being done in that regard, I think more of that will occur as we explore through the Health transformation agenda and particularly that primary health care and community-based approach, what are those areas in which we can really make a difference? I don't think we are today where we will be, I hope, in two or three years, but we have started to move in that direction.

MR. GLAVINE: Thank you.

MADAM CHAIRMAN: Leonard.

MR. PREYRA: I have a question about the elimination of mandatory retirement and its impact on a number of people who might participate before 65 or after 65 and also how it relates to the late penalty. Is there any provision being made for those who will participate later as a result of mandatory retirement because they will be probably in a Blue Cross type of program while they're employed, and I'm wondering what that impact will be on numbers and also if they will be in on the penalty?

MS. DOIRON: What we're seeing, certainly with the numbers that I'm aware of at this point, is that even though there was a necessity for mandatory retirement, we're not tending to see people working full time at 65 and beyond. What we're tending to see and actually what we're trying to encourage, some of the adjustments made to the nurses' contract in the last round of negotiations were there specifically to try to keep people in the workforce longer, even if it's on a part-time basis.

If we take a look, as we do, when we're projecting our Health human resource requirements across various disciplines, if we can impact keeping people in the workforce for say even two years beyond our average retirement rate at this point, it isn't going to take them to 65, but it would have a tremendous impact on the availability of human resources. So that hasn't become focused as an issue in a sense to say, what happens to my benefits at 65 because right now the retirement age, generally speaking, for most of the professions we're working with tends to be earlier. What we are seeing is a number of

physicians who are tending to want to stay beyond 65, but even there it's not a lot of those physicians because many of them are wanting to, as you probably know, have a different lifestyle and expectation around retirement as well.

We are very open in our negotiations at this point to say that we will explore other routes that would help us to keep our experienced people in the system, whether that means looking at benefits or it means looking at pensions or things like that. We have started down that road to dialogue around what's going to make that work better.

MS. MCPHEE: Just to add to that, the late penalty doesn't apply if somebody is coming from private insurance into the program. The late penalty is more designed for those people, as we talked about earlier, that have made a conscious decision not to join until they need it.

MADAM CHAIRMAN: Thank you. I'll reserve the last question for myself. You referred earlier to the regional and national expert committee. I'm just wondering if there are any Nova Scotians on the regional committee and do they have geriatric specialties experience? I'm assuming they put drugs on the formulary for all disease categories, not just for seniors. I'm just wondering if you have some specifics on who's on there and are we represented?

MS. MCPHEE: I'll start with first of all the national, it's the national Common Drug Review. All jurisdictions in Canada participate, all public drug plans, with the exception of Quebec, so there are 18 public plans that participate in the Common Drug Review. In the Common Drug Review right now its mandate is to review all new drugs that are coming on the market and all old drugs that have a new indication. So they're reviewing the bulk of the drugs.

We do have a representative; the Common Drug Review began in September 2003. It's not a regional representation because the skill set that you need you can't always get in every jurisdiction, especially if you want the committee to be turning over at a regular rate to get new blood on there. In Nova Scotia we have had a member, who is a geriatrician, on that committee since its inception. She has just been re-nominated so will continue for another two years. We have another Nova Scotian that will be starting on that committee on January 1st for a two-year term - they are two-year terms.

As far as the Atlantic Common Drug Review, it is representatives from all four Atlantic provinces, it was in existence before the Common Drug Review and used to do all drugs so there were a number of geriatricians on that committee.

Now that the Common Drug Review - we're relying heavily on them on that committee for new drugs and old drugs with new indications. The Atlantic Common Drug Review's focus has changed somewhat and they're doing a lot of line extensions, class reviews and that kind of thing. There are two geriatricians on that committee - one from

P.E.I. and one from Nova Scotia. As well, there are a number of GPs and pharmacists on that committee.

MADAM CHAIRMAN: Thank you very much. So, deputy minister, if you'd like to make some closing remarks but just before you do, I want to thank you both very much. You've been very informative and I'm sure I speak on behalf of the whole committee, that we certainly know a lot more about the Seniors' Pharmacare Program. We thank you for that and for the good work you're doing. Always looking forward to improvements so we'll look forward to that as well. Thank you.

MS. DOIRON: Thank you very much. I won't make any long statement except to say that we were also pleased to be able to come here today and to be able to talk about this subject because I know that any MLA is often in a position of having to respond to the challenges and to the exceptions and the more information we can provide for you, I think the better off we all are. So at any point that any member would like to have any particular question answered or any particular situation reviewed, we're very open to that and we would invite you to be in contact with us.

[2:45 p.m.]

I think that we have all recognized today that the whole world of medications is one that is costly but it also can be extremely effective. I think that was the basis of the decision that was made to go down the Family Pharmacare road because we knew that not only did we have many seniors who required a number of drugs, but we also have a lot of people who are younger than 65 entering into chronic disease states, many of whom were not able to afford the drugs and consequently were getting as you pointed out, Madam Chairman - if you're not getting the appropriate medications you're usually ending up sicker or using even more costly alternatives in the system.

So I hope we're on the right track, I think we are. We certainly are interested in seeing how far we can go in this country with the national pharmaceutical strategy and we are great advocates of saying that we need to work together across the country to do what we can best do, in the most reasonable way for our citizens. Basically we would also very much like to see the federal government come into this world as participants as well. So we thank you for your support and for the time you've given us today.

MADAM CHAIRMAN: Thank you for your comments and especially for your time, you've been very generous. Thank you to you and all your staff.

So you certainly may leave if you wish because we're going to do some follow-up from our Forum on Disabilities. So you remember at the end of the forum, we really didn't have a chance to discuss as a committee, the follow-up or the next steps we wanted to take with the information and recommendations and suggestions that we received from our presenters. So I'm just wondering, what is the will of the committee?

I think that as a minimum step perhaps we should invite representatives from the Disabled Persons Commission to come before the committee and just see if they're acting on any of the concerns that were raised and what their plans are, so that we can combine sort of both sides of the situation. I'm certainly interested to hear how you would like to approach the matter. Wayne.

MR. GAUDET: Madam Chairman, I think that's a wonderful first step to bring them in, basically hear what they have done, or if they're planning on doing anything, before we actually decide. That certainly would be helpful in determining a course of action, so I would certainly support that, Madam Chairman.

MADAM CHAIRMAN: Okay, any further discussion on that?

Well, let's look ahead because that actually combines with our next item, which is our meeting schedule and topics. If you'll remember last year, or it may have been the year before, the committee decided that it would not meet when the House was in budget session, but that doesn't really apply to the Fall session. So I'm wondering what you'd like to do about the timing of our next meeting. Do you want to time it for November or do you want to delay that and have our next meeting in December? Obviously we're going in session on October 30th.

MR. GOUCHER: It depends on how long the session is, I guess, but I would prefer, personally, and it's not to delay or put off any of these meetings, but I would prefer that when we're sitting in the House, that we've all got other things on our minds, although these are extremely important, but I would prefer to put the committee meetings off while we're in session. That's my own opinion.

MADAM CHAIRMAN: Is there any discussion on the timing? Wayne.

MR. GAUDET: I want to comment on that. I'm sitting on the Veterans Affairs Committee and on the Resources Committee and when the House is sitting, our committee does not meet. So I was kind of surprised, Madam Chairman, when you indicated that this committee does meet.

MADAM CHAIRMAN: Just in the Fall session, not the Spring session.

MR. GAUDET: But on those two committees, we don't meet when the House is in session - just for the record, thank you.

MADAM CHAIRMAN: I don't see any disagreement so I'm assuming, then, let's move our next meeting to the second Tuesday of December - if the session is over, obviously. So I'm just wondering - oh, it's the first Tuesday, okay. So we'll have to play it by ear, obviously, but let's tentatively schedule it then for the afternoon of Tuesday, December 2nd. It's the first Tuesday, that's our new regular meeting day.

What do you want to do about topics? We could see if representatives from the Disabled Persons Commission were available. We do have a couple of outstanding topics from our list that we came up with at our last organizational meeting, and that was the Canadian Federation of Students and the Provincial Autism Centre. So if we add the Disabled Persons Commission, what priority do you want to give the list of witnesses?

MR DUNN: Silence is golden.

MR. ZINCK: Could you go over the list again?

MADAM CHAIRMAN: Well, we just agreed that we should have the Disabled Persons Commission and we still have the Canadian Federation of Students and the Provincial Autism Centre. Wayne.

MR. GAUDET: Madam Chairman, I would suggest that we try to bring in the Disabled Persons Commission, if possible. As a backup, if that's not possible, then we'd fall on the Provincial Autism Centre.

MR. GLAVINE: Is this for November?

MADAM CHAIRMAN: December 2nd, we've decided not to meet in the month of November and we'll wait and see if the session is finished by the next - okay, is there agreement? We'll try to schedule the Disabled Persons Commission and, if not, we'll go with the Provincial Autism Centre.

So if you could just take a look at your letter from Maureen MacDonald, Chair of the Public Accounts Committee, I think as a matter of courtesy, because I guess this would normally come under the mandate of our standing committee. She's letting us know that organization and topic would be coming before the Public Accounts Committee. It's just an information item but this is your opportunity, if you have any comment.

Okay, hearing none, our next meeting then is tentatively Tuesday - oh, just a second now, I may have misread the letter. They're forwarding it to us, yes, sorry. (Interruptions) So we'll put it down as our fourth topic.

So any questions or comments? The meeting is adjourned.

[The committee adjourned at 2:53 p.m.]