HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, June 1, 2011

LEGISLATIVE CHAMBER

Department of Health and Wellness
Family Pharmacare Program

Printed and Published by Nova Scotia Hansard Reporting Services

Public Accounts Committee

Ms. Diana Whalen, Chairman
Mr. Howard Epstein, Vice-Chairman
Mr. Clarrie MacKinnon
Ms. Michele Raymond
Mr. Mat Whynott
Mr. Brian Skabar
Hon. Keith Colwell
Mr. Chuck Porter
Mr. Allan MacMaster

[Ms. Pam Birdsall replaced Mr. Howard Epstein]
[Mr. Sidney Prest replaced Ms. Michele Raymond]
[Mr. Gary Burrill replaced Mr. Brian Skabar]

In Attendance:

Mrs. Darlene Henry
Legislative Committee Clerk

Ms. Evangeline Colman-Sadd
Assistant Auditor General

Mr. Gordon Hebb
Chief Legislative Counsel

WITNESSES

Department of Health and Wellness

Mr. Kevin McNamara, Deputy Minister
Ms. Linda Penny, Chief Financial Officer
Ms. Judy McPhee, Executive Director of Pharmaceutical Services

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, JUNE 1, 2011

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Ms. Diana Whalen

VICE-CHAIRMAN
Mr. Howard Epstein

MADAM CHAIRMAN: Well, members of the committee, I'm going to start. It's 9:03 a.m. by this clock and we'll begin; we have our quorum. Today we are here with Public Accounts. We are usually, as you know, in the other room so there won't be any television for this one but it is recorded for Hansard.

Our witnesses today are from the Department of Health and Wellness and the subject is the Family Pharmacare Program. I'd like to begin with the opening statement from the Deputy Minister, Mr. McNamara, and welcome.

Well actually we have to introduce ourselves, that's right. I'll begin with Mr. MacKinnon.

[The committee members introduced themselves.]

We'll turn it over to you, Mr. McNamara. You can introduce your staff with you and we'll look forward to your opening statement.

[Mr. Mat Whynott took the Chair.]

MR. KEVIN MCNAMARA: Thank you very much and good morning, members of the committee. I'd like to introduce Judy McPhee, who is our Acting Director of Pharmaceutical Services at the Department of Health and Wellness, as well as Linda Penny on my right, who is our Chief Financial Officer. I am pleased to be here this morning to speak to you about the Family Pharmacare Program, as well as prescription drug coverage in Nova Scotia.

The Family Pharmacare Program is one of the province's five Pharmacare Programs which help Nova Scotians with the cost of prescription drugs. Many Nova Scotians are struggling to make ends meet and it sometimes can be difficult for people to afford the prescription drugs they need, along with the regular, day-to-day household costs.

Our department's goal with Pharmacare Programs is to help ensure Nova Scotians are able to get safe, effective prescription drugs at a price they can afford. In particular, the Pharmacare Programs are designed to help Nova Scotians who need it most with their drug costs: seniors with fixed incomes, people with lower incomes, families without insurance or those with high drug costs due to chronic disease and conditions such as cancer, not covered by their own private insurance.

In total, government helped more than 200,000 Nova Scotians pay for more than five million prescriptions last year, at a total cost to the province of approximately $300 million. In addition, more than 6,000 drugs are listed on the formulary for coverage through Pharmacare, with 300 new generic drugs added to our formulary last year.

Today we are here to discuss and answer your questions regarding the Family Pharmacare Program. Thousands of Nova Scotians have benefited from Family Pharmacare since it was introduced in March 2008. Today there are 25,000 families, equaling 44,000 individuals enrolled in our program. Enrolment has been growing steadily since it was launched three years ago. While it is open to all Nova Scotians, Family Pharmacare is particularly helpful for those families and individuals with lower income who do not have private insurance and those with high drug costs not covered by their private insurance. It is there to help Nova Scotians when they need it.

With Family Pharmacare, we are confident we have a program that helps Nova Scotians bridge the gap between the cost of their prescription drugs and what they can afford to pay - a program that is beneficial to people who need help with drug costs and is affordable for taxpayers.

Government spending on drugs through our public drug plan is growing at an astonishing rate. Last year the cost of prescription drugs to government was $300 million and the year before that it was $285 million. It has more than doubled in the past eight years and there has been an average growth of 9 per cent each year over the last decade. This growth, as you know, is not sustainable. Yet many Nova Scotians depend on help from pharmacare programs. They would not be able to afford their medications without this

help. In Nova Scotia, government is taking action to give better drug prices for Nova Scotians and ensure Pharmacare remains sustainable and affordable with the new Fair Drug Pricing Act and regulations.

Governments across Canada are dealing with the issue of how to make drugs affordable for their residents, those who rely on public drug plans for help with drug costs, and to the taxpayers who pay for these plans. This is a continually evolving issue, one we are constantly reviewing to ensure we're able to provide the most effective public drug plans so they're able to ensure safe, effective and affordable medications are available to Nova Scotians in a way that responsibly manages taxpayers' money. The fair drug pricing plan, which will see caps on the prices of generic drugs for Nova Scotians covered by Pharmacare, is a first step. This will help us get fair prices for generic drugs for Nova Scotians, bringing the price for these drugs more in line with those paid in other provinces.

Getting better drug prices is just part of the solution. We need to ensure better utilization of drugs. Medications are being prescribed more and more. Medications are costing more and new expensive drugs continue to become available. Governments across Canada face pressure to fund these high-cost drugs. We need to carefully examine these drugs to ensure they are effective and safe as well as cost-effective for patients and our taxpayers. An example of this is drugs that are slightly better or just as effective as other drugs but cost a lot more.

Solving these issues cannot be done by one province alone. We need to work together to find common solutions in addition to initiatives in our province such as our fair drug pricing plan and our new Drug Management Policy Unit. Examples of collaboration with other provinces include our work with other Atlantic Provinces to the Atlantic Common Drug Review and with other provinces on the pan-Canadian Oncology Drug Review. We will continue to explore opportunities to work together to manage the growing cost of drugs as well as improve utilization of them. The new Drug Management Policy Unit will focus on better use of drugs and more effectively managed drug costs. Through this unit, we will work with doctors and other prescribers to ensure the best possible prescribing practices and look for opportunities to work with drug manufacturers to ensure the most appropriate use of drugs for Nova Scotians.

The changes we have made to date, as well as the capping set on generic drugs starting on July 1st, have already made a difference to the sustainability of Family Pharmacare and other Pharmacare Programs. As a result of these changes, premiums, deductibles and co-payments are staying the same this year as they were last year. Drug pricing needs to change and it has been changing across Canada since 2006. We recognize that this brings some uncertainty to pharmacists and pharmacy owners which is why changes are being phased in over a year to give pharmacies time to adjust to our new pricing.

The Department of Health and Wellness values pharmacists as important members of our province's health care teams. We want to ensure they remain viable businesses so they can provide the advice and service many people count on. The approach taken will be balanced and fair to all. Through these efforts, we are working hard to make sure Pharmacare is available to Nova Scotians who need help with drug costs for years to come and that they're able to get safe, effective drugs that make a difference to their lives. Thank you for this opportunity and we look forward to answering your questions.

MR. CHAIRMAN: Thank you very much and I'd also like to recognize the member for Inverness, Mr. MacMaster, thank you for coming. We'll hand things over now to the Liberal caucus for their 20 minutes and it's 9:12 a.m.

MS. DIANA WHALEN: Thank you very much and again welcome to you, Mr. McNamara, we're pleased to have you here to talk about Family Pharmacare, in particular, although I know the cost of drugs has been a part of your presentation as well, in the background to that. This is a program that I know when it was introduced was certainly welcomed and needed because we know there are a large number of Nova Scotians with no coverage whatsoever. If you don't have that then you are very vulnerable if anything should happen. So it was important that we got in the game and began to offer a program but I guess today we'll look at the extent of it and how well it has worked and questions of that nature. Initially my understanding was there are about 180,000 Nova Scotians with no coverage, would that be correct when you brought this in in March 2008?

MS. JUDY MCPHEE: Yes, that was our best estimate at the time of uninsured and underinsured.

MS. WHALEN: Underinsured as well, so about 180,000. So what was the expectation that you would be covering when the program came into effect, how many people did you think would sign up?

MS. MCPHEE: We thought that we would have, based on data from other provinces, around 50,000.

MS. WHALEN: So hoping to have 50,000 or expecting that 50,000 would see this as a program they needed and would sign up for. After the first year, and I think you've just given us figures today for now which is 25,000 for families.

MS. MCPHEE: It's 25,000 families, 44,000 individuals.

MS. WHALEN: Okay and you were looking at 50,000 individuals or families?

MS. MCPHEE: Individuals.

MS. WHALEN: Individuals. So was it just expected that the other 130,000 individuals would not have any need for this?

MS. MCPHEE: Again it was our best estimate because Family Pharmacare is based on a deductible and co-payment, there's no requirement to join. What we don't know about the individuals who are uninsured and underinsured is whether they have drug needs and are sick.

MS. WHALEN: But at the same time if they get sick they haven't already registered, they're not in the system and that can be a problem, if they don't know about it.

MS. MCPHEE: That's right and that's why we try to encourage them to join up front so that that first prescription would count towards their deductible.

MS. WHALEN: Has there been any effort to increase awareness around the program. I'm looking at the shortfall between the 44,000.

MS. MCPHEE: Certainly when we rolled out the program there was a very large campaign. There was a postcard mailed out to all postal codes in Nova Scotia. All physicians and all pharmacists and pharmacies are aware of the program and continue to have materials and promote the program, as they see people coming in with drug needs.

MS. WHALEN: I realize you've only had two full fiscal years that we can look at but how has this growth moved forward because I think that it hasn't grown much in this last year. You started at square one, March 2008, how have the enrolment numbers gone?

MS. MCPHEE: In March 2008, of the first year there were approximately 17,000, the following year there were around 22,000 and now we're up to 25,000.

MS. WHALEN: And that again is families.

MS. MCPHEE: Families.

MS. WHALEN: It still seems like pretty small growth, very incremental now in this last year from 22,000 to 25,000. So what you've told me on the raising awareness part is that there was an initial flurry of activity when it first got rolled out. Has there been any suggestion, even from the minister, asking that there be more awareness, that there be a campaign to increase it? I'm just wondering if at the highest levels there's been any concern about getting higher awareness.

MR. MCNAMARA: What we are doing is continuing trying to advertise it through our Web site, through other communications that go out from the department. We haven't gone to the intense program that we had, for example, on initial start. At the same time we are making sure physicians and pharmacists, who are advocates for their patients, have the

information and would obviously make them aware of this program. We count on health care providers to assist us in also promoting the program.

MS. WHALEN: Would it be fair to say that most people don't know about the program until they get seriously ill?

MR. MCNAMARA: That would be speculation, I'm not sure. I think, again I would be speculating, I think people are aware of it, some may not be aware of it and they may not be aware of the details of the program until they need it.

MS. WHALEN: I can just say again, a little bit anecdotally, but in speaking to the Canadian Cancer Society, they say when people arrive at The Lodge That Gives, they often have no idea about this program, so that's where they are hearing about it. They are already cancer patients, they are in for treatment, they have expenses and they just hear of it.

My concern then would be, if you haven't pre-registered or got - as you say, there's no deductible to start with - so if you haven't registered and been in a position to start at least applying it to your prescriptions that may come up, even though you're not very seriously ill, how long does it take? If I find myself at The Lodge That Gives and I send in my papers right away because I realize there is this program, how long would it take to be in the system?

MS. MCPHEE: It's very, very quick and actually we can expedite it. Normally, if you enrolled, it would take seven to 10 days but we do expedite as well. We work very closely with the Cancer Centre so they are well aware of the program and the folks at the Cancer Centre who are dealing with patients who are uninsured or under-insured.

MS. WHALEN: I think they are making it their business to make sure people know that because this is an important program, as I said from the onset, that people need it.

If they did come in with those seven to 10 days, was there any way you could go back and say, well look at the drugs you've already paid for in the last month, or two months, or year, if they haven't known about this program, maybe they've already paid their deductible? I know the deductibles are on a sliding scale, based on their income, but perhaps they've already paid that. Do you ever go back or does it have to come from the moment they sign the application?

MS. MCPHEE: It comes from when they join that month; it would go back to the beginning of that month.

MS. WHALEN: And that's as far back as you would go.

MS. MCPHEE: That's as far as we go.

MS. WHALEN: It's a bit unusual that there's no way for people to pay even a small amount to say now I'm in, because then we could get a lot of people in if the choice had been to make even a small premium payment. Was that looked at when the program first ran out, I wonder, Mr. McNamara?

MR. MCNAMARA: Not to my knowledge. No, that wouldn't be one of the things that we would have. There would have been a number of options explored but the one that we put forward was the one we felt was most effective, that would help the lowest income and move individuals forward. I think as Judy was saying, trying to ensure that practitioners and health care providers are aware is probably one of our most effective ways of making sure individuals can be aware of our programs.

MS. WHALEN: Right. One of the things I'd like to know about is around the barrier to accessing the program and I would say the cost is a barrier. Has that ever been expressed? Have staff ever expressed that concern to management or to the minister?

MR. MCNAMARA: When we looked at our program and compared it to other provinces, we're more generous on the lower income and we're less generous as income rises than other provinces, if we do a comparison, so we try to help those who need it the most with the dollars that we do have.

MS. WHALEN: Okay and I will agree with you, at the lowest about $15,000 income level, perhaps up to $20,000, we're still better than the rest of Canada but then it quickly changes, the reverse becomes the case.

I do want to know whether that has been an issue that has been raised by the minister, that there is the fact that the deductibles are high as your income is still pretty low, we're below the low income cut-off level, at $20,000, significantly.

MR. MCNAMARA: Once we deal with the drug pricing issue and deal with some of the other issues, then maybe we'll have some more flexibility to do some changes to our program that we haven't been able to do with the funds available to us. Part of the issue with utilization, too, we've got a lot of work to do on utilization, how we help individuals.

There are some ideas that we are discussing with others - how do we help people, for example, with a chronic disease on their first prescription? We know that individuals will buy that first prescription and sometimes never go back for a second one, for all kinds of reasons, they think it doesn't work. There may be ways to do it differently than working with manufacturers. The first prescription might be a sample to see if people try it and then we go a different way to go for the second and third, in order to pay. There are options we have to work our way through, but it takes a lot of work to get there.

MS. WHALEN: I understand that. Anyway, as I said, the question I had really was whether the minister had ever been asked about the barriers to accessing the program. I

have a briefing note that shows that it was raised in March 2009, as a note saying that - and I'll just read it to you: Concerns have been raised that the program deductible may be a barrier in some situations for clients to participate in NSFP. It goes on to say now that the program has been in existence for a year, a review will be done to identify issues and recommend changes if needed. That was, as I said, March 2009, so more than two years ago now.

MR. MCNAMARA: What I can say of the minister, she's always challenging me to come up with new ways to try and help more people, but again, within our ability to afford it and we're coming at it from different angles. One is to try to get our drug costs in place, to try and get our utilization, not in just this program, in many programs. Once we've got some flexibility with dollars, then we can start adding. But at the same time we have to recognize that we have added new drugs in the past year, both in cancer care and generics and we have done changes that do help individuals. We've also managed to keep our deductible the same this year without increasing it, which is a positive.

MS. WHALEN: There are some positives and there are the generics that are coming on stream as well, which will give you some flexibility I hope, and I was going to have a few questions for that maybe later. I would like to know whether after that note to the minister in 2009 - and that was March so that was the previous government, I'd say - was a review ever done of the program? It was one year in. Was there a review done, as was suggested in that note that a review will be done to identify issues and recommend changes if needed?

MR. MCNAMARA: I can't speak for the previous government because I didn't work with them.

MS. WHALEN: No, but staff is ongoing.

MR. MCNAMARA: Yes, well, I'm speaking about me. One of the things, we're constantly looking at the plan and trying to come up with new ways to do things. I mean, for example, the legislation that just went through one part of a review based on and done differently in Ontario. What we're doing with drug utilization is we're moving that unit into place that's going to help us in these areas and what we're doing in terms of adding new drugs, it's a constant program under review, but again, it's going to take time; it's not going to happen overnight.

MS. WHALEN: Perhaps I could ask Ms. MacPhee if there has been any formal review, even another briefing note to any of the ministers.

MS. MCPHEE: I think the briefing note that you're referring to - when the program was first introduced we did hear that there were some individuals in the program who were having problems with the deductibles, so we are looking at the program. At the time in 2009, when that briefing note was written, we really didn't have enough data. One year,

new program, there were 17,000 families, there really wasn't enough to do a full review of that program at the time.

MS. WHALEN: Does that mean that no real review was done?

MS. MCPHEE: That's right.

MS. WHALEN: You've just been sort of monitoring it, but not really doing a written review of it.

MS. MCPHEE: That's right.

MS. WHALEN: But we're three years in now. When you talk about the deductibles and the cost here in Nova Scotia, I did look at a comparison of the programs across Canada and the deputy minister has pointed out we do start at a good level for the lowest end. The very low-income Nova Scotians, your annual amount there would be just if you earn $15,000 family income you'd pay $300 so that's not too much, but even when you move to $20,000, you go up by $5,000 in income, you've more than doubled your total to $660 per year. It's not a sliding scale, it's jumping a lot and it jumps to the point where you're paying something like 22 per cent of your income at $80,000 before you're eligible. Well, I guess that's the whole total, so that's your deductible as well before you're capped out. We're really way out of whack on the top end of helping people.

I think the context of it is that a lot of the drugs we need, particularly the cancer drugs, but some others, are very expensive. I understand there are a lot more oral cancer drugs being used nowadays so you're not always going into the hospital for chemotherapy. You can go home with some of the oral cancer drugs, but the cost is so high. I think we have a problem in terms of that sliding scale. I know that we'll hear from other members, I'm sure, as the questions go on about the calls that we get in our constituency and what we're hearing from people where they feel it's just more than they can afford. Are you getting complaints of that nature too?

MR. MCNAMARA: We're getting complaints every day on every issue you can think of, but in effect, that's not one that we get a lot of complaints on, that I've seen a lot of letters on. I think to also just speak to your point about cancer drugs, there are certain cancer drugs we cover as well for the full cost of outside of the Pharmacare Program. I can't name them, but Judy can probably support on those. That wouldn't be part of the same issue. On the higher income, we recognize it as an issue and that's something we will address in the future as we work our way and get our budget in balance.

MS. WHALEN: Again, I'm sure you've looked at these charts that show how we compare.

MR. MCNAMARA: Yes.

MS. WHALEN: Would you agree that we are the most expensive coverage in Canada, certainly above that $15,000 or $20,000 level?

MR. MCNAMARA: Well, it's very hard to compare province to province. They cover different drugs in different provinces and you cover in different ways. Yes, on a pure deductible, you're correct, but there are other things that we do as advantages that are different than other provinces as well. It's an impossibility, in this country, to compare drugs from province to province and say this is apples to apples.

MS. WHALEN: But this isn't really drugs, this is money out of your pocket. If I earned $50,000 in Manitoba, I'll pay a lot less to be covered under their Family Pharmacare Program than I do if I earn $50,000 here.

MR. MCNAMARA: Yes.

MS. WHALEN: And the average family income in Nova Scotia is $47,000, I think.

MR. MCNAMARA: I don't disagree with you, if you're doing that part, but also you have to look at the plans to see what drugs are covered by the Pharmacare in each province. They are different. Some would have more drugs than others, some have less. I don't have that comparison with me but I know it isn't exactly the same and I think you also have to see that there are two provinces that have no coverage at all.

MS. WHALEN: Yes.

MR. MCNAMARA: And so to be fair, Nova Scotia has stepped up to the plate versus two of our neighbouring provinces, New Brunswick and P.E.I.

MS. WHALEN: Well, I did agree when it came in that it was something desperately needed but to be on the very high end like that, I think, means that there is a problem with accessing the program, of actually getting into it because it looks so high that people would think, well, why bother, I'm not going to do it, it's just too much. I think, when you look at what it costs to live, you're going to see that people can't afford it. I think that's why we haven't got the uptake, it may be awareness, people don't know about it, and so the uptake is because of the high cost.

As I say, it's great on that lowest level but we very quickly get into people earning $25,000 and $30,000 family income, which isn't very high to live on, let's face it, and being asked to pay a big percentage of their income towards this. So, that's a concern to me. I think it rises well above the 3 per cent that was recommended by the Kirby Report and I'm sure you're aware of the 2002 Kirby Report. Their recommendation was 3 per cent should be the maximum for pharmaceuticals.

MR. MCNAMARA: Well, as we get the money to work with, we can do changes, but I think we also have to recognize that there are some drugs we cover 100 per cent, for organ transplant, for example, for renal failure, for MS, for HIV/AIDS, for schizophrenia, I can never pronounce the other one, neutropenia, is that right?

MS. WHALEN: So there are some. I wouldn't say that overall our program is better even in terms of drug coverage because we know we were the last one for Lucentis, certainly in the country. So I realize each program is different but ours is at the top end; if you earn $80,000, you'll pay 22.2 per cent of your income.

MR. MCNAMARA: I don't disagree with you on that.

MS. WHALEN: Which is very high compared to 4 per cent, which is a flat rate in Ontario, or Saskatchewan which isn't - well, I guess they're getting to be a wealthier province with 3.4 per cent there, 4 per cent in B.C., flat rates.

MR. MCNAMARA: Or you can move across the border and pay 100 per cent.

MS. WHALEN: Yes, yes. Well, it's always good but I would rather compare us to the ones that are doing well rather than the ones that are doing poorly.

MR. MCNAMARA: I understand.

MS. WHALEN: And I think you would, too. I'm sure we're all right with that.

MR. MCNAMARA: Yes.

MS. WHALEN: Can you explain if there's any plan now to look at these rates, to review them?

MR. MCNAMARA: Not at this time, until we get our house in order on finances.

MS. WHALEN: No time frame even to look at that?

MR. MCNAMARA: Well, we're working towards trying to balance the budget and when we can get there then we'll have some dollars to work with.

MS. WHALEN: So you know these figures as well as I do, have you rejected the idea then right now of going to a program like Manitoba has?

MR. MCNAMARA: That's correct.

MS. WHALEN: British Columbia has a program where they pay $100 twice a year and that registers you in and it goes towards your deductible. They don't call it a premium;

it goes towards your deductible right off the bat. Have you looked at that program so that more people would line up and I think pay that cost so that they would have, it's insurance, right? Have we looked at that model?

MR. MCNAMARA: Well, we developed a Nova Scotia model which is what we're working with and, again as I said, to try to help the lower income ones is where we put our emphasis.

MS. WHALEN: Again, as MLAs, I know we think people who are making $25,000 and $30,000 with a family is pretty low income and we hear from them every day with their power being shut off and different things. So they're also needy.

MR. MCNAMARA: I understand that.

MS. WHALEN: And so I'm just looking to see how we can move forward and get a little bit more help on this. You know, again, I've got examples of how they compare between us and Manitoba but it is significantly different and really half the price, even at the lower end of their pay. So, you know, I'm concerned that we're not looking at reviewing this now.

MR. MCNAMARA: I think the approach we're taking, which is looking at utilization and other things, will be just as beneficial to many of those individuals, also looking at trying to ensure with drugs we approve, that we don't end up getting lobbied into paying high, expensive drugs when more effective, cheaper ones will work. So we have to keep working hard to do the right thing for both the taxpayers as well as for the patient.

MS. WHALEN: One thing you mentioned was that you don't hear much from patients on this issue but how about DHAs? Are they signalling any alarm, because they are discharging people to go home, who can't afford their drugs as they are going home from the hospital? I'm thinking particularly with cancer therapy.

MR. MCNAMARA: We dealt with one individual from Capital Health and we are looking at doing some initiatives with her that may help us in how we can do a better job in working with some of the manufactures on drugs but other than that, I haven't heard anything.

MS. WHALEN: I think this is certainly an issue for MLAs and if we heard about it, they must be hearing it, doctors' offices, at the DHA level, so it surprises me that you're not hearing that.

MR. CHAIRMAN: Order. The time has expired for the Liberal caucus and we will now go to the Progressive Conservative caucus with Mr. MacMaster. The time is 9:32 a.m. and you have 20 minutes.

MR. ALLAN MACMASTER: Thank you, Mr. Chairman, and I'd like to thank the Department of Health and Wellness today for coming and offering us a chance to ask some questions about this program. We know that Canada's health care system, we place a lot of investment in it and it's respected by a lot of people. Sometimes it is touted as being the best system in the world. I don't know if that's true or not but I guess one of the things that we had a gap in, in this province, was around people and especially the working poor, lower income people. A lot of those people didn't have access to a drug plan so there were costs that they had to bear, as I know you well know, so I think this was a good program to start in Nova Scotia.

You mentioned in your opening statement about the cost of the program, it was about $300 million and there were about 200,000 Nova Scotians served last year. What happened before? What was the cost before? We know it is $300 million now to pay for the program - was that just a brand new budget item?

MR. MCNAMARA: I'll defer it to Judy; she was here before.

MS. MCPHEE: The $300 million is the cost of all our programs, not just Family Pharmacare.

MR. MACMASTER: So what would be the cost before? We know that it cost $300 million today, before the Family Pharmacare Program was brought in. What was the budget at that time, was it $200 million?

MR. MCNAMARA: I would ask Linda, she's got the financial details.

MS. LINDA PENNY: So if we go back to 2007-08, before the program was introduced, it was $255 million.

MR. MACMASTER: So would it be safe to say that it's about a $45 million increase on the provincial budget?

MS. PENNY: Yes, altogether. That's all drug programs we're talking about.

MR. MACMASTER: That's more than just the Family Pharmacare Program.

MS. PENNY: Yes, the $300 million is all drug programs.

MR. MACMASTER: I guess what I'm trying to get at and maybe I'll phrase the question another way - this is a good program but it has added new costs to the provincial budget. I'm just trying to get a handle on the exact amount that it added.

MS. PENNY: It's $24.67 million.

MR. MACMASTER: Okay, thank you. I believe you mentioned that it was 180,000 Nova Scotians who are now being served, new people being served by this program?

MS. MCPHEE: By the Family Pharmacare Program?

MR. MACMASTER: Yes.

MS. MCPHEE: By the Family Pharmacare Program, it is about 44,000.

MR. MACMASTER: Okay, thank you. I have a number of questions here, they are in no particular order. The first one is, with respect to generic drugs, I know that at a certain point in time if a drug comes off the patent list and a generic can be produced and once that is produced - how do we determine in this province when we go to a generic drug? I know the obvious consideration is price but is there some other process that it goes through?

MS. MCPHEE: Absolutely. There is a committee of experts who actually look at all generic drugs and they look at the evidence to ensure that that generic drug is high quality and will act the same when it is taken as the brand name. In fact many generics are the brand name, just repackaged. There are fasting and fed studies, it's all based on scientific evidence.

MR. MACMASTER: Do you have sort of a time frame by which you try to implement, to try to start using a generic drug - like three months or nine months?

MS. MCPHEE: Yes, as quickly as possible because they do save money and typically it takes about six weeks to three months to bring a generic on. We've just streamlined our process to hopefully get that down even further, to 30 days to six weeks.

MR. MACMASTER: I don't think this would be the case but have you had situations where a generic drug hasn't been able to do what the brand name was able to do before the generic was produced?

MS. MCPHEE: No because our process is fairy rigorous and so they are high quality drugs and many of them are the brand name drug just repackaged.

MR. MACMASTER: Okay, that's good to know, because sometimes that comes up as an issue and it's interesting to hear your perspective on that. What about from a long range perspective, where do you see this program going cost-wise, the Family Pharmacare Program?

MR. MCNAMARA: I would say that hopefully, when we get our deal in place with PANS after July 1st, and I'm looking forward to generic drugs, we should see some savings in the program, which will allow us to ensure fair prices for drugs. We also are hoping, and

this has happened in other provinces, that the companies usually pass those same prices on to the general public that they give to governments so we're hoping that, even though it's not in our legislation to mandate it, the norm is that companies usually follow that pattern so we should see benefits not just to government but to all Nova Scotians.

MR. MACMASTER: Okay. I'm going to ask another question with that later on but what would you say are the main cost drivers of the programs?

MR. MCNAMARA: Main cost drivers of drugs?

MR. MACMASTER: Well of the program itself. I guess if we look at the demographics of the province, we're not having an increase of population, so I wouldn't think that would be a driver.

MR. MCNAMARA: There are a number of things. One is the increase in chronic disease, which we know is an issue. There is also the belief by many of us that if we get a pill it will solve our problems, and it does not always do that. Sometimes it's a placebo effect - and I'm giving you my personal opinion - of getting something from the doctor when you go in that you believe may - and sometimes it does have some good works. There are also the things that we're facing as new drugs are coming out and becoming more specific and more refined in the targeted ways, we're not sure if the benefits are really there but there are good marketing programs that we have to deal with. So what we're trying to do is put more rigour into how we approve drugs and what we pay for them.

MR. MACMASTER: You mentioned, it was interesting, like a pill solves all is sometimes the sense people have. Are we working with our physicians in the province who are prescribing medications to try to change the way that happens? I've mentioned it before, I think physicians have a crucial role to play because people really respect their opinion about trying to get people to live more healthy so you could cut down on the amount of chronic disease we have and change the notion that a pill is a solution when maybe there are other means that may even work better for people.

MR. MCNAMARA: Through the CME done through Dalhousie University with physicians, part of it is looking at prescribing practices and how we can do a better job. As well, that's also with new physicians, part of the medical education is trying to get physicians to look at other avenues of how you treat people. It's not perfect, as in any system, but they are working their way through that. I think one of the things that we have to do as we get more work done in our utilization, is being able to advise people. One of the hard things to overcome is American television with the ads that say this miracle drug will solve all your problems and unfortunately it doesn't. Part of it is the belief that the advertised drug will solve every problem and unfortunately it doesn't.

MR. MACMASTER: I respect that, it's a challenge. You mentioned that they we're doing some work at Dalhousie. Have they had any successes with physicians and helping them to - just to stay on the same topic, it looks like you're ready to answer.

MS. MCPHEE: Actually drug utilization is one of our big cost drivers, so we need to promote optimal prescribing. We're very lucky in Nova Scotia that we have the Drug Evaluation Alliance of Nova Scotia, which is a program that's funded by the Department of Health and Wellness and works with prescribers and researchers and other stakeholders, in ensuring that there is effective prescribing, that there is optimum prescribing and that we're getting more effective drug usage from a health and outcomes perspective. That is quite unique in Canada. We are the only province actually that has a program. We work extensively with the physician, prescriber community and pharmacists as well, to ensure that there is optimal prescribing. We do three or four large initiatives per year with them.

MR. MACMASTER: That's good to hear. In this last sitting of the Legislature, one of the hot items was the pharmacists and the changing in their business models. One of the things that was apparent to me was - and I know the department is trying to expand the role of pharmacists in the health care system - how much pharmacists can save the health care system. They also can provide a bit of a backstop or a second set of eyes on medications that are prescribed. I know there have been instances, I'm sure, where you might have two medications that might even be conflicting and that might be something that can be caught at the pharmacist's shop or what have you. Have you any thoughts on that? We were concerned about the pharmacist business model, especially in rural areas.

If we're changing those models and changing their operations - one gentleman indicated to me that he could be bankrupt in a year and a half, but I do know that you're also looking at their dispensing fees. That's another important part of their business model. What do you see, as far as the security of this program in rural areas? It, of course, depends on the network of pharmacists around the province. What do you see as far as the role the pharmacists play and their ability to maybe help to keep the cost of the program down?

MR. MCNAMARA: If I can start, a couple of things; one is that we know that pharmacists are a valuable member of the health care team. They've been doing a lot of this work, as we all know, in the past on a basis, but we are expanding their scope because we think there are things that they can do that will save individuals from going to a family doctor and taking up to three weeks to get prescription refills. To help them and help all health care practitioners, we're also in the early stages of putting in a drug information system, which will connect between drug stores and hospitals and physicians so that people will know, for example, if you've got a prescription in Cape Breton and you go to a doctor in Yarmouth, they'll be able to know that you have got that prescription and what it was so the drug store will also know. This will help them with people getting unnecessary drugs; it will help with double doctoring. It will help individuals.

Once the system is mature, they will know the mix of drugs that people have because when individuals go to different drug stores, for example, they may not remember what drugs they're on, the pharmacist won't know, so this is a system that we believe will improve health care, save lives and reduce addictions in the long run.

MR. MACMASTER: I think that's very good. That system, it's basically you're improving your IT systems to be able to do that.

MR. MCNAMARA: That's the drug information system. It will be province-wide. We expect in the next two years to have it implemented.

MR. MACMASTER: So a pharmacist or a physician can sort of log onto the system and see what the patient or client or hospital . . .

MR. MCNAMARA: That is correct.

MR. MACMASTER: When did you say that was going to be fully up and running?

MR. MCNAMARA: In the next two years. We've put the RP out for the vendor, I believe. We're also working with some of our sister provinces. For example, I believe P.E.I., New Brunswick and ourselves will have a similar system so that you can almost check across three provinces eventually as we work our way through privacy.

MR. MACMASTER: Do you have any idea, like improperly prescribed or taking medication, what cost that has on the system?

MR. MCNAMARA: I wouldn't know the cost, but I can tell from being in the health care system for a long time, a lot of drugs are inappropriate, sometimes because of not having the knowledge, sometimes of patient pressure because of the advertisements that individuals have seen. Or, sometimes because the salesman has just gone through for the drug companies, promoting his or her drug as the next best thing. Remembering at the same time that sometimes physicians are fairly busy and when they're looking at things - or the other thing that does influence how doctors may prescribe it are the free samples that they're given by drug companies and that's the first drug to come to mind rather than thinking their way through it at a busy time.

MR. MACMASTER: Physicians are very busy and they might go for what is expedient at the moment. You mentioned that the growth in prescription drug coverage was about 9 per cent, as an annual rate of growth, which is quite significant. I presume some of these measures will start to impact that rate of growth. Have you any prediction? Would that maybe drop in half, to say, four or five per cent annual growth?

MR. MCNAMARA: Four per cent, that's for the upcoming year, as we work and mature our programs there should be greater savings.

MR. MACMASTER: Is that primarily based on - I guess that new system is not going to be in place for a couple of years.

MR. MCNAMARA: It's based on generic drugs, there's a lot . . .

MR. MACMASTER: On the generic drugs, okay. What about if we look at drugs, would you say that most of the savings are going to come on the retail side of those drugs?

MR. MCNAMARA: Initially, then as we work our way through utilization then we hope to get savings, and maybe in the long run it will be bigger, but I think we have to - not just Nova Scotia - we have to work with other provinces to do this.

One of the frustrations for any province, I think, in the business of paying for prescriptions, is that when one province recognizes a new drug then the push is in every other province, whether it is an appropriate drug or not. Drugs get recognized in different provinces for different reasons. It can be based on a lobby group, it can be based on the pharmacy, it can be based on God knows what, so if you look across the country, we do not have consistent coverage of programs and that's something we really have to put a lot of time in but it's not going to happen overnight, I can tell you.

Even with the issue when we talk about dealing with catastrophic drugs, there should be a national program. To even get there it will take a lot of work because we do not have consistent coverage of drugs.

MR. MACMASTER: How much control do you have over, say, the wholesale price of a brand name drug? What I mean by that is, if you don't have a lot of control, it's hard for the government to try to control the cost of those drugs. Can you offer some comment on that?

MS. MCPHEE: Yes, with brand name drugs, as provinces, we don't have a lot of control. There is a federal agency called the PMPRB, the Patented Medicine Prices Review Board of Canada. What they do is look at the price of a brand name drug being introduced in Canada, do a scan of the top European countries to ensure that we're not paying excessive prices compared to those countries. That doesn't mean that those countries are not paying excessive prices, too, it's all relative, so we do have that.

Then, we're more and more moving into - if the drug passes the clinical and the scientific evidence, in terms of patient outcomes and it's a drug that should be funded, then we are moving more and more to working with the manufacturers to get a better price. We need to do that together, as a country, we need a pan-Canadian approach to that because usually what has happened in the past is as soon as the manufacturer will work with Ontario and B.C., which are large provinces, and Quebec, and get a large piece of the market, then they're not interested in working with smaller jurisdictions and cutting a better price but there is commitment from most jurisdictions to work together on that issue.

That's something we're also looking at, to get better brand name prices because we don't have a lot of leverage.

MR. MACMASTER: I know the focus has been on the retail price so whatever the drug costs when it lands in the pharmacy, the focus is going to be to try to reduce the profit margin on the drugs being sold that are covered by this plan. Is there any risk that the wholesale price of the drug might start to rise, as the person making the drug sees well, if the price of the drugs are going down, maybe there's some way we can try to raise our price a bit to fill in the void if it's being reduced on the retail side.

MS. MCPHEE: For brand name drug or for generic drugs?

MR. MACMASTER: For generic drugs.

MR. MCNAMARA: Maybe I can answer. The manufacturer of generic drugs doesn't lose one penny in the program that we have in place. What they used that money for was to pay rebates and so what they did is restricted really some of their ability to - they're still going to pay rebates, we know that - pay rebates. So the actual manufacturing is not losing a penny through this whole program.

MR. MACMASTER: Do you think the manufacturers will lower their price coming in to the pharmacy owner?

MR. MCNAMARA: Hopefully.

MS. MCPHEE: They have to.

MR. MCNAMARA: They have to, to the percentages we've put in place.

MR. MACMASTER: So you've made that part of the deal.

MR. MCNAMARA: That's legislated, yes.

MADAM CHAIRMAN: Mr. MacMaster, your time has elapsed. Who will be asking questions? Mr. MacKinnon for the NDP, you have 20 minutes until 10:12 a.m.

MR. CLARRIE MACKINNON: Thank you very much, Madam Chairman. It's great to have you here this morning. As a rural MLA, this program is more important than it is to urban constituencies because the demographics are so different in my constituency from a population perspective of aging. I believe that this is a good program. I believe that there could be some changes made in it to make it somewhat better. I'm sure you're looking at possible changes as well. I'm wondering if you could begin by recapping some of the milestones since March 2008. There have to have been a number of important steps since then that you felt good about or perhaps were more hopeful about.

MS. MCPHEE: Certainly it was a long time coming in implementing this program. When it was implemented in 2008, it was a culmination of a number of years of trying to put in place a program that was affordable to taxpayers of Nova Scotia and as well would benefit our patient population. Primarily we were looking at the lower income population; those who were not Community Services clients, so, if you will, the working poor.

In 2009, when we started looking at who we actually were serving, it was very gratifying to see that it was, in fact, the lower income folks or those families that had huge drug costs that we were benefiting. Now 90 per cent of the government's costs for Family Pharmacare is for those families that are earning less than $35,000 per year, which was the target population that we were looking for so that was very good to see.

MR. MCNAMARA: Linda wanted to make a clarification on one of our previous answers on figures.

MS. PENNY: I just wanted to be clear if I answered the question that you were actually asking. The number I gave was the number for the Family Pharmacare budget for the 2011-12 fiscal year, so the $24.67 million; the total that we actually have spent on this program is $53.73 million, so the previous three fiscal years, that was the amount. It brings us up to a total projection of $78.4 million. I believe you were asking what it added to the provincial budget.

MADAM CHAIRMAN: It will be in Hansard. We'll go back to that. It's cutting into Mr. MacKinnon's time, so I'm going to turn back to Mr. MacKinnon.

MR. MACKINNON: Can you comment on what is happening in some other provinces and are there some provinces or territories that don't have the Family Pharmacare Program?

MS. MCPHEE: Yes, there are some provinces that don't have a Family Pharmacare Program or a universal program. So just to be clear, Family Pharmacare is open to all residents in Nova Scotia as long as there is a valid health card. Even those patients who have third party or private insurance can join Family Pharmacare because, as you know, with some private insurers, if you have a pre-existing medical condition, those drugs would not be insured. Some private insurers are capped out. So those people would benefit as well from Family Pharmacare if they have a lot of drug needs. So it is open to all residents, so if you will, it could be termed universal or open, or a universal program. The jurisdictions that do not have one right now are New Brunswick and P.E.I.

Newfoundland and Labrador and Ontario have a program based on income and most of the western provinces do as well, and they do all vary a little bit.

MR. MACKINNON: The deputy mentioned in his opening remarks that a province cannot deal with the issues alone, cannot solve the issues alone and, deputy, you mentioned

the Atlantic Common Drug Review and the PanCanadian Oncology Drug Review. You just mentioned them in passing. Could you just have a comment, perhaps a quick comment, on each of those?

MR. MCNAMARA: I'm going to ask Judy to give you the details.

MS. MCPHEE: When we're deciding whether or not to fund a drug under the public system, we have a number of review systems and those are two of them. We actually have four. The largest one is the Common Drug Review which is a Canadian drug review program. So that panel of experts looks at drugs and makes recommendations to all jurisdictions with a public program in Canada and there are actually 18. There are 19, Quebec is the only non-participant, and there are 18 public plans. Most of our reviews are done nationally through the Common Drug Review. They make recommendations to each government on whether or not to fund those drugs.

The Atlantic Common Drug Review was in existence prior to the Common Drug Review, and actually the Common Drug Review was somewhat modelled on that, and that's a co-operation of the four Atlantic Provinces. Now, since we have the Common Drug Review, the Atlantic Common Drug Review will do all drugs with the exception of generics and oncology drugs, so all drugs that the Common Drug Review does not do, and make recommendations to government. The whole purpose of this is to try to get more consistency on funding drugs.

The PanCanadian Oncology Drug Review, or PCODR, is a new review system that is just getting up and running, although we have been doing an interim co-operative around oncology drugs, the same thing, looking at oncology drugs specifically and making recommendations to each jurisdiction and then our fourth one is on generics, which I already spoke to about looking at how they work.

MR. MACKINNON: From a constituency perspective, I have run into a lot of people who really appreciate what you're doing, but there are others, one woman I was dealing with last week, who had a total income of $840 a month and was trying to maintain her housing and so on, she was saying that she has such a difficulty with the premium and the buildup of the co-pay to the maximum and I'm wondering on her behalf, on behalf of a lot of other low-income Nova Scotians, is there anything that you can do with this program to spread the co-pay out over a longer period? I know you tried to deal with the premiums over a period of time as well but can you just explain the difficulties that you must be hearing from some folks as well?

MS. MCPHEE: So if it's premiums, that would be Seniors' Pharmacare and not Family Pharmacare.

MR. MACKINNON: Yes, I'm sorry, yes, this would be a senior in this case.

MS. MCPHEE: Seniors can pay co-payments monthly and they can spread their co-payments out quarterly or monthly. That went into place four or five years ago, there hasn't been a large uptake. It was something that the senior community actually asked us to do so we did do that. There has not been a huge uptake on that from seniors, there are only about 25,000 of our 100,000 seniors that actually take that option because then they'll pay the entire premium. I guess they want to be assured that they're going to reach that co-payment with their drug cost.

MR. MACKINNON: I'm wondering if seniors are fully aware of what they can and can't do. I'm sorry, I'm getting away from the family end of it but this is a very important issue.

MS. MCPHEE: They do get a booklet every year that outlines that but certainly, if you have the name of somebody, we'd be happy to contact them and explain that to them.

MR. MACKINNON: And what about penalties for someone who turns 65 and doesn't register right away? That's a hardship that seems to affect quite a number of people. Now I'm still dealing with the senior issue but while we have you here I thought I'd bounce on that.

MS. MCPHEE: There is a penalty if a senior chooses not to join Seniors' Pharmacare until they actually require drug needs and then joins later, then they do pay a penalty. That was put in place to make the program affordable. If everybody waited until they were sick and older then we would not be able to keep the co-payments and the premiums at the level that they are because we rely on those monies, that money, knowing that it's coming to fund the program.

MR. MACKINNON: How are decisions to fund drugs made, because the formulary situation, I see that you've added, is it 300 new generic drugs were added to the formulary? There are always requests for many, many more to be added and I have a situation I'd like to deal with you folks before you leave if I could, one that came up yesterday. Can you just perhaps explain the process involved with the formulary?

MS. MCPHEE: Sure, again, it goes back to those four committees; so when a drug comes on the market or there is a new indication for a drug, it is reviewed on scientific evidence and cost effectiveness as well. So making sure that we're only listing effective drugs from a health and cost perspective, we're looking at value for money. It is a group of experts, whether it's the Common Drug Review, the Atlantic Common Drug Review, the PanCanadian Oncology Drug Review or our generic review committee that will make recommendations to government whether this drug is effective, passes the scientific evidence and as well, is cost effective, so offers value for money relative to other things that treat the same condition.

MR. MACKINNON: No matter how good a program is there's always a possibility for good evolution to take place and what I'm wondering is are you looking at any changes to the program that would be beneficial to Nova Scotians? Is there currently a review on a way to look at better ways of administering this program and making it somewhat better?

MR. MCNAMARA: We are looking at, I go back to hang my hat, to some degree, on drug utilization which we are going to look at. We also want to look at - I talked about the drug information system that we have coming in place which is another enhancement to our system. We are also looking, are there some other ways of working with, particularly, the big pharmacy companies to be able to introduce drugs for individuals on the first prescription in a better way. So there are a number of things we're looking at, again, at the same time, it takes time to get us there. It's something, unfortunately, we can't do overnight. So it's going to be manpower hours to work our way through all the various stakeholders to get there.

I believe in the long run, as we get smarter by using the information system, we can then be able to track what is happening and be able to do a better job than we have in the past. One of the things about not having a common drug system is, we're not always sure of what is happening out in the real world so this will help us in being able to track what is being prescribed where and where it makes some sense maybe to suggest better ways of doing it and to keep prices lower.

MR. MACKINNON: There's a very high percentage of the government spending on this program by families earning less than $35,000 a year. Is that something in the order of 90 per cent, is that the figure that you use? Do we have any breakdown in relation to the incomes of those who are in the program, and perhaps a few details on it?

MS. MCPHEE: Yes, we do. We know that 56 per cent of the government's costs are generated by families earning less than $15,000; 79 per cent earning less than $25,000; and 90 per cent earning less than $35,000. We also know that the family size - we have those figures as well - 49 per cent have a family size of one so those are singles; 37 per cent have a family size of two. When we implemented this program in 2008, those were the people who were the lower income families that we were targeting at the time.

MR. MACKINNON: As follow-up to Mr. MacMaster's questioning earlier, can you perhaps again give us the figures on how much the program cost the province last year and what is the estimate for this year?

MS. PENNY: The program cost $22.61 million in 2010-11 and we are projecting $24.67 million for 2011-12, for the Family Pharmacare Program.

MR. MACKINNON: All right, and from the first year, how much is that up? It's up considerably, isn't it, from the very first year?

MS. PENNY: It's up $2 million from last year, an additional $2 million.

MR. MACKINNON: Is the program working well, in your opinions?

MR. MCNAMARA: In my opinion, the program is working. We'd all like to see it working better but as we work our way through some of the work we're doing in the department to try and get affordability, then we will be able to do enhancements that will make it better for individuals, and I still think we have to concentrate on the lower income ones.

MR. MACKINNON: Thank you very much. I'm willing to share my time. You've done a very good job in answering some of the questions I have. Is there another member who wants to jump in on this round, or wait for the next one?

MR. CHAIRMAN: Mr. Burrill. You have one or two minutes.

MR. MACKINNON: Two, that's all I saved for you. (Laughter)

MR. GARY BURRILL: Thank you so much, Brother MacKinnon. (Laughter) I'm just thinking about this point you were making about the upward pressure on drug prices that comes from the intense marketing effort of the pharmaceuticals, and in particular the pressure towards less than optimally appropriate drug use that comes from the direct pressure exerted on our physician community, through the mega marketing budgets of the larger pharmaceutical companies.

Are we giving any thought or have we ever given any thought to what we might be able to do to restrict or curtail in any way the impact of that direct lobbying effort? This is kind of a gaping hole in the side of our balloon, isn't it?

MR. MCNAMARA: I'll try. We have talked about, are there ways, for example, to ban samples in this province? Some individuals will say samples are a free prescription to some individuals and yes they are to that individual, but usually the samples are ones that have a high market, so we have to think differently. There are different ways to look at how samples can be given out.

The other thing we have to think about samples too, has it expired? How long does it sit in the doctor's office? It's not through a pharmacy. It may have been in the salesman's car in the heat of summer or the cold of winter, which may impact the medication as well, so we're not always positive that it's the best medication that an individual is getting. Sometimes it is. It's a crap-shoot at times. I think we have to be smarter in how we deal with that.

I've talked to the big pharmaceutical companies and they'd like to get out of it as well, but unfortunately if one company gets out of it and the other one doesn't, it's

obviously a market - we have to remember that big pharmacies as well as generic companies are on the stock market and their job is to increase profits; they are big business and we sometimes forget that. They have lots of money to put into marketing and quite honestly I think we as a government do not have the same amount of marketing dollars to be able to combat some of it.

Also, at the same time, I don't want to say it's all bad. There are some very good drugs that come out through marketing and sometimes physicians only become aware, even of the good ones, through the salesmen. We have to handle that one very carefully and we have to do it right.

MR. CHAIRMAN: Order, please. The time has expired for the NDP caucus. We'll go to the Liberal caucus and the time is now 10:13 a.m.

MS. WHALEN: For 14 minutes, right?

MR. CHAIRMAN: That's right.

MS. WHALEN: Thank you, just so everybody knows. I've got a list of questions so I'm going to try and go through them quickly because 14 minutes is not much time. One question I had, and in your briefing note when you started your introductory comments, you referred to the Drug Management Policy Unit that is coming. I don't think it's quite in place yet. I wonder if you can confirm that the CEO from PHARMAC, in New Zealand, has been hired to fill the position as head of Nova Scotia's Drug Policy Management Unit.

MR. MCNAMARA: I can confirm that he has not.

MS. WHALEN: He has not yet been?

MR. MCNAMARA: Has not.

MS. WHALEN: Has not. Okay, are we looking at the PHARMAC model at all for Nova Scotia's Drug Policy Management Unit?

MR. MCNAMARA: There is some information out of the PHARMAC that we are looking at, yes. I doubt that Nova Scotia, or anywhere in Canada, would go to the extreme of the PHARMAC model, but there are some good lessons in it.

MS. WHALEN: Earlier in my questioning I was talking about the difference between plans and I wanted to give an example just to lead into a question and that is that at $47,000 per year - that's the average income in Nova Scotia - if you have a two-income family, both people working at $47,000 with two children, they would pay, to reach their maximum, $25,500 a year, which is 27 per cent of their income. A comparable family in

Manitoba, two people earning $47,000, would pay $5,700. It's about five times as much here. They're paying 6 per cent of their income.

With that as a start, what I wanted to use as an example is, if a person suddenly gets sick and requires this program, chances are they've gone on EI or on disability because they won't be working. I'm thinking more catastrophic, that they've become incapacitated or they have cancer or so on. What I wanted to know was, does this family still have to reach the cap of $25,500 before their cancer drug is covered, if they've had a drop in income as well?

MS. MCPHEE: No, it's based on line 150 from their previous income. However, if any time during the year, from their previous income tax submission, that income changes, then they can call Medavie Blue Cross, whoever is their administrator, and we look at that and readjust their payments.

MS. WHALEN: So if they have gone on EI because they're home sick, they can get an immediate adjustment to the amount they have to pay?

MS. MCPHEE: Absolutely.

MS. WHALEN: I think that's really important. How many of those adjustments has the department had in the last year?

MS. MCPHEE: I don't have those figures with me, but I can get them.

MS. WHALEN: Could we ask for that?

MS. MCPHEE: Absolutely.

MS. WHALEN: That would be great if you would. I'd also like to get a list of the drugs that the deputy minister was saying are 100 per cent covered. I know we started to go through a listing. I think all MLAs would like to know that so we can tell our constituents and be better informed. If I could get both of those things, that would be just great. Again, if you applied for a deductible adjustment, would that be as fast as the original intake? You said seven to ten days on the original intake.

MS. MCPHEE: Yes.

MS. WHALEN: Okay, I just wanted to double-check that. Another question, a little bit different again; when the program was established in 2008, can you confirm that a position paper was produced by health charities and submitted to the department, that recommended that a deductible for the program be paid up front, similar to the program in Saskatchewan?

MS. MCPHEE: I'm not aware of that.

MS. WHALEN: You weren't aware of any sort of suggestion or policy paper that was submitted by health charities at the onset of the program?

MS. MCPHEE: No, I'm not. There may have been but I was not in this position at the time and I don't recall one.

MS. WHALEN: Could I ask that you see if there's such a paper? I'd like to know if there was such a paper, I think it would be interesting as we go forward in looking at possible improvements. So, not aware.

All the other jurisdictions have pretty much got a percentage cap as they go up, although they jump, a couple of them have jumped levels where it jumps up. I'm really wondering why Nova Scotia didn't go with a percentage of their income, a more flat percentage. Maybe it's Mr. McNamara.

MR. MCNAMARA: I can't answer for when the program was introduced but I think what we've been working on as we're moving the program forward is recognizing that we're trying to do best for the lower income side. I think as I mentioned earlier, once we've got our budget in place and we've got a more balanced budget, then we can look at enhancements.

MS. WHALEN: We might expect to see those enhancements start at the lower end, then, following that same principle, but at the moment we have ignored the 3 per cent from the Kirby Report, in terms of it being a good amount of money, a reasonable amount of money.

MR. MCNAMARA: We haven't followed the recommendation of the Kirby Report on that but there are others. I think you have to go back and say what do we do that is better than some of the things that are offered in the Kirby Report or other provinces as well.

MS. WHALEN: Can I ask if you've done any analysis on the types of drugs that are being accessed through the Family Pharmacare Program?

MR. MCNAMARA: What I can tell you is that 12 drugs account for 36 per cent of the total cost of the Family Pharmacare Program and they account for 0.71 per cent of prescriptions filled, so it tells you that individuals who are taking advantage of the higher priced drugs are the ones that are taking more advantage of the program.

MS. WHALEN: Could we get a list of that? Would it be possible for us to see which drugs are being accessed? Again, it gives a window into how the program is working.

Have you looked right now at the generic savings that are coming with the number of drugs coming off patent in the next short while? Some have already begun. Have you been looking at that as a means to improve the Family Pharmacare Program?

MR. MCNAMARA: Definitely.

MS. WHALEN: So that's on the agenda, good. Another question here is, can you confirm whether or not the Barrington Group, or Tom Barrington who is a consultant, has produced a report either for the department or Cancer Care Nova Scotia or the Cancer Systemic Therapy Policy Committee, which recommended changes to the Family Pharmacare Program, based on the ability of those in the program to access oral cancer drugs - specifically relating to oral cancer drugs being prescribed outside of hospital?

MS. MCPHEE: No, he has not, and it's Tom Roberts from the Barrington Consulting Group. Tom Roberts was a consultant who worked with us in developing and implementing the Family Pharmacare Program.

MS. WHALEN: So that report was done - did he do a report at all?

MS. MCPHEE: He did not do a report.

MS. WHALEN: No report, just working with you.

MS. MCPHEE: In implementing the program.

MS. WHALEN: Okay, that's good. So there's no report that can be accessed, that's too bad.

I wanted to go back to the number of families enrolled. I think there was a mistake in our first round of questioning. I believe, Ms. McPhee, you said there were 50,000 - maybe you said 50,000 individuals were currently enrolled, is that right?

MS. MCPHEE: No, 44,000.

MS. WHALEN: When I looked at the briefing note again, it's 50,000 families were your original goal and you are currently at 25,000 families. So that shows clearly that there's 50 per cent of the way towards what we thought we would be adding in 2010, in terms of expectation. So if only 50 per cent of the families that we expected have joined, I wanted to go back again to the awareness efforts, just to see if you have any plans to increase the awareness efforts around this because again, as you've said today in the briefing notes, it says there is no cost to join.

So really, when I read this, I think my daughter, who is 23, should be a member of this plan because even if she has a small plan with Blue Cross, she can protect herself by

joining this now, anybody could, so more of them should be joining is what I'm saying, so any plans to make people more aware of this?

MS. MCPHEE: Again, we're working with the pharmacy community and the physician community in promoting the program.

MS. WHALEN: Okay. Could I ask, maybe Ms. Penny could answer this question for me, I'm wondering what the budget is for the Department of Health and Wellness for media communication ads – maybe it's your whole communications budget? You have staff who are in communications and we know you're running lots of ads on Better Care Sooner.

MS. PENNY: Yes.

MS. WHALEN: Well, Better Care Sooner is a great slogan but here we have a program that people should be involved in now, registering at no cost, and actually, you know, being in a position that if something happens to them and they have to take an expensive drug, they'll be on their way to being in the program and having it covered.

MS. PENNY: I don't actually have that exact number with me.

MS. WHALEN: Could we ask for just the total budget on the communications end of the department? I would like to know the cost for ads because I think we need to be more aggressive on this program because it has such benefits. So that's what I would like to know.

On the complaint side, I just wanted to go back to that. I would like to know if you've had any complaints from health groups, groups that represent, you said not too many from patients, are the health groups that are their representatives giving you suggestions or whatever - I'm thinking of Cancer Care or the Diabetic Association, or MS, any of the groups that might have been speaking out?

MR. MCNAMARA: Obviously, the MS lobby has been on the Liberation treatment.

MS. WHALEN: I'm thinking around Family Pharmacare.

MR. MCNAMARA: Yes, I'm trying to think but none come to mind.

MS. WHALEN: No?

MR. MCNAMARA: No.

MS. WHALEN: This program actually moved a lot of the diabetics into the Family Pharmacare Program, did it not?

MR. MCNAMARA: It did two things. First, it has grandfathered the existing people or they could move into the Family Pharmacare. In some cases it is a better program for individuals who need other drugs because the diabetic one applied only for the diabetic drugs but all new ones have to register to the Family Pharmacare Program.

MS. WHALEN: So some of them have moved over?

MR. MCNAMARA: That's correct.

MS. WHALEN: Have there been any complaints there of people who did not like the program from the diabetic side?

MR. MCNAMARA: I haven't heard any.

MS. WHALEN: That was a concern to me as well. Okay, so we're just not finding those complaints and I think people don't know about the program so they haven't begun to say too much.

I wanted to ask you again about the budgets because I'm always interested in the amounts paid. You indicated how much was spent but could you tell me how much underspent those budgets were because, again, we've established that people haven't signed up to the degree we expected?

MS. PENNY: If we look at the 2010-11 estimate, we had $26.184 million in for the Family Pharmacare Program. Our actual is $22.61 million. So it was underspent by $2 million and, again, it's the difficulty in trying to estimate the number of patients, the price of the drugs, and the number of people.

MS. WHALEN: The first year you were underspent by more. Could you go back to 2009-10, or 2008, actually we have 2008 as well. Do you have 2008?

MS. PENNY: Yes, I have 2008-09 spending was $12.48 million. I don't have the 2008-09 budget but I do remember it was fairly significant and the reason being it was difficult to establish the program and, as Judy had mentioned, to try and determine and guess how many people might enroll. So that's why, as we're proceeding through the fiscal years, we're becoming more and more accurate.

MS. WHALEN: How about 2009-10, just to let us know the actual?

MS. PENNY: The spending was $18.63 million and, again, I don't have the 2008-09, 2009-10 budget numbers with me.

MS. WHALEN: Maybe you could provide that to us because that's a gap that I would like to know, if you could.

MS. PENNY: Sure.

MS. WHALEN: Just to see, because I think again we have an expectation that more people would be involved and that this program would actually be helping more people. Because, I think, we need to go back to what a program is set up to do and whether or not it's effectively reaching the people who need it the most or certainly can make use of it. So would your opinion be that we are hitting the most critically ill people, the ones who really have high drug costs?

MR. MCNAMARA: That would be my sense, based on looking at the higher cost drugs that are being part of it. Also recognizing that there are a number of drugs that we do cover that aren't part of the Family Pharmacare Program, could be some of the high cost cancer drugs, age drugs that I mentioned earlier.

MS. WHALEN: As I say, I was concerned about whether we're hitting them because I think we've budgeted quite a bit more in that first year. You don't have the actual amount but I think I had $7 million underspent.

MR. MCNAMARA: She has found it so we can give you that.

MS. WHALEN: Okay.

MS. PENNY: I found the 2009-10 estimate which was again $26.184 million compared to what we've spent of $18.63 million.

MS. WHALEN: So you kept the same estimate for two years?

MS. PENNY: We did.

MS. WHALEN: And it's inching up but again that's money that was established for that purpose and isn't being accessed. I really would suggest it needs more advertisement and more awareness, perhaps a lot with young people too, who don't know about and aren't thinking about these things, which they should be. Can you tell me when it was first set up what model we chose to follow in terms of - you said we had a made in Nova Scotia version, but was there a model that was closest that help established the parameters for this?

MS. MCPHEE: It is similar, different income bands, but it's more similar to the Manitoba model in that it's a deductable, co-payment model based on income.

MR. CHAIRMAN: The time for the Liberal caucus has elapsed and we will now go to the Progressive Conservative caucus with 14 minutes and the time is 10:27 a.m.

MR. MACMASTER: Thank you Mr. Chairman. When we left off you had mentioned that some of the savings from the program this year were going to come from the retail side of generic drugs, initially, but it sounds like there were going be some other savings, maybe somewhere else.

MR. MCNAMARA: That has to work its way through utilization and will be some of the savings that we work on but it is more futurist than immediate. The immediate savings would be from the cap on generic drugs.

MR. MACMASTER: So then afterwards it is utilization, you mean the amount of prescriptions being filled will decrease.

MR. MCNAMARA: Yes, and looking at the type of drugs that we cover, how we do it, how do we ensure that we get the right effective drug for individuals, how do we deal with physicians on prescribing? I talked about the sampling idea; again it's not going to be one year, that's why we're putting a unit in place to be able to look at those bigger issues and to assist us.

MR. MACMASTER: And you'll be keeping track of that I'm sure, some kind of a measured approach.

MR. MCNAMARA: Definitely.

MR. MACMASTER: Okay. You had mentioned that there were 12 drugs that account for about 36 per cent of the drug costs and I know that a list was requested. May I ask, what are most of those drugs used for? Are there a few conditions that seem to be costing the system a lot?

MS. MCPHEE: The 12 drugs that account for 36 per cent of the government costs are the very expensive drugs, mainly biologic. Remicade, Humira, and Enbrel are all used for various diseases but rheumatoid arthritis is one, Crohn's disease, Ankylosing Spondylitis, so rheumatoid-type diseases. One of the other drugs is Sutent, which is used for renal cell carcinoma or kidney cancer.

MR. MACMASTER: When I think rheumatoid arthritis I think that's something that a lot of people can't really protect themselves against, can they?

MS. MCPHEE: No, that's correct, it's autoimmune.

MR. MACMASTER: So it's hard for us to expect that the cost of those drugs and their usage would decline over time based on say healthier lifestyles in the province.

MS. MCPHEE: Correct.

MR. MACMASTER: Okay. I just thought I would ask that because if it's a significant cost driver it will be interesting to see if we can be doing anything to help with that but it doesn't sound like there is much we can do.

Next question, I'll try to get to the right side of my brain. A lot of my questions have been around numbers. This program has been very helpful for many Nova Scotians. Can you give us a comment on – to me it seems like if somebody had access to the program it would create more stability in their life and maybe improve their confidence to know that they have something looking out for their health and well-being by having a program that can pay for drugs when they need them. Have you heard about any stories where this program has made a real difference in people's lives?

MS. MCPHEE: Yes, certainly, the one that comes to mind was a single mother with two children. She was struggling. One of her children had ADHD so was on medication for the ADHD. She was actually interviewed, I believe, by one of the radio stations a couple of years ago about the difference that this program made in providing medication for her son.

MR. MACMASTER: I believe somebody who would be on community services would have access through those programs but somebody who might have been working and maybe not earning a big paycheque would not have any access to drugs like this, so this program really filled that gap, didn't it?

MS. MCPHEE: Yes, and that was the targeted population when we implemented the program.

MR. MACMASTER: That's good. I have another question, I was thinking about this today. This is a good program and it's filling a gap because obviously there wasn't anything there for those people before. Was there any analysis done to compare the pricing of this program and how it would relate to, say, privately-offered programs, so if somebody wanted to walk in off the street and buy a Blue Cross family medical drug plan, was there any analysis to sort of compare the costs?

MS. MCPHEE: When we were developing or designing a program, one of the concerns in designing a public program is to continue to maintain the private market because often what you'll see is that as soon as there is a publicly-funded program, the private market may pull out. We see that sometimes with drugs that we cover.

There was concern in how this program was developed, that it would preserve that market, so there was a lot of thought put into that in order not to have private insurers pull out.

MR. MACMASTER: I can appreciate that because if there wasn't a lot of thought put into that and we lost that section of the market, everybody would be on the provincial plan and, of course, the cost would be higher and then it's harder to maintain the program for those for whom it was intended. Okay, thank you for that.

I know the pricing varies and you have a calculator on your Web site so that people can go on it and it depends, I guess, the more your family income is, the more you pay for the program. What would you say the range is, from the lowest amount to the highest amount per year that a family would pay? Even if you have a rough estimate because I know that there are variables that will probably affect it in every case.

MS. MCPHEE: We know that it ranges from about 2 per cent to 22 per cent of family income - from the lowest to the highest. In Nova Scotia we've got 2 per cent to about 22 per cent.

MR. MACMASTER: Is there a maximum income amount? Like say, if we looked at the 22 per cent of . . .

MS. MCPHEE: That 22 per cent would be over $80,000 but there's no maximum, you can go, your income can be as high as - I think that's our last income band.

MR. MACMASTER: Okay, thank you. Just for interest sake, if the cost of the program, which we know is about - it is projected to be just over $24 million this year, if we cut the Pharmacare premiums in half, would that ultimately double that $24 million figure? Would that be safe to say or am I generalizing too much?

MS. MCPHEE: With this program there aren't premiums, it is deductibles. It would be very difficult, I think, to estimate that because you don't know what the deductible is because it depends on the drug usage in that particular year for a particular family.

MR. MACMASTER: It's very difficult to estimate.

MS. MCPHEE: It would be, yes.

MR. MACMASTER: So if the deductibles were cut in half, it wouldn't necessarily lead to a doubling but it would lead to an increase.

MS. MCPHEE: It would lead to an increase. It depends on the types of drugs that are being used as well.

MR. MACMASTER: Right, okay. I just have some other questions here. They are just general questions. One of the issues that I heard come up was about insulin pumps for diabetics' use. I know that especially for children, I think the pumps are a lot easier for children to absorb the medications that they need to take. Where does that stand now? If a

person has joined under the Family Pharmacare Program, can they get access to diabetes pumps?

MR. MCNAMARA: No, we do not fund insulin pumps in this province and, again, it's something we've looked at. We know that the program we have in place works. Going to an insulin pump, yes, we know it is convenient for some children and maybe in some cases it makes it a little easier for some of them. At the same time, we have to look at the dollars we have to work with and we know there is an effective system of individuals getting insulin using the existing system.

That's one of the things we have to look at sometimes too - new things come on the market on a regular basis. I think we have to be astute at times and say, okay, we've got an effective program that works, yes, something might be a bit better but if I've got so much money, am I better off using it on something that makes it a bit more convenient for some individuals, or using it for somebody who has got nothing and then trying to do something. For example, being able to change a little bit, we were able to help, for example, in out-of-country travel by being able to move our dollars around. If I had spent it on insulin pumps, I wouldn't be able to do that. So we've got choices and they aren't always easy.

MR. MACMASTER: I respect that and that kind of leads me to my next question. I know that prescriptions can't be filled outside of province and I can see that. I mean you want to have it done inside the province because you have better control over the cost and whatnot. What if there was sort of an emergency kind of situation, is there some discretion within the system to allow for that?

MS. MCPHEE: Yes, there is.

MR. MACMASTER: Okay, and what about for ambulance service? I know there were situations in the past where somebody might be travelling out-of-province and take a heart attack or something, they need to be rushed to the hospital. I know in the past that that wasn't covered - and I think I may be, if I'm veering away from the program, forgive me, because I suppose that wouldn't really be covered under the Family Pharmacare probably, that's something else?

MR. MCNAMARA: That's another program. You can ask me after.

MR. MACMASTER: I'll ask you after, okay. Can you tell us a bit about how this program compares with the Seniors' Pharmacare Program? I noticed by looking at the statement that seniors pay - it looks like about, and this just in average terms - 22 per cent of the cost of the drugs that they pay for and in Pharmacare people pay about 38 per cent of the cost. There's probably a good reason for that, maybe because seniors are on fixed incomes and maybe lower incomes generally, but can you just give us some comment to compare the two programs?

MR. MCNAMARA: I'll ask Judy to respond to that.

MS. MCPHEE: The Seniors' Pharmacare Program is differently structured. It does not have a deductible, it has a premium instead, so if you will, a joining fee, and it has a co-payment maximum. So the most any senior would pay would be $806 per year. So it is structured quite differently where the Family Pharmacare Program does not have a premium or a joining fee, it has a deductible and a co-payment. So once a family meets their deductible, then they just have the co-payment until they meet their co-payment maximum and that is based on income, so it's tiered whereas Family Pharmacare, or Seniors' Pharmacare, is not. So that's the main difference.

MR. MACMASTER: And why was it designed as such, like why were they designed differently? Can you give us just a little background on that?

MS. MCPHEE: The Seniors' Pharmacare has been in existence for many, many years so I don't have the history behind that one. Family Pharmacare, when it was being implemented, needed to be something that the government could afford and still offer some assistance to the population that were most at risk for drug costs and those are the lower income families that did not fit the Community Services model and were not getting Family Pharmacare benefits under Community Services.

[Ms. Diana Whalen resumed the Chair.]

MADAM CHAIRMAN: Your time is just about up.

MR. MACMASTER: It's just about up and I have exhausted my questions for today. So thank you very much for your answers.

MADAM CHAIRMAN: Mr. Whynott.

MR. MAT WHYNOTT: Madam Chairman, I have a few questions I think that haven't been asked yet. I have a question around the work that the province does and the work that the federal government does. I know you talked about the PanCanadian Council, what other sort of initiatives, or are there any other initiatives that provinces do to work with the federal government on drug costs?

MR. MCNAMARA: I'll start and then Judy can add to it. One of the things we have to recognize is what the federal government does, their role is to approve a drug to say is it safe and is it effective. Judy mentioned cost but the federal government does not say that this drug, for example, is - even though we're proving it is effective and there is another drug that is $1,000 cheaper is just as effective, they do not give us that type of advice. That's something we have to do ourselves. Their role is more in the standard setting and making sure that they meet a regulation.

MR. WHYNOTT: Have there been any discussions with the federal government at this time for, say, a national Pharmacare Program?

MR. MCNAMARA: There have been discussions, but it hasn't gone very far.

MR. WHYNOTT: Any sense with the new federal government that something like that would be moving forward?

MR. MCNAMARA: My prediction will be, unless it becomes an agenda item for the federal government, it will not occur.

MR. WHYNOTT: Do you think that you would see that become a discussion that could take place at the negotiations in 2014?

MR. MCNAMARA: One of the things that the minister has committed to in talking to her peer ministers when we meet this Fall is putting that on the table and making that one of the agenda items with the federal government. I was giving you my prediction earlier. Hopefully, we will be more successful in my prediction. I believe that there will be a concerted effort from Ministers of Health and following up on that by the Council of the Federation of Premiers on the same issue at some point.

MR. WHYNOTT: I would assume the idea is that if other provinces all come together then we can move the issue forward? Is that the idea?

MR. MCNAMARA: You have a better chance when everybody is on the same page.

MR. WHYNOTT: Are most provinces on the same page? I would assume it varies depending on the province.

MR. MCNAMARA: It varies on which province and which area, like if you're talking about the Accord, using that, in some provinces the Accord is led by Finance and some provinces led by Intergovernmental Affairs and some by departments trying to do things. It's not a consistent approach across the country so it is hard sometimes to have a consistent agenda moving forward. But we all recognize at the end of the day it probably will end up being a first ministers meeting and so if we can all get it there, it may be something that is considered.

MR. WHYNOTT: I understand the importance of allowing families to be part of the Pharmacare Program, but I also want to ask the question, how important is it to stay within budget to ensure that we can afford the programs that we have?

MR. MCNAMARA: It is extremely important. What we're trying to do is help those who are most vulnerable in a number of ways to any of our programs. We're trying to

see how we can introduce incrementally some new achievements and improvements in health, at the same time trying to watch our dollars. One of the things we do know is that as a province, we have the lowest increase in the country in terms of a Health budget, again, because of the deficit of the past and trying to manage that. We're also trying to position ourselves so that we can become a sound foundation to move forward. At the same time we're trying to build on what we can do that we can do in a different way that maybe costs little or nothing.

A good example would be that we have introduced province-wide the ability for the clot buster drug to be available in ambulances, the only province to do so. Other than a bit of training, it did not cost one extra cent because when a patient arrived at an ER, they were still given it, we just do it in a different way. We're looking at ideas like that that we can try and make things more effective. I think there are a number of things we could do by being smarter in the interim until we try and get our ship in place.

MR. WHYNOTT: I think that's an important thing. I know when I was out knocking on doors on Thursday, a constituent said to me, we just need to do things smarter. I think that takes leadership so I thank you for that.

Earlier you mentioned that 300 new drugs or generic drugs were added to the formulary. Can you talk about some of the kind of drugs that the ordinary Jane Smith might know about that would benefit a family who is on the Family Pharmacare Program?

MS. MCPHEE: Yes, certainly the biggest one would be Lipitor, a drug use for cholesterol, it is our number one drug, in terms of being prescribed and in dollars. It went generic so Atorvastatin is the chemical name or the generic name, so there are now eight different companies that are making or marketing Lipitor and the price has gone down to 35 per cent of brand, so there's a huge saving there.

MR. WHYNOTT: So how many people - you said it is the most-used drug, how many people would use it? I'm talking about on the Pharmacare?

MS. MCPHEE: On the Family Pharmacare Program, I don't know what the split is between the Family Pharmacare Program and seniors'.

MR. WHYNOTT: Or I guess the overall drug plan.

MS. MCPHEE: There would probably be about 40,000 people.

MR. WHYNOTT: So how much of a savings is that for the province, because of that one drug?

MS. MCPHEE: That one drug, it was about $7 million.

MR. WHYNOTT: And was that reflected in the estimated budget for 2011-12?

MS. MCPHEE: Yes.

MR. WHYNOTT: How many prescriptions were given out under the program?

MS. MCPHEE: Under the Family Pharmacare Program? I believe almost half a million, 461,266.

MR. WHYNOTT: And what about all programs?

MS. MCPHEE: All programs, just about 5.2 million prescriptions.

MR. WHYNOTT: I guess I want to talk a little bit about the Fair Drug Pricing Act quickly. Will you put the savings from the Act into improving the Family Pharmacare Program?

MR. MCNAMARA: The initial savings will go into - I mean our overall budget targets that I talked about being the lowest in the country, so we, in due course with some of those and as we get additional savings, they will have an opportunity to be able to put in improvements.

MR. WHYNOTT: Any indication of how much savings that will have for the province?

MR. MCNAMARA: We predicted for this year around $6 million.

MR. WHYNOTT: Okay, so you said $7 million for Lipitor alone . . .

MR. MCNAMARA: That was last year.

MR. WHYNOTT: So is that $13 million that we've saved because of the actions of the government?

MR. MCNAMARA: I'd say that's correct, yes.

MR. WHYNOTT: I mean that's significant savings for an overall budget that it - what was the budget number again?

MS. PENNY: All the programs $258 million.

MR. MCNAMARA: And as we go through utilization and other things, we will have some other opportunities as we work our way through. It's difficult sometimes working our way through some of those drugs. I mean a good example is Avastin and

whether it can be used in place of Lucentis and there's good evidence now saying it should be and it's a lot cheaper and there's a recent study that came out showing that. We still have to work our way through those things to be able to make sure that individuals can take advantage of it.

MR. WHYNOTT: That's a significant saving, so how important is that?

MR. MCNAMARA: Extremely important. If you look at - how much is Lucentis?

MS. MCPHEE: Lucentis, the way that we're providing it, was about $1,100 and Avastin about $11.25.

MR. MCNAMARA: The difficulty is that all the signs by the drug company itself, who has the same parent company, hasn't done the research on the Avastin although others have. In Nova Scotia we were one of the two provinces that approved Avastin as an off-label drug to be able to give advantage to any individuals, so this is something we'll work on.

MR. WHYNOTT: I think previous members talked about doing another round of advertising or potential communications with seniors. Is that in the books or is it in the plan?

MR. MCNAMARA: We've heard the comments and so what we have to do is go back and work through and say is there something that we can do within existing media, within our existing budgets, are there things, for example making sure that all MLAs have access to the information? Making sure that we repeat the information, whether our physicians and pharmacists - which is a quicker way of getter information out. We take these comments to heed and we'll see what we can do.

MR. WHYNOTT: I know in particular, it's just an idea I had, not necessarily Family Pharmacare but Seniors' Pharmacare would be the, we have senior housing in the province and some are subsidized by the federal government for rent. That would be a really great opportunity to get with those folks, to get in touch with them, to move forward. It would be a good positive step for those folks.

MS. MCPHEE: Just to mention that all seniors on their 65th birthday do get a mailed package.

MR. WHYNOTT: Great. What's the estimated percentage of growth expected for Pharmacare over the next few years for the budget?

MR. MCNAMARA: Four per cent.

MR. WHYNOTT: So how important is that to stay with that? Because I understand that it's been 9 per cent, is that what I read, over the last number of years?

MR. MCNAMARA: It's extremely important to stay within if we're going to be able to afford to continue doing the programs we're doing. First we have to be able to afford what we're doing and then try and see how we can add some new things.

MR. WHYNOTT: What sort of pressures would increase the value? Why would you have a four per cent increase or a nine per cent increase?

MR. MCNAMARA: Well, there could be a new drug tomorrow that's out there that's marketed. It could be a new procedure that comes on the market that we're expected to - there are things that we have to seriously address when they arrive that impact the life and safety of individuals, so there are some things that are appropriate to do so we have to work our way through. So our cost drivers are the number of prescriptions that are given, so that's one of the things we might be able control to working to our new unit.

For example, we know there are a fair number of prescriptions that people get that are in their medicine cabinets and are used so how do we help people change that and go onto a new drug. I know there has been talk about if there are ways of being able to reuse drugs that are not used appropriately which I wish there was a safe way to do it because there are a lot drugs that would be a big advantage to people if we could figure out a way to guarantee the safety of those drugs in a different way.

MR. WHYNOTT: I want to use an example of - let's say you had a family of four and their annual income was $13,000 per year and say they're being treated for high blood pressure. What sort of a saving would that give to that family?

MS. MCPHEE: A family of four with an income of about $13,000 per year - I think the deductible and co-payment for that family would be somewhere around $200.

MR. WHYNOTT: So they'd be saving a thousand.

MS. MCPHEE: About a thousand.

MR. WHYNOTT: Before that program was in place people were paying out of pocket.

MS. MCPHEE: They would have paid out of pocket without any insurance.

MR. WHYNOTT: I know that when we were in Opposition, we certainly supported the idea of this Family Pharmacare being put into place. Again, it's a positive step forward, people are saving money from it. One more example is a family of four with an income of $81,000 per year - say Crohn's disease with drug costs of $30,000 per year? The deductible

and co-payment for the families is $17,870 so the family is really saving almost $12,000. Again, they would be paying out of pocket if this program wasn't in place.

MS. MCPHEE: That's correct, they have high drug costs.

MR. WHYNOTT: It is a positive thing and I appreciate the opportunity to have you come forward today and have questions answered for all of us. So thank you very much.

MADAM CHAIRMAN: Thank you very much and we're right on time Mr. Whynott, exactly. I'd like to leave a couple of minutes for any closing comments that you might have, Mr. McNamara.

MR. MCNAMARA: Just to thank the committee very much for the opportunity to present and I think the department is interested in always improving and as we work our way through our financial situation, hopefully we can do more benefits to Nova Scotia. Again, our first emphasis will be on the lower income and then moving to others as we can. Thank you very much.

MADAM CHAIRMAN: Thank you very much and it is, you know, still a very new program. We're looking forward to seeing where it goes in the future and we appreciate the chance to learn more about it today.

There were a number of requests for information and I know our clerk has a list of that and perhaps you took some notes as well, but she'll be in touch with you to let you know. That really is all we have there except one piece of committee business and there is a memo that's here from Mrs. Henry. Are you going to circulate it now?

MRS. DARLENE HENRY (Legislative Committee Clerk): Yes.

MADAM CHAIRMAN: Yes, she'll just circulate it now. It's about the upcoming conference, the CCPAC and CCOLA Conference. Again, it's a conference for members of the Public Accounts Committees and I would say for Nova Scotia, other interested MLAs, because I know we have a few substitutes today. This conference is held annually across the country in different capitals.

It's our turn this year in Halifax and we really are urging the members of our committee, and any others who would like to sign up of our MLAs, to come because it's the only committee that has a conference. Of all the other committees that we have at our Legislature, this is the only committee that is in place in every province that does hold a conference annually to talk about accountability and our role as Public Accounts Committee members. So I'm really hoping that you'll have a look at that and move forward with it and, hopefully, sign up. That's what we need, is participation.

So I'll have a motion to adjourn.

MR. WHYNOTT: So moved.

MADAM CHAIRMAN: Thank you, I appreciate it, see you next week.

We stand adjourned.

[The committee adjourned at 10:56 a.m.]