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Thursday 29 April 2010

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Jeudi 29 avril 2010

Standing Committee on Finance and Economic Affairs

Creating the Foundation for Jobs and Growth Act, 2010

Comité permanent des finances et des affaires économiques

Loi de 2010 posant les fondations de l'emploi et de la croissance

Chair: Pat Hoy
Clerk: William Short

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

Thursday 29 April 2010

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Jeudi 29 avril 2010

The committee met at 0902 in room 151.

SUBCOMMITTEE REPORT

The Chair (Mr. Pat Hoy): The Standing Committee on Finance and Economic Affairs will now come to order.

Our first order of business would be to have the subcommittee report read. Ms. Albanese.

Mrs. Laura Albanese: Your subcommittee met on Thursday, April 22, 2010, to consider the method of proceeding on Bill 16, An Act to implement 2010 Budget measures and to enact, amend or repeal various Acts, and recommends the following:

(1) That, pursuant to the order of the House dated April 21, 2010, the committee hold public hearings in Toronto on Thursday, April 29, 2010.

(2) That the committee clerk, in consultation with the Chair, post information regarding public hearings on Canada NewsWire, the Ontario parliamentary channel and the committee's website.

(3) That interested parties who wish to be considered to make an oral presentation contact the committee clerk by 5 p.m. on Tuesday, April 27, 2010.

(4) That the committee clerk be directed to commence scheduling witnesses on a first come, first served basis.

(5) That, if necessary, the members of the subcommittee prioritize the list of requests to appear that have not been scheduled by the deadline of 5 p.m. on Tuesday, April 27, 2010, and return their prioritized lists to the committee clerk by 12 noon on Wednesday, April 28, 2010.

(6) That witnesses be offered 10 minutes for their presentation, and that witnesses be scheduled in 15-minute intervals to allow for questions from committee members.

(7) That the deadline for written submissions be 5 p.m. on Thursday, April 29, 2010.

(8) That the research officer provide a summary of presentations by 12 noon on Monday, May 3, 2010.

(9) That, pursuant to the order of the House dated April 21, 2010, amendments to the bill be filed with the clerk of the committee by 12 noon on Tuesday, May 4, 2010.

(10) That, pursuant to the order of the House dated April 21, 2010, the committee meet on Thursday, May 6, 2010, for clause-by-clause consideration of the bill.

(11) That the committee clerk, in consultation with the Chair, be authorized prior to the adoption of the report of the subcommittee to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Pat Hoy): There we have our subcommittee report. All in favour?

Mr. Norm Miller: Comments, please?

The Chair (Mr. Pat Hoy): Yes.

Mr. Norm Miller: I'd just like to get on the record that there wasn't that much for the subcommittee to decide because of the draconian time allocation put forward by the government, which limits public hearings on this budget bill to one day, today, even though it's a substantial budget bill with 31 separate schedules—the one schedule, in particular, which affects the pharmacists in this province. So even though there's been very limited advertising because we only had days to make people aware of it, we do have a full slate of presenters here today, many of which I see are pharmacies or pharmacists.

But I would certainly like to get on record that I don't think this is the way we should be handling a major, significant budget bill, that we're really not allowing any time at all for those people who might be interested in that one schedule, but also the other 30 schedules, to even be aware that this process is going on. Thank you.

The Chair (Mr. Pat Hoy): Thank you. Any other comment? Hearing none, all in favour of the subcommittee report? Carried. Very good.

Our first presenter of the day has cancelled, so we will recess until 9:15 or when some other presenter would arrive.

The committee recessed from 0906 to 0915.

CREATING THE FOUNDATION FOR JOBS AND GROWTH ACT, 2010

LOI DE 2010 POSANT LES FONDATIONS DE L'EMPLOI ET DE LA CROISSANCE

Consideration of Bill 16, An Act to implement 2010 Budget measures and to enact or amend various Acts / Projet de loi 16, Loi mettant en oeuvre certaines mesures énoncées dans le Budget de 2010 et édictant ou modifiant diverses lois.

HAWTHORNE PHARMACY

The Chair (Mr. Pat Hoy): The committee will now come to order again. We have Hawthorne Pharmacy. We appreciate you coming in early so that we can begin. You have up to 10 minutes for your presentation. There could be up to five minutes of questioning following that. I would ask you to identify yourself for our recording, and then you can begin.

Mr. Faisal Khawaja: Thank you, Mr. Chairman. Good morning. My name is Faisal Khawaja, and I'm a community pharmacist. I am grateful for the opportunity to address this committee this morning.

For many years, early in my career, I worked as a palliative care pharmacist, advising family doctors, specialists, nurses and caregivers on how to best use medications for pain and symptom management in end-of-life care, a competency I maintain to this day.

I'm certified in diabetes, asthma and hypertension disease state management, and I have 15 years of experience in specialty compounding. For the past nine years, I have worked as an independent pharmacy practitioner and, recently, have delved further into the field of substance abuse and recovery, an interest I've held since university. And that is just an excerpt.

If you think my qualifications are unusual, then you don't understand what it is that pharmacists know and do for their patients every day and why the people of this province are ready to revolt against these funding cuts.

Four years ago, during the many oral presentations on Bill 102, I stood before a similar committee, with some of the same faces perhaps present at the table, and I explained, or so I thought, very clearly that the massive funding cuts being proposed at that time were putting patient care and Ontarians' lives at risk. You acknowledged that fact, or so it seemed, and although Ontario's pharmacies still ended up suffering cuts of a staggering $600 million per year, we were still allowed a small measure of ability to keep our doors open.

In particular, the McGuinty government acknowledged that, like similar legislation in the US, it could only justify the regulation of prices and practices for prescriptions that it paid for and left private prescriptions alone. But within these walls, it seems memory is exceedingly short. Here I am again, four years later, in front of another committee, facing not just more cuts but a complete and utter amputation of the health care infrastructure that allows pharmacists to provide Ontarians with safe, effective drug treatment and comprehensive health care.

Forgive me, but I'm sick and tired of hearing that our health care system is broken. It may not be perfect, but it is definitely not broken—at least not as far as pharmacist care is concerned. Even with all of the negative rhetoric from the government in the past few months, I have not heard a single MPP or a member of the public claim that the people of this province receive anything less than world-class health care from their pharmacists. That fact is undisputed.

Ontarians enjoy a level of pharmacist care that is more accessible, more in-depth and more comprehensive than at any time in our history. This care is delivered by pharmacists who are better trained, better equipped and more directly involved in achieving health outcomes for patients than ever before. In fact, Ontario's pharmacies do such a great job of delivering lean, efficient health care that this government seeks to leverage our expertise and our numbers in the future by expanding our scope of practice to include ordering lab work, renewing prescriptions, administering injections etc.

As an aside, the government has talked about $100 million in new funding for these expanded services, and that's great. More work deserves more funding, but those services are many years and many amendments to other pieces of legislation away. So let's agree right now to stop pretending that that funding announcement for those extra services has anything at all to do with these cuts. Okay?

The current system also ensures our society secure, reliable distribution of thousands of medications that have the power not just to save lives, but also the power, except for the constant vigilance of Ontario's hard-working pharmacists, to cause great harm, even death. How can you, as MPPs, be so cavalier about the lives of the people you have been elected by, and who we, as pharmacists, have sworn to protect? If you want to see a broken system, visit one where pharmacists have no role in patient care, are inaccessible or non-existent. That's where we are headed with the proposed cuts.

0920

Forgive my chastising tone, but I cannot help but feel that it is warranted when a government, which cannot possibly deny knowledge of an issue so critical to the lives of Ontarians, feigns ignorance.

Yasir Naqvi, MPP for Ottawa Centre, stood up in this Legislature last week and said that he had been—and I quote—"talking to them"—pharmacists—"for some time about this particular issue and I've asked this question again and again of them: 'Please explain to me why prices for drugs are so high in the province of Ontario.' And there is no reasonable explanation for it."

So, for the benefit of Mr. Naqvi, and anyone else who is new to this committee, this province or this planet, permit me to enlighten you with a brief history lesson.

In a nutshell, the Ontario government pays for prescriptions for seniors, low-income families, people with disabilities and those in nursing homes. Over the last 20 years, the government has raised the prescription fee that it pays to pharmacies by just 56 cents. It now stands at $7. Over those same 20 years, the average cost—our cost to provide this medication—has risen to about $14, which is double what we actually receive. This massive funding gap means that pharmacies would lose money on every prescription we dispensed. Professional allowances, set into law by this government in 2006, bridge that gap. So, private funding has paid for what is, in fact, a public responsibility. Maybe, just maybe, that's one possible reason why we have higher generic prices. Now,

raise your hands if you didn't understand that. That took me all of 15 seconds.

Actually, allowances were a pretty good deal for the government, when you think about it. No wonder they gave their tacit approval for years and even enacted them into law in 2006. Now, in a turn of—pardon me—shameless duplicity, mendacity, greed, desperation or, at the very least, utter ignorance, they claim to know of "no reasonable explanation for it."

What's worse, they seek to punish those who, in safeguarding public health, seek only fair compensation that addresses their costs and the risks associated with running a retail health care practice. This should be a cause for shame and remorse on the part of the government. Instead, they choose to demonize pharmacists and attempt to smear our image in the media.

Pharmacists are committed to making our funding system more straightforward and transparent. We support lowering drug prices, branded and generic, and we support the replacement of professional allowances with a model that more directly pays us for the myriad of services we provide every day.

Amazingly, we've even agreed to change how much we are paid. Our coalition's final proposal would have saved the government $260 million in the first year alone and $1.3 billion over three years. This is on top of the $600 million annually taken out since 2006. I can tell you that even our own proposal has some pharmacies wondering how they will survive. Not everyone is happy about it.

Remember, we've acknowledged that pharmacies run pretty lean already. We did our share in social contract, we did our share when we became user-fee tax collectors for the government in 1995, and we did our share in 2006. Pharmacists are committed to the sustainability of our health care budgets, as we always have been.

Our coalition negotiating committee never left the bargaining table. The government folded the table up and closed the door. By the way, the Ontario Pharmacists' Association is not our negotiating body in this matter, as Minister Matthews would have the public believe, and a fact that she knows full well.

We have agreed to straightforwardness and transparency, even if the government cannot or will not. All that remains is for the government to do the right thing for Ontarians and for those of us who serve them.

Ladies and gentlemen, pharmacists are health care providers. Pharmacists are stewards of the controlled distribution of powerful prescription medicines. Patients live or die by the vigilance of their pharmacist. Ontario's pharmacists provide a level of patient care that is second to none in the world.

Combined with the fact that there are countries where the price of generic drugs is actually even higher than Ontario, for example, Switzerland and France, we can conclude that Ontario's taxpayers receive excellent value for their money from pharmacists today. However, our ability to continue to provide that vigilance is directly threatened by the cuts currently proposed by the government.

Could we be doing even more to enhance the health of our patients and save taxpayers even more money? Yes, and we have the training and the expertise. But those few pharmacies that survive these proposed cuts will not have the time, will not have the resources and will not have the energy to provide any kind of expanded services because they'll be too busy, heads down, trying to fill enough prescriptions to keep the doors open and the lights on.

The Chair (Mr. Pat Hoy): You have about a minute left.

Mr. Faisal Khawaja: Thank you. I will conclude.

The infrastructure will simply not be there.

In closing, I will leave you with this thought. Last week, I sat in the gallery here at Queen's Park and I listened to the Minister of Health lament the fact that Ontarians are still dying on organ and tissue transplant waiting lists because of the lack of donors. She called on her fellow MPPs to sign their donor cards and to help get the word out about the need to sign your donor card.

If Minister Matthews chose to respect pharmacists instead of attacking us, to leverage our unparalleled accessibility instead of criticizing our numbers, to truly partner with us, I'm willing to bet that, together, we could lick that problem in a heartbeat. So consider our invitation extended. End the rhetoric and let's get to work on a solution that works for both sides. That's what Ontarians want. Just imagine Ontario's pharmacies as 3,000 immunization centres, 3,000 pandemic rapid-response sites, 3,000 health promotion clinics. That's how Ontarians see us, not just as so many Tim Hortons. Thank you.

The Chair (Mr. Pat Hoy): And thank you. The questioning in this round will go to the official opposition. Mr. Miller.

Mr. Norm Miller: Thank you, Faisal, for your presentation. I know Toby has a question as well, so I would like to get a couple in first.

Mr. Faisal Khawaja: Sure.

Mr. Norm Miller: First of all, what will these cuts mean to the health care services you provide for your clients?

Mr. Faisal Khawaja: First of all, the cuts are so deep that essentially they will remove the equivalent of two pharmacists from my pharmacy. I only employ two pharmacists, myself and another. There will be no one left to provide patient service at all in my store, and a pharmacy cannot open, cannot operate, without a pharmacist present. So what it means for patients is that they cannot have access to the pharmacist of their choice and, inevitably, across the whole of this province, patient care will suffer.

Mr. Norm Miller: Secondly—and thank you for that answer—as you explained, there's kind of this wonky system that we have in Ontario where you're not paid the actual cost of dispensing with the fees for drugs on the Ontario drug benefit plan. You say you are willing to work with the government. You were working with the government. You support lower drug prices. What kinds of things were you suggesting, and why is the government not willing to work with you?

Mr. Faisal Khawaja: Well, our coalition had presented, over the course of nine months of research, third

party validated information. We had developed and presented three separate proposals to the government that would have saved about $1.3 billion over three years. Those strategies were all outlined within those proposals. The government has those proposals in hand.

So, like I said, we're committed to lowering generic drug prices; we're committed to the elimination of professional allowances. Pharmacists' professional services that are provided today—not an expanded scope of practice for the future, but the professional services that we provide today—need to continue to be funded. I am the last line of defence for a patient who's receiving medication influences from their family doctor, their specialist, a walk-in clinic, emergency or infomercials on TV to make sure that whatever they are taking does not harm them or kill them.

Those are the types of professional services that we would like to ensure continue to be accessible for the people of this province, and those must be funded.

Mr. Norm Miller: Thank you, and I'll pass it on to Toby.

Mr. Toby Barrett: Thank you, Faisal. I don't know whether you can address this. The government has claimed it will be providing a larger dispensing fee for rural and remote pharmacies to help cushion the blow, but they haven't defined what "rural" is. We know with respect to physician recruitment that the Ministry of Health has changed the rules and many areas are no longer officially defined as "rural." Any discussion of that with your colleagues?

Mr. Faisal Khawaja: I'm not aware of how the government is going to decide or determine what the rules will be for designation of a rural pharmacy, but I think that's a bit of a red herring, frankly. The number of pharmacies that could potentially be designated is probably not more than 200 or 300. That leaves 2,700-plus pharmacies in the lurch which represent the large bulk of the patients of this province who are going to suffer. Even if the government were to increase it by $4 for those rural pharmacies, it will still fall below what the cost of dispensing is in this province.

Mr. Toby Barrett: Okay. Thank you very much.

The Chair (Mr. Pat Hoy): And thank you for your presentation.

0930

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Pat Hoy): Now I call on the Registered Nurses' Association of Ontario to come forward, please. Good morning. You have 10 minutes for your presentation. There could be up to five minutes of questioning following that. I would ask you to identify yourselves for our recording Hansard.

Ms. Doris Grinspun: Thank you very much. Good morning, everyone. My name is Doris Grinspun, and I'm the executive director of the Registered Nurses' Association of Ontario, RNAO. With me today is Rob Milling, our director of health and medicine policy.

RNAO is the professional association for registered nurses who practise in all roles and sectors of the province. Today, we represent over 30,000 registered nurses. Our mandate is to advocate for healthy public policy and for the role of registered nurses in enhancing the health of Ontarians.

We appreciate the opportunity to present to you today on Bill 16.

Registered nurses know there are certain things that shape our ability to be healthy: where we are born, how we are raised, opportunities for education and work. Our environment is also a crucial factor.

We learned recently, for example, that almost 250 people die each year as a result of coal-fired electricity generation. Although Ontario has committed to ending its reliance on coal by 2014, we know that closing these plants now, instead of four years down the road, would save 1,000 lives, in addition to the over 100,000 illnesses, such as asthma attacks, that people will suffer while waiting for the phase-out.

We also know that addressing poverty so that every Ontarian has access to adequate amounts of healthy food and access to affordable housing will allow people to achieve their full potential.

RNAO welcomed the 1% increase to social assistance rates announced in the 2010 budget. However, we all know that it does not reflect the real cost of living in Ontario. In fact, by the time the increase is implemented late next fall, only $6 will be added to the pockets of people on assistance. That's nothing.

Just the other day, I attended a public health summit, together with the agency for public health, and listened to the eloquent words of Michael Creek. He belongs to a group called Voices from the Street. Michael and others talk openly about their shared experiences of what it's like to live in hunger, to experience the shame, humiliation and anger of not having enough and trying desperately to make ends meet. Commitment to a poverty reduction strategy must mean, in addition to words and a plan, multi-year sustainable funding so that all Ontarians can achieve their full potential with dignity.

That's why Ontario's registered nurses urge the government to transform Ontario's social assistance system from a punitive system of complicated and contradictory rules and regulations into one that is focused on people and families and that treats them with respect. This includes raising rates significantly so that they are based on actual local living costs for food and shelter.

We're asking you to introduce a $100-per-month healthy food supplement as a step towards addressing the gap between dangerously low social assistance rates and nutritional requirements.

And with respect to the recently announced changes to the special diet allowance program, we ask that the government make sure that access to healthy food is maintained by retaining at least the current budget allocation of $250 million and by not restricting these funds

only to complex medical illnesses. Pregnant women who live in poverty also need a healthy diet to sustain themselves and their soon-to-be baby, and if we don't do that, we will pay in other ways later on as a society. Not only will they and their kids pay, but we will pay in financial terms too.

Ontario's registered nurses are also committed to strengthening our publicly financed, not-for-profit health care system as the most efficient, effective and equitable way to allocate health care services based on need rather than market forces that reward greed.

Our platform, Creating Vibrant Communities, highlights the evidence of not-for-profit health care, proving this approach delivers higher quality and lower cost than other alternatives while at the same time improving continuity of care and caregiver, standards for long-term care and access to home care, mental health and addiction services.

The 2010 budget's affirmation of the government's commitment to open all of the 25 additional nurse-practitioner-led clinics will help thousands of people who are currently having difficulty getting access to primary care. Most importantly, though, these clinics must not only be announcements. To serve the public, they must be open now.

As the province begins to emerge from the recession, we look forward to government efforts to fast-track funding and implementation of the promised 9,000 additional full-time nursing positions. RNAO is becoming increasingly concerned with experiences shared by RNs across the province about fewer employment opportunities. We are now, and for the first time in many years, sounding the alarm bell and saying to government and employers: We must not return to the 1990s. We cannot return to the 1990s. Open the doors wide and fully so that RNs, including all our new graduates, remain in Ontario. This is necessary if we are to ensure patients receive the quality care they need and deserve. In fact, replacing RNs with less qualified care providers is foolish and irresponsible for patients.

RNAO is very pleased with the budget's commitment to review the Public Hospitals Act to tap the expertise of all health care professionals and community partners. This includes moving swiftly to authorize nurse practitioners to admit, treat and discharge patients in in-patient units. This will facilitate the decrease of wait times and facilitate patients' flow through the system.

We also welcome promised legislation that will make health care providers and executives more accountable for improving patient care. We ask that the same wisdom be applied to changing organizational structures such as medical advisory committees, MACs, for more inclusive and interdisciplinary ones such as the interprofessional advisory committees, IPACs, proposed by RNAO following the murder of our colleague Lori Dupont.

In the limited time we have, I would like to focus the rest of our remarks on how we can work together to strengthen our health care system. Let me start with a statement for our colleagues, the pharmacists. We support pharmacists in this province. In fact, RNAO has supported their expanded scope of practice from the beginning when they asked until it was proposed by the government.

RNAO welcomes proposed changes to Ontario's drug system that would facilitate lower prices for generic drugs, increase supports for pharmacies in rural and underserviced areas, and support the expansion of clinical services provided by pharmacists.

In 2009, spending on drugs accounted for 16.4%, or $30 billion, of health care expenditures in Canada. Health care spending on drugs nationally has almost doubled over the last 30 years and now makes up the second-largest share of health spending. Among the OECD countries, Canada has the second-highest level of total drug expenditures per capita, after the United States, which is not a good example either.

Banning professional allowances or product placement bonuses paid to pharmacies by generic manufacturers could save the health care system $500 million annually. Ontario pays higher generic drug prices than most industrialized countries. For example, a benchmark of generic drug prices based on the top 18 Ministry of Health drugs showed that the United States paid 25% less than Canada while Spain paid 53% less and the UK 77% less. Removing these professional allowances and ensuring that prices for generic drugs sold in Canada are not significantly higher than they are in other industrialized countries will increase accountability and allow resources to be allocated to other health care needs which are urgent.

The Chair (Mr. Pat Hoy): You have about a minute left.

Ms. Doris Grinspun: While these changes to generic drugs are welcome and in the right direction, we believe that similar bold leadership must also be taken to deal with brand name pharmaceuticals. Big Pharma accounts for about 73% of the roughly $4 billion spent annually on Ontario's drugs. We believe that Ontario needs to and can provide national leadership to move this next step forward in the country.

0940

The Chair (Mr. Pat Hoy): Thank you for the presentation. This round of questioning will go to the NDP. Mr. Tabuns.

Mr. Peter Tabuns: Doris, thanks very much for coming this morning. The first thing I want to ask you about is the health care impact of eliminating the special diet, and inadequate food for people on welfare. Could you talk about what your members see coming out of this?

Ms. Doris Grinspun: Yes. Let me tell you first that I had a lengthy conversation—twice, in fact—with Minister Deb Matthews. We are not accepting yet that it will be eliminated. We understand, first of all, that those that are currently receiving the allowance will not be affected until there is a new program.

We are urging the minister to actually not cut that funding, not by a penny. If anything, we need to increase that funding. It is basically dealing with an upstream

approach to social determinants of health, or a downstream approach of paying later on in illnesses or, in the case of pregnant women who don't have the means for proper nutrition, in the education system and in other types of systems, and I don't even want to go there.

It is foolish, and we need to ensure that that funding remains intact if nothing else, or increases, and provides the right supports.

Mr. Peter Tabuns: One of the questions or issues you raise here is about hiring of nurses and ensuring that we have a proper level of nursing staffing in this province. We've been raising questions in the Legislature about the loss of nurses. We've been told by the Minister of Health that in fact the nurses are just moving on to community care. Is that what you see?

Ms. Doris Grinspun: The statistics are statistics that we had from a year ago, right? Statistics are always lagging a year, and the statistics don't show a decrease in nursing at this point. But the reason we are raising the alarm bell today, for the first time, is because we are hearing across this province many nurses sharing their experiences that they are either losing their jobs or being moved and not finding other jobs.

What we need to understand is that while we support health system transformation, hospitals will become more acute than ever. Some hospitals are replacing RNs by less-educated and less-prepared people, which is again foolish, based on the evidence and based on the requirements of patients with higher complexity of needs and even shorter lengths of stays.

So we are saying, "Watch it." We cannot go back to the mid- to late 1990s and the hula-hoop era, because we will never be able to recover again.

Mr. Peter Tabuns: One of the things that you talk about is making sure that nurses can graduate and go into employment positions rather than having to leave the province. Are you seeing a loss of nurses out of province now?

Ms. Doris Grinspun: This government needs to be congratulated that, in the midst of the recession, and now, as we are beginning to come out of the recession, it decided, with our advice, to retain the new-graduate guarantee funding and to continue the HealthForceOntario program. The issue is that the government now needs to also pick up the bold leadership on its discourse to employers: that they ought to retain the nurses they have—this is not about replacing them, because we can't afford that in terms of hours of patient care—and integrate the new graduates.

It is our estimate that once the recession is over, many RNs—and RPNs, but RNs mainly—who have put their plans on hold for retirement because of the situation in their family will retire. And unless we do everything to keep as many here as possible and integrate the new graduates, we will be in a terrible situation where we have invested in education but the people will have gone to the US. That's what happened in the late 1990s, as you remember.

The move to retain the new-grad guarantee was the perfect move. Now we need to again ensure that employers are directed, if need be—I mean, in the time of George Smitherman, employers were directed—to retain as many nurses in this province and to speed up the increase of registered nurses. The replacement of RNs with other, lesser-educated personnel or with unregulated workers is happening in certain facilities across this province. It's not as bad as it was in the mid- to late 1990s, but it brings us the shivers that that period brought, and we need to stop it in its tracks.

The Chair (Mr. Pat Hoy): Thank you for your presentation.

McKESSON CANADA

The Chair (Mr. Pat Hoy): Now I'd ask McKesson Canada to come forward, please. Good morning, gentlemen. You have 10 minutes for your presentation. There could be up to five minutes of questioning following that. I would just ask you to identify yourselves for our recording, and you can begin.

Mr. Jeff Faria: Good morning, Mr. Chair and members of the committee. My name is Jeff Faria. I am the vice-president and general manager for Ontario of McKesson Canada. With me is Anthony Leong, our director of government relations.

Not many people have heard of McKesson Canada, but we are the leading provider of logistics within the Canadian health care marketplace. McKesson Canada's Ontario operations offer same-day and next-day delivery of 35,000 products from 800 manufacturers to 2,600 pharmacies and 270 health care institutions. Our geographical coverage includes 400 pharmacies in the most remote areas of the province, ensuring that patients receive their prescribed therapy in a timely manner no matter where they live.

In Ontario last year, our company provided logistics for over $3 billion worth of pharmaceutical products. In Ontario, we operate five distribution centres, which provide employment for 900 local residents directly and another 300 indirectly.

Mr. Chair, I would like to also point out that one of our distribution centres is located in your home riding of Chatham–Kent–Essex and we have 71 employees at that facility. We invite you to visit our facility and meet our families.

Patients do not see us or even know about us, but we play a vital role in making drug access and distribution possible. If a patient is prescribed a drug that their local pharmacy does not have in stock or normally does not carry, the pharmacy can go online or pick up the phone and order it from McKesson Canada. Whether the order is for a single bottle of a $5 medication or multiple medications valued in the thousands, the pharmacy will receive it either the same day or the next day.

We support the Ontario government's mandate to improve the value and accountability of the Ontario drug system. We have watched the work of the Ministry of Health and Long-Term Care and have provided input wherever possible into that process. Unfortunately, our company and, indeed, our industry would suffer great

collateral damage, however unintentionally, by the contents of Bill 16, as well as the proposed regulations that were published on April 8. In this regard, I'd like to draw your attention to two specific issues.

Number one, Bill 16 effectively abolishes professional allowances as a source of funding for community pharmacy. The proposed regulations of April 8 have professional allowances being cut from 25% down to 5% in the ODB market, and gradually reduced to 25% in the private market. This will have an indirect yet significant impact on the wholesale industry.

The sudden loss of income by the pharmacy retailers, who constitute most of our business, increases our risk of bad debt. Today, McKesson Canada provides, on an ongoing basis through extended payment terms, about $300 million of credit to pharmacies across the province. There is a real possibility that a number of pharmacies may go out of business because of the sudden changes. Unfortunately, pharmacies that go out of business leave their creditors unpaid. We extend, on average, $150,000 of credit to each pharmacy. For every pharmacy that goes bankrupt, we must find $12 million of new sales to make up for the loss due to our extremely low margins. To mitigate the risk of bad debt, we are forced to tighten the availability of credit to pharmacies, further exacerbating the financial pressures that they will face.

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We therefore recommend that professional allowances be phased out more gradually over an extended period. This will give pharmacy operators time to adjust their business models accordingly and for new sources of public funding for pharmacies to be implemented, as promised by the government.

Our second issue is with the proposed generic price reductions, which have been outlined in the enabling regulations as part of the overall drug system renewal process, which Bill 16 supports.

When the Transparent Drug System for Patients Act passed in 2006, generic prices were reduced by 20% and, consequently, wholesaler distribution margins on ODB drugs were pushed to a level barely covering costs. The operating margin for pharmaceutical wholesalers in Canada is approximately 1%. It has been proposed by the Ministry of Health that generic prices be reduced for both the public and private markets to 25% of the corresponding brand, effectively halving prices in the ODB market and reducing prices in the private market by 60%.

This dramatic reduction in generic prices will result in wholesalers distributing generic drugs at a loss, threatening the viability of the entire industry. We estimate that between the effective date of May 15, 2010, and the end of 2013, the proposed generic price reductions would result in approximately $172 million of funding being removed from the Ontario wholesale channel. To put it into perspective, the entire industry would need $17 billion of new sales, or just over half of Canada's national drug spend, in order to make up this loss.

To address this funding shortfall, we would have no choice but to re-evaluate the key cost drivers of our distribution services, including geographical reach, delivery frequency and minimum order sizes. This would ultimately result in less timely access to vital medications by patients.

Therefore, similar to what we are advocating for professional allowances, we are proposing that generic prices be reduced in a more gradual manner. If generic price reductions must occur, target a higher pricing level, perhaps 35% instead of 25%, and reduce generic prices gradually over three years. Alternatively, the ministry could price all new generics going forward at 25%, while existing generics be reduced to 25% over a three-year period. This would allow the Ministry of Health to achieve its goals—especially with many significant drugs being genericized very shortly and in the next few years—while at the same time not allowing too crippling an impact on the different sectors within the pharmacy supply chain.

These measures would not completely eliminate the wholesale funding shortfall, but would help to soften the blow. To restore the wholesale industry's funding shortfall, we have also proposed a compensatory financial mechanism in a written submission to the executive officer of the Ontario public drug programs.

In closing, we support the Ontario government's mandate to improve the value and accountability of the Ontario drug system, and we believe that our recommendations will allow the government to pursue its mandate while ensuring that Ontario's pharmacy and wholesale pharmaceutical industries remain viable. For over 100 years, McKesson has taken pride in providing timely and efficient service to all pharmacies and their patients, and we would greatly appreciate the support of the government to continue doing so. Thank you for your attention.

The Chair (Mr. Pat Hoy): Thank you for the presentation. This round of questioning will go to the government. Ms. Albanese.

Mrs. Laura Albanese: Thank you for your presentation and for being here this morning.

In your presentation, you state that you support the Ontario government's mandate to improve the value and accountability of the Ontario drug system. You go on to say that this will have an indirect yet significant impact on the wholesale industry. You then proceed to say that you recommend that professional allowances be phased out more gradually over an extended period of time.

The ODB portion is immediate, but the other is being phased in in three years. Do you not deem that to be sufficient time?

Mr. Jeff Faria: No. The immediate on the ODB is obviously very—it takes a lot of money very quickly out of an industry that will have to redefine itself. We don't believe it gives retail time to define itself, and it doesn't give wholesale time to define itself. Along with how quickly the non-ODB is also going, it just takes too much out too quickly to allow the industry to—

Mrs. Laura Albanese: But did I understand correctly that it makes up about 1% of your margin there? You already only have 1%.

Mr. Jeff Faria: Our margin is only 1% right now. Once that goes below that, the margin disappears very quickly.

Mrs. Laura Albanese: But the rest is going to be phased in in three years.

Mr. Jeff Faria: Our current margin overall—everything—is 1%. Once you take out the generic side, it destroys that margin.

Mrs. Laura Albanese: Oh, I see. Okay. But to improve the accountability of the Ontario drug system, as you know, we are paying a lot more than other countries for drugs. As a government, we do have a duty to make sure that Ontarians are paying a fair price for their drugs.

I have a couple of examples that have really surprised me. I see, for example, this drug for diabetes—and I know that especially, for example, in the riding that I represent, there are many people who suffer from diabetes—and pardon the pronunciation, but I think it's pioglitazone. I read that this drug today costs $1,253.56. After the reform, it would cost $313.39. That's a savings of $940.17 annually. That's a lot of money. Wouldn't you agree that Ontarians are paying too much compared to other countries and that this is a very high savings that they would be getting?

Mr. Anthony Leong: Yes, that's understandable, and certainly we do support the government getting better value for its health care dollars. However, what we believe is that this change that is happening is too much too quickly. For example, the new pharmacy funding that's promised by the governments: There are still no details available. I am actually a pharmacist by background. What we feel is that to gradually transition from this professional allowance funding to the new sources of funding, which will give our pharmacy customers time to adjust and hopefully prevent them from going out of business—which we definitely see the risk of and it's a very significant risk. Eventually, if this transition is done smoothly, we can get to that place where we are getting a better value for the drug spending, while at the same time community pharmacy remains viable and pharmacists can be paid to do these new health care services and supplement the rest of the health care system in terms of providing access to patients. That's what we want too.

Mr. Jeff Faria: There's a danger to looking at the pharmacy—just at the price of the drug, because there's so much more that a pharmacist does that right now has no compensation to it. So it's changing that model.

Mrs. Laura Albanese: I want to stress that our government has great respect for pharmacists and we do value the relationship with them. We know they're highly trained and they're highly skilled experts, so the aim is to better empower them to use these skills. Removing professional allowances will enable the province to reduce the price, but at the same time, I believe that the intent is also to fund these services that the pharmacies give to patients, not through the professional allowances. I guess you would agree that pharmacies should get the funding not from drug companies through these rebates. Would you?

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Mr. Anthony Leong: As long as the pharmacy continues to receive the funding it needs, we are in support of pharmacists getting it for the services that they provide. However, we are concerned that this transition is happening too quickly, the money is being taken away too quickly, and the new funds coming in may not be coming in fast enough.

The Chair (Mr. Pat Hoy): Thank you. We'll take that—

Mr. Jeff Faria: Lost in all that is the wholesaler, who is not involved in this at all. With the drop in prices—we get a fee for service. The fee for service on half the price or a quarter of the price significantly impacts us.

The Chair (Mr. Pat Hoy): Thank you for your presentation.

PSYCHIATRIC PATIENT ADVOCATE OFFICE

The Chair (Mr. Pat Hoy): Now I call on the Psychiatric Patient Advocate Office to come forward, please. Good morning. You have up to 10 minutes for your presentation. There could be up to five minutes of questioning following that. I would just ask you to identify yourselves for our recording Hansard, and you can begin.

Mr. Stanley Stylianos: Good morning, Mr. Hoy and committee members. I'm Stanley Stylianos, program manager with the Psychiatric Patient Advocate Office, and I'm joined today by my colleague Ryan Fritsch, who is our legal counsel. We are a rights protection organization that has been around for more than 25 years now, and an arm's-length program of the Ministry of Health and Long-Term Care. The opinions we express today are our own and don't necessarily represent those of the Ministry of Health and Long-Term Care.

We provide rights advice and advocacy services throughout the province. With respect to the provision of rights advice, in the past year we've done more than 22,000 instances of rights advice across the province to both the 10 psychiatric specialty hospitals that were the former provincial psych hospitals and also 54 schedule 1 psychiatric facilities in general hospitals.

We want to focus our concerns on amendments that are proposed in the current bill that concern changes to the Mental Health Act and focus specifically on three areas, some of which pertain to the provision of rights advice, and a new area in the Mental Health Act which introduces a mechanism for transfer of patients who are involuntarily detained under the Mental Health Act.

As you probably know, community treatment orders, under the authority of the Mental Health Act, allow for the development of a community treatment plan that supports patients who would normally be what we have identified as revolving-door patients, allows them to live in the community, and supports their community tenure. Because a community treatment order is a form of treatment, it requires consent, and where an individual is

not capable of consenting to their own community treatment plan, a substitute decision-maker will decide on the community treatment order. The public guardian and trustee acts as a substitute decision-maker in cases where another individual can't be identified.

The current proposed legislation has an amendment which allows for the waiver of the provision of rights advice to the public guardian and trustee as the substitute decision-maker for community treatment orders on both the issuance and the renewal of community treatment orders. We are concerned that the provision of rights advice is an important check and balance in the system and we're concerned that the public guardian and trustee acting as a substitute decision-maker will not be made aware of its obligations as substitute decision-maker, which is a very important function. In fact, the rights advice to the SDM is not something that can be refused by the SDM, so the legislation places a great deal of emphasis on the importance of providing rights advice to the substitute decision-maker. So what we are recommending is that, at least, or minimally, on the issuance of the community treatment order, that substitute decision-makers be provided with rights advice, which is something of a departure from your proposed amendments.

The other proposed amendment that affects the provision of rights advice is where a community treatment order is about to be issued or renewed. There are instances where it is difficult to locate the individual who is subject to the community treatment order. Sometimes this is a function of I guess what we would identify as not the best discharge planning, where the mandated notice to the rights adviser is not made in a timely way. In that instance, the person may be discharged before they actually receive rights advice. We, as the designated rights adviser, may try to locate them, and after our best efforts, may not be able to actually find them in the community. Similarly, if the community treatment order is being renewed, we may have to make considerable efforts to locate a person in the community and provide them with rights advice.

Our concern in this area is that it's the nature of a community treatment order to build in supports and develop a plan that will ensure a person's stay in the community and will support that stay. People who sign or participate in the community treatment plan have an obligation to provide service, in some instances, or to adhere to agreed-upon treatment or a treatment regimen.

If the plan is well crafted—everybody is doing their job—and what is really important is that the person who's subject to the community treatment order buy into and agree to follow the guidelines of the treatment plan. When we as the rights adviser have difficulty locating a person, in our minds, it calls into question how adequately supported that individual may be, because if, at the outset, as in in the issuance of a community treatment order, we're already having difficulty locating the person—although, pragmatically, it makes sense to us. We've made our best effort to provide rights advice, and the treatment order will not be further held up—we'll not be further obligated to try to find that person. This could go on for a long time. It certainly helps us from a practical standpoint. So we support the amendment from that standpoint. However, we want to call to your attention the fact that our belief that where we're experiencing this kind of difficulty and where this sort of amendment is built into the legislation, it also suggests that maybe the community treatment plan and community treatment order are not working in a way that they should be, because these are plans that are supposed to engage the person who's subject to the order.

The next amendment which we are concerned about is the continuance of a community treatment order where an order for an examination has been issued. What this bill is proposing is that where an order for an examination has been issued, which is called a form 47, the person is brought back to the physician who has signed and issued the community treatment order for examination. It's our belief that this is such an extraordinary measure—returning someone to hospital for examination, likely because they're not doing well—and indicates that the community treatment plan and the community treatment order are no longer viable. So we think that it is, respectfully, wrong-minded to contemplate a continuance of an order that now requires someone to be returned to hospital for the purpose of examination.

The folks who are subject to community treatment orders, by and large, I guess, in common parlance, have been identified as the revolving-door patient. So if you were trying to support a person's tenure in the community and break the cycle of repeated readmissions, this is not the kind of thing that you'd like to see.

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A community treatment order is supposed to provide the least restrictive environment that enables someone to live in the community. A return to the hospital for examination, in our opinion, should indicate the termination of the community treatment order as it currently exists. So we would ask that that amendment be reconsidered.

Finally, the proposed legislation introduces a mechanism for transferring involuntarily detained patients from one facility to another. Our office supports this as a means of addressing issues related to a patient's recovery, treatment and rehabilitation planning. It makes sense to us that if a person is detained involuntarily for a lengthy period of time, they should have an opportunity to transfer to another facility where the resources that are available there might—

The Chair (Mr. Pat Hoy): You have about a minute left.

Mr. Stanley Stylianos: Yes—might better serve their needs.

What we feel needs some clarification is the point, if there is a mechanism introduced in the amendments to the Mental Health Act allowing for the transfer—what we are suggesting is that a careful look be taken at the time frames for review by the Consent and Capacity Board, which is the oversight body that would be reviewing a request for transfer. What we're proposing is

that there be an opportunity to review every six months, because if you look at the history of someone normally detained in hospital for a long period of time on an involuntary basis, the clock begins ticking again if that person's status changes. A person might be held for a long period of time, but their status may change. They may be made voluntary, then made involuntary again. They may have a lengthy, essentially involuntary stay in hospital, but with the time frames that are indicated in the proposed amendments, we don't think there will be an adequate opportunity to review the request for transfer, and so request a shorter period for application for review before the board. Again, this is in support of the proposed amendment but to provide for a more accessible review of the request.

We would also suggest that when contemplating the transfer of a patient to another hospital, there be a clear indication that the receiving hospital will actually be able to provide a bed for that individual and the necessary resources; in the case of people who have physical disabilities, that they will be able to fully access the services of that hospital.

That is the substance of our presentation to the committee today.

The Chair (Mr. Pat Hoy): Thank you. The questioning will go to the official opposition. Mr. Barrett.

Mr. Toby Barrett: I appreciate the Psychiatric Patient Advocate Office testifying today and thank you for the work that you do for people who are so often in no position to look after themselves or who sometimes get in trouble.

Your presentation and the amendments are quite detailed. I just wanted to go back to the beginning. With respect to the government bringing forward amendments, you've grouped them into kind of three categories. What's been driving this? Is this because of deinstitutionalization? Has there been a lawsuit or someone who has gotten into serious trouble?

Mr. Stanley Stylianos: Just in general, or—

Mr. Toby Barrett: You seem to be suggesting in some areas a loss of rights and loss of civil liberties. Is this coming from staff?

Mr. Stanley Stylianos: No. I think this is really drawn from our experience over many years and our continuing experience in serving consumers of mental health services. What we've identified are areas that may encroach on—I mean, we are supporting much of the proposed legislation in this respect, but what we are highlighting for your attention are the areas where patient rights, where people are in-patients in hospital, may be abridged because certain protective mechanisms are loosened.

The first instance, the provision of rights advice to the public guardian and trustee as a substitute decision-maker, on the surface may seem—I mean, the public guardian and trustee in a sense is a professional substitute decision-maker. However, I think they are no less obligated to adhere to the guidelines for SDMs, or substitute decision-makers, than any other substitute decision-maker who is identified under the consent and capacity legislation. That's an example of an area where, in our experience, plans that are developed in consultation with the PGT suffer from some of the same ills that other plans do. They are not always carefully vetted; sometimes they are boilerplate in their construction. The opportunity for a rights adviser to review a community treatment plan with the PGT as a substitute decision-maker is a chance to review the community treatment plan and bring to the attention of the public guardian and trustee, as the SDM, the features of that plan.

Our concern is also that within the legislation, we think it would be a mistake to create a tiered system of obligation where one category of substitute decision-maker does not have to adhere to the letter of the legislation, but other folks do. What other check and balance would there be for the public guardian and trustee to ensure that it was performing its duties and obligations as a substitute decision-maker?

So we have identified areas where we feel the proposed amendments would be strengthened.

Mr. Toby Barrett: I see that, yes. Did you see this coming? Was there consultation? Did organizations know these amendments were going to be made to the acts?

Mr. Stanley Stylianos: There's always a bit of a buzz, but I don't recall any outreach being done in terms of consulting around the issues. In fact, I guess because this is an omnibus bill—it has a lot of different features to it—we could easily have missed some of the proposed amendments.

I don't know if your question is heading in this direction, but we do have a concern that some of these fairly substantive changes were not more carefully vetted with stakeholders prior to the writing of the proposed amendments.

The Chair (Mr. Pat Hoy): Thank you for your presentation before the committee.

Mr. Stanley Stylianos: Thank you very much.

The Chair (Mr. Pat Hoy): We are recessed until 2 p.m. this afternoon. We expect people to be here for 2 o'clock, so try to be prompt, committee.

The committee recessed from 1016 to 1402.

ONTARIO'S COMMUNITY PHARMACIES

The Chair (Mr. Pat Hoy): The Standing Committee on Finance and Economic Affairs will now come to order.

Our first presentation—who are seated, I assume—is Ontario's Community Pharmacies. You have up to 10 minutes for your presentation. There could be up to five minutes of questioning following that. I would just ask you to identify yourselves for the purposes of our recording Hansard. You can begin.

Ms. Nadine Saby: Good afternoon, Mr. Chair, members of the committee and guests. My name is Nadine Saby. I'm president and CEO of CACDS, the Canadian Association of Chain Drug Stores. My colleagues here today with me are Janet McCutchon, who is vice-chair of

the Ontario Pharmacists' Association, and Ben Shenouda, who is president of the Independent Pharmacists Association of Ontario. Collectively we represent Ontario's community pharmacies and pharmacists.

Let me be perfectly clear from the outset: Ontario's Community Pharmacies fully support the intent of Bill 16, the creation of a foundation for growth and jobs in Ontario. However, the elements of Bill 16 related to the government's drug program and the associated proposed regulatory amendments, already published for the Ontario Drug Benefit Act and the Drug Interchangeability and Dispensing Fee Act, will reverse growth in the private sector of community pharmacies by forcing a decrease in the number of pharmacies and the services we can provide. This will cause loss of jobs for pharmacy employees, loss of employment opportunities for pharmacy students and interns, and loss of critical front-line health care services for many Ontario communities. We consider this action on the part of the Ontario government to be callous and unnecessarily reckless.

More than an economic issue, our sector is concerned with the impact of a $3-billion-over-three-years cut to front-line health care in Ontario. Local pharmacists in this province are now the primary resource for those without family doctors, for seniors and for the increasing number of families coping with chronic diseases. They serve Ontarians when others are unavailable. They work into the night and are accessible on weekends. They are there when they are needed. They live to serve. For many, it is their life's work.

Pharmacists have clearly stated that we support the overall intent of reforming Ontario's drug system, to transition toward a different, transparent, predictable and sustainable funding model, one that best serves the interests of our patients and the people of Ontario. We have consistently stated that pharmacy services should not be dependent on the indirect funding provided by drug manufacturers in the form of professional allowances. We support the government's intent to lower the cost of generic drugs and to continue to expand the provincial formulary with new drug listings.

If we're in agreement on the fundamentals, why, then, is there such a disagreement on the approach between pharmacy and government and what ultimately constitutes a reasonable way forward?

The underlying issue is a workable approach to a new model of pharmacy and health care that meets the needs of Ontario's patients. Instead, what we've been forced to endure is an aggressive approach and time frame that makes massive cuts to health care and puts seniors, the poor and the vulnerable in harm's way. The government's actions do not create the basis for a reasonable transition for pharmacies or pharmacists and puts the services that patients have come to expect and trust at extreme risk.

The associated proposed regulations confirm for us that, while pharmacy and the government may agree on a desired end point of transparent funding and expanded scope of pharmacy practice, we are in absolute disagreement as to how to manage this change.

To put it simply, we are in favour of lower drug costs, the elimination of professional allowances, and the definition of commercial terms, provided that front-line pharmacy and health care services are not jeopardized. Such an approach takes careful and collaborative planning, not a hammer to attempt to force change into a complex and interdependent system.

The proposals we put forward during our negotiations with the ministry, which ended with the government of Ontario walking away from the table, were clear in describing the rationale and approach to a new model to ensure continued and enhanced provision of pharmacy services to the people of Ontario. It is unreasonable to assume that an entire industry and profession can be forcefully and substantively reformed virtually overnight, under threat.

The government demonstrated its understanding of this concept as recently as April 27 of this year, when it announced a significant investment of one-time funding to assist in the transition process required for long-term-care homes to implement changes under the new Long-Term Care Homes Act.

The government of Alberta provided a significant investment in transition funding for pharmacies in its solution for pharmaceutical reform this year. The minister recognized the importance of the community pharmacy infrastructure in supporting a solution that benefited Albertans and the fiscal realities of the province of Alberta. Unfortunately, this approach has not been followed in Ontario.

Ms. Janet McCutchon: Our message is clear: Pharmacists support government policy to lower generic drug prices, eliminate professional allowances, pay directly for pharmacy services, and enable normal, unregulated commercial terms to exist in the marketplace.

Pharmacists disagree with both the speed and the scope of the changes proposed in Bill 16 and the associated proposed regulations. Because we work on the ground with patients every day, we know the system, both its strengths and weaknesses. The government's approach will not work.

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Ontario's Community Pharmacies' approach to negotiations is to work collaboratively to find a solution that meets the government's cost-containment objectives while enhancing the level of quality, front-line health care provided by pharmacists. It's unfortunate that the process was terminated by the ministry before an agreement was reached.

We are encouraged by the minister's response to us on April 27, as she has asked her officials to identify opportunities to meet. We call upon the minister to engage in a comprehensive discussion that includes all key stakeholders and ensures the fundamental foundation for the provision of pharmacy and health care services and the continued viability of Ontario community pharmacy.

Ontario's Community Pharmacies—all pharmacies in Ontario—stand united in our belief that existing pharmacy services must remain viable, and our patients agree.

We are ready and willing to enter into constructive, fact-based discussions with this government, to create alignment on a reasonable approach to a system that appropriately manages costs and access to pharmacy services.

In the meantime, we respectfully reiterate our request that the consultation period be extended beyond the established 30 days for at least an additional two-week period, which is in keeping with the government's own procedures for a minimum 45-day consultation period for regulations affecting Ontario businesses.

Mr. Ben Shenouda: It's a fact: Decreasing generic prices to 25% of brand and elimination of professional allowances removes over $750 million from pharmacy patient care in the first year.

It is a fact: This is not a one-time funding cut. This number will increase annually so that the cuts will total over $3 billion in three years' time.

It is a fact: These cuts amount to $300,000 per pharmacy, which represents the equivalent of up to three pharmacists for each store in Ontario.

Professional allowances support health care. They have been approved, legislated, regulated by the government, reported and audited. These are funds that allow pharmacists to provide accessible and effective community health care. We take offence at the minister's maligning the entire sector on this issue. It's simply not true.

There are solutions, generating savings directly from lower generic prices, and what is disturbing is that alternative approaches to significant savings over and above generic prices were rejected outright. We know this because we tabled them with the minister.

Here are several key questions: Do these swift and severe cuts provide a platform for a reasonable approach to a new model? Can pharmacists really be expected to do more while being paid much less? How will the accessibility of community pharmacy be maintained? Which health care provider is accessible, able or willing to close the care gap, and what is the cost of filling that gap? There are just no answers to these questions coming from government.

We are ready and willing, and we have stated our intent to move pharmacy away from a reliance on professional allowances to an appropriate direct-funding model.

We must ensure that the people of Ontario have access to pharmacy services. We must ensure that pharmacies maintain their critical role as community health care centres and that pharmacists maintain their role of community health care providers. This is what the people of Ontario need and expect from pharmacies and from their government.

We will be providing solutions in our comprehensive regulatory submission. This is a complex issue and requires time for full understanding and comprehensive dialogue. We believe that third reading should be delayed and the consultation period should be extended by two weeks to allow for proper response. Thank you.

The Chair (Mr. Pat Hoy): Thank you. This round of questioning will go to Mr. Tabuns of the NDP.

Mr. Peter Tabuns: Thank you for coming in today and making this presentation. It's interesting: We had a presentation first thing this morning by a pharmacist. He said that the package that you had offered to the government would have reduced costs by $1.3 billion over three years. Your estimate, and it's consistent with my memory, is that the government savings package is worth about $3 billion. So there's $1.7 billion on the table between the two positions.

First of all, can you tell me the framework of thinking that you brought to the table to reach that $1.3 billion in savings? What is it that could be done differently that would reduce the cost for government drug plans?

Mr. Ben Shenouda: We already discussed the reduction of prices of generic.

Mr. Peter Tabuns: Right.

Mr. Ben Shenouda: We also brought to the attention of the government that one of the key drivers of the increase in costs is utilization. Then, as a negotiation group, we already have put forward a proposition for the government to maintain the utilization under control, and this will save the government—

Mr. Peter Tabuns: I'm going to stop you for a second.

Mr. Ben Shenouda: Sure.

Mr. Peter Tabuns: What does "utilization" mean?

Mr. Ben Shenouda: I'll give you an example—a real example, actually. In 2000, there were 24 prescriptions written for one drug recipient in Ontario. Over six years, this 24 went to 44. There are too many drugs per patient now. The reason for that is that lobbying and promotion by the brand name companies to doctors, to the government side, is increasing, so the number of medications written for patients—it's not necessary to be with any medical significance—is increasing. This is one of the major drivers of cost.

Mr. Peter Tabuns: Fascinating. I have more questions, but that's one part. Are there other parts to your presentation?

Mr. Ben Shenouda: Yes. We already have showed to the government the value that pharmacists can provide when it comes to saving money by moving the burden from the doctor's office and emergency room to the pharmacy and having pharmacists give prescriptions and make some triage and help the patient, with the associated fees for that. We showed them that this will save them more than $200 million a year.

Mr. Peter Tabuns: You need to fill me in on this: When I go to see a doctor, they do a diagnosis, they do a variety of tests and then they give a prescription; if you're prescribing drugs, what's your diagnostic training that allows you to do that with safety for yourself and for the patient?

Mr. Ben Shenouda: It is not really the diagnosis that we're talking about. How many of our patients go see the family physician for constipation or a headache for two or three days or athlete's foot or minor things like that?

Pharmacists can definitely help with this. It would save visits for the government. Basically, every visit is about $32 to pay to the physician. You can add those up. We save for the whole system, not specifically for the drug system.

Mr. Peter Tabuns: Okay. I understand that for very minor things, yes, you could recognize it and make a recommendation.

I'm going to go back to utilization. How do you drive down that utilization? How do you eliminate unnecessary prescriptions or overmedication? What would you bring to the table that would allow Ontario to cut its costs?

Ms. Janet McCutchon: MedsCheck is a good way that we already do recognize whether some medications are used for the same disease state, and maybe that's not necessary. Sometimes those can be errors of omission rather than seeing several doctors and not realizing, or discontinuing those things that are no longer needed because they were only needed for a short period of time while there was some urgent, identified risk. Those are two of the areas where I think that we can do that.

I think a lot of it is patient education. You don't have to necessarily treat every ear infection—giving parents some solace that they can probably manage, unless the condition lasts for a certain length of time. Adults, too, at home—we can often manage without an antibiotic. But recognizing those situations where they need to get to see the doctor is just as prudent. Those are just a couple of things that come to mind.

The Chair (Mr. Pat Hoy): Thank you.

Mr. Ben Shenouda: But to build up on Janet's point, I'll give you an example. For instance, there is a medication that is very famous that is used to treat cholesterol. It's called Zocor. This medication was widely prescribed. Once the medication became generic, the doctors started to stop writing simvastatin, which is the generic version of Zocor, and they started to go for Crestor and Lipitor. Of course, the difference—if it comes to the pharmacy, the pharmacy will call the doctor and tell him that the patient had been on this medication for the last two years and his cholesterol is under control. Why not keep him on simvastatin? This will cost the system money if we don't switch that. We give them the cheaper alternative, which will not impact the medical outcome of the treatment on the patient.

Mr. Peter Tabuns: Thank you. This has been very useful.

Mr. Toby Barrett: On a point of order, Chair: We have a request from this deputation to extend the consultation period to 45 days and to delay third reading. When's the appropriate time to make a motion to that effect?

The Chair (Mr. Pat Hoy): When we do amendments.

1420

Mr. Toby Barrett: And that would be next Friday?

The Chair (Mr. Pat Hoy): Yes.

Interjection.

Mr. Toby Barrett: Or Thursday.

Mr. John O'Toole: Chair, if I could question that—

Interjections.

The Chair (Mr. Pat Hoy): Extend the public hearings?

Mr. Toby Barrett: Yes.

The Chair (Mr. Pat Hoy): But we're time-allocated from the House, so we can't.

Mr. Toby Barrett: I'm sorry: to extend public hearings to 45 days and to delay third reading.

The Chair (Mr. Pat Hoy): We're time-allocated from the House and we cannot do that.

Mr. Toby Barrett: On either issue?

The Chair (Mr. Pat Hoy): On either. Mr. O'Toole.

Mr. John O'Toole: So in other words, all these deputations are basically without any consequence, because we can't extend them—

The Chair (Mr. Pat Hoy): No, we're all here listening.

Mr. John O'Toole: The two requests are made. Do we have assurance that those moved amendments that address these issues they've raised would be considered, or are they outright rejected by the government members, as they've been told? I assume that they're just futile. It's unfortunate.

The Chair (Mr. Pat Hoy): If you are making an amendment to the bill, that would be done next Thursday. Any amendment to how we function here isn't going to happen because we're time-allocated from the vote in the House.

That concludes your presentation. Thank you very much.

PHARMASAVE ONTARIO

The Chair (Mr. Pat Hoy): Now I call Pharmasave Ontario to come forward, please. Good afternoon, gentlemen. You have up to 10 minutes for your presentation. There could be up to five minutes of questioning following that. I'd just ask you to identify yourselves for our recording Hansard.

Mr. Glenn Coon: I will. Thank you.

Two weeks ago, I quite possibly saved a patient's life. He was 45 years old. He was in for his usual blood pressure check during a break from his work. It was relatively normal for him. In consultation, he'd been feeling a little tight in the chest since the night before. I sent him to the hospital. He had surgery the next day—90% blockage—and a stent inserted. Normal health care in a small town: disease-state intervention, life-threatening allergic intervention, drug interaction intervention.

My name is Glenn Coon. My business's name is Port Rowan Pharmasave. My pharmacy is an independent pharmacy that has come together with other independent owners under the banner name of Pharmasave. The leader and person in charge of protecting the independent culture of Pharmasave in Ontario is Doug Sherman. He is here to answer any questions that you may have about our 165 independent pharmacies in Ontario.

My face and the face of my wife, Pam, who is a pharmacist and my business partner, are the faces that my

community seeks for health care. My business is located in Port Rowan, Ontario, and my oldest patients tell me that there has been a retail pharmacy in Port Rowan for over 100 years. Port Rowan is on the north shore of Lake Erie in one of the most rural areas of southwestern Ontario. We are a small retirement community with only one pharmacy. The driving time to the next town with a pharmacy is almost half an hour.

Seventy per cent of my patients and customers are seniors. Because such a high percentage of my patients are seniors, the financial impact of Bill 16 on my store will be more severe than pharmacies serving younger populations. The legislation is even more financially punishing to the pharmacists who serve high senior population demographics, the very group that needs our services the most.

If you have been to my town, you know that Port Rowan is as rural as rural gets. You will not be able to find a more humble, salt-of-the-earth community. Politicians and policy-makers have told me that the citizens of Port Rowan don't complain and will often be overlooked because they don't complain.

They are complaining now. Hundreds of postcards and faxes and petition signatures have been delivered to my MPP. They do not want to lose their pharmacy. They rely upon and trust the health care services I provide.

In small communities like Port Rowan, there are no specialized health service clinics and agencies. Patients come to the local pharmacy to do it all. Anything they ask for, we will make every effort to provide. We will turn no one away, and we deliver trusted and reliable health care.

Home health care, trusted and delivered:

—medication blister packaging for seniors and patients with medication regimes too complex to manage by themselves, trusted and delivered;

—hospital discharge equipment loaning program for mobility and personal hygiene, trusted and delivered, no charge;

—free rural delivery for shut-ins and anyone who asks, trusted and delivered, no charge;

—safe disposal of outdated and unused medication, preventing the flushing of drugs and long line ups at hazardous waste drop-off day, trusted and delivered, no charge;

—safe disposal of sharps and syringes, preventing inadvertent needle pricks and disease transmission, trusted and delivered, no charge;

—disease state management: diabetes, smoking cessation, blood pressure monitoring, nutrition and exercise advice, one-on-one counselling on any disease state, trusted and delivered, no charge;

—over-the-counter-drug interaction advice, including herbal products and vitamins, trusted and delivered, no charge;

—at any time of the day or even after hours, whenever our patients need us, Pam and I respond to Port Rowan's health needs with a phone call at our home or a knock at our front door. I will always open at midnight, trusted and delivered, no charge.

You get the picture. Just follow your small-town pharmacist around the pharmacy, you'll understand, but bring your roller skates. We don't stand still.

Bill 16 will change that. No professional allowances plus no meaningful professional fee increase equals health care cuts and a US-style pharmacy model in Ontario: big stores with big volumes and no access to pharmacists and their care.

As for the new revenue that Bill 16 provides, the complex rural indexing allowance of ODB has not been defined and thus, I cannot comment on it. Based on the lack of details provided, I am anticipating the same compensation as a pharmacy at Yonge and Bloor.

The lack of detail about the $100-million professional services component means that I cannot comment on it. I am anticipating that I will not have the professional staff available to access this envelope.

The lack of clarity to Bill 16's "ordinary commercial terms" leaves me only guessing what the financial impact will be to my business, and so, again, I cannot comment on it. All I know is that Bill 16 is removing professional allowances.

Pharmasave Ontario is a group of small independent pharmacy owners situated largely outside of the GTA. We are a member-owned and member-governed cooperative of pharmacist business owners spread across this province. They are just like me. For the last two years, they have elected me to be their chairman and for 13 years they have employed Doug to protect their independency and, of course, their financial viability.

We pool our resources to employ operational and professional staff. They assist us in offering the highest levels of pharmacy patient care and retail business practices so that, even in the smallest communities of our province, patients can receive immediate quality health care and advice.

With this bill, it will be much harder for Pharmasave members to pay for these support employees who are so vital to our existence. There is a fierce competitive retail environment in Ontario. These cuts put independent pharmacy at risk, especially in small communities.

The Pharmasave pharmacists would like me to say that if their business is taken over by the bank and closed, the communities that they serve will be hurt. The people of Port Rowan will have to travel a minimum of 30 minutes to get their prescription filled. Who is going to be there for them when the doctor's office is closed or they don't have an appointment? The emergency room will have to suffice, a half hour away.

Pharmasave pharmacists give back to our communities. They are generous supporters of community events and local causes. The charitable work of Pharmasave independent owners has contributed almost $700,000 to the Children's Wish Foundation alone. It raises our emotions when we think how we had to cancel our major fundraising work in 2010 on account of the impending Bill 16.

Pharmasave employees donate their time to run volunteer programs in our communities and even abroad. Today, Gord Lane, the owner of Lane Family Pharmasave in Parry Sound, is in Nicaragua with a team that is offering patient care to an impoverished community. A pharmacist's care stretches far and wide.

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We are not against the eventual elimination of professional allowances, but right now professional allowances are an essential government program that keep independent pharmacies in existence. Yes, Bill 16 and the elimination of professional allowances will put independent pharmacies in a loss position on their bottom line. Yes, the one expense line we can control is wages. And yes, the removal of professional allowances will eliminate and remove good-paying retail sector jobs.

I estimate two full-time equivalent job losses in my small drugstore alone. Multiply that across my fellow Pharmasaves—320 jobs, not to mention the impact on the professional pharmacy and retail support staff of Pharmasave Ontario—quality Ontario jobs. Then multiply that number by the independent pharmacies across the province. And it's not only independents, it's the whole industry: all pharmacies, all suppliers, all wholesalers, all spin-off health care providers. You get the picture. You have a big number of job losses because of Bill 16. Based on the throne speech, this is not what the Minister of Finance had intended, I'm sure.

I am not against the eventual elimination of professional allowances. A well-thought-out transition to full, direct funding by the government that would not compromise patient care in rural Ontario is required. Bill 16 is not the answer.

There is, right now, a tremendous opportunity to protect these patient services and implement more and save a whole lot of money. Don Renaud of Solutions in Health Inc. in Windsor has conducted many studies to prove that patients are better off and use less medication when under a pharmacist's care. Pharmacists save money. Pharmacists improve quality of life. Pharmacists decrease hospitalizations. Pharmacists decrease worker absenteeism. Pharmacists effectively manage disease states, specifically diseases like diabetes and heart disease. Pharmacists save money.

But there is one thing that pharmacists do that cannot be measured: Pharmacists care. Pharmacists really care, and caring is a powerful force. That's why I'm here. And that's why you will continue to hear from my patients in Port Rowan, with postcards, faxes, emails and petitions, until the detrimental effects of Bill 16 on small-town, front-line health care is fixed. Thank you.

The Chair (Mr. Pat Hoy): Thank you. This round of questioning will go to the government. Mr. Arthurs.

Mr. Wayne Arthurs: This is the first opportunity I've had, since I was elsewhere this morning, to hear from some of the deputants, both the last submission and this one.

First, Glenn, as you made the presentation, let me just obviously say thank you for your opening part of the submission, in particular the work that you do and your reference to the sort of life-saving work that you're doing at that point in time. It doesn't matter who was speaking, at this point we want you to extend that thanks on behalf of all the legislators.

Mr. Glenn Coon: Thank you.

Mr. Wayne Arthurs: A couple of things, if I could. The regulations that have been posted on the ministry website for some feedback, have you seen those? Have you had a chance to provide any feedback on them, or is it your plan at this point to do so or to forego that process?

Mr. Glenn Coon: I have looked at the regulations, specifically the ones that will impact my pharmacy financially. Unfortunately, there are no details to the indexing of the rural fee that will indicate if I'm able to collect a $1 increase in fee because I'm losing a lot of money on professional allowances. So the direct government funding must make up the difference, and it's unclear.

I'd also like to know what "normal commercial terms" are because what's being pulled out are professional allowances, as it states in the bill, but "normal commercial terms" are not defined and I don't know what that means.

The other thing that is unclear is the $100 million that is being inputted into professional services. I'm all about that. I want to get that money. I want to know what that professional service money is all about because that's what I do all day long, and that's supported by professional allowances. Right now I don't need to be going after extra professional direct funding from either the patient or the government because professional allowances have made up that funding gap for the things that I do every day in my practice.

Mr. Wayne Arthurs: I've heard, if not almost universally, to a large extent that the removal of the professional allowance—in some cases, the request is that it be over time as opposed to immediately, and it's something that seems to be generally supported. Is that—

Mr. Glenn Coon: Absolutely, yes. We would rather be supported with direct insurance or direct patient funding—

Mr. Doug Sherman: Or a higher dispensing fee or being compensated for the services that are regularly applied, but to remove $3 billion over three years and replace it with $300 million in compensation for services that our stores' owners may not be able to provide—because in order to make up the gap they've had to let people go. Where are they going to have the people to actually provide these services for which there's supposedly going to be compensation?

Mr. Wayne Arthurs: We're going to have a deputation later today, and I think the way things are we may not have a chance to ask this question. Susan Eng, the vice-president of advocacy for CARP, the Canadian Association of Retired Persons, has said that, "Lowering the cost of all prescription drugs is a major priority for our members, regardless of whether they are covered by

the Ontario government, private drug plans or paid out of their own pockets."

It would appear, broadly, that seniors, those retired persons, members of that organization, have indicated their support as well for the reductions in costs of drugs by virtue of reforms of this nature. I know what you're saying: that a lot of your patients are seniors. Would you suggest they probably fall under that group that wants to see lower costs?

Mr. Glenn Coon: If direct funding in the dispensing fee had been raised over the last 20 years to a significant and acceptable level, we would not have needed professional allowances in the first place, then the drug costs would be lower and the dispensing fee would be higher. That's where we're going to end up. We're going to end up with very high dispensing fees put on the back of the working Ontarian to compensate for the lack of funding from the Ontario government and other third party insurers. The people without the drug plans are the ones that are going to pay astronomically high dispensing fees to make up the difference.

Mr. Doug Sherman: If I might add, I don't think Ms. Eng, who seems to be a very intelligent individual, has talked to one of Glenn's seniors in his community or any senior, for that matter, in the communities all across Ontario.

While I haven't followed every single media submission, I'm not so sure that Ms. Eng has the full support that she claims to have when I've heard other things from other people who represent seniors, who would tell you that Bill 16 is going to be devastating to the seniors, specifically and particularly, because they're not going to be able to access the health care that they have been used to accessing, and the concomitant challenges of the ability of all patients to go to their local pharmacy, as opposed to lining up in the emergency room or trying to get a doctor's appointment.

The Chair (Mr. Pat Hoy): Thank you. We're about two minutes over.

Mr. Glenn Coon: Thank you.

The Chair (Mr. Pat Hoy): I don't think you mentioned your name. If you would.

Mr. Glenn Coon: I did. It's Doug Sherman.

Mr. Doug Sherman: I try to keep a low profile. We are member-owned and -governed, and I'm just the hired hand.

The Chair (Mr. Pat Hoy): I wanted you officially on the record. Thanks.

Mr. Doug Sherman: Thanks for your time. We appreciate it.

MR. MICHAEL PROUSSALIDIS

The Chair (Mr. Pat Hoy): Now I ask Michael Proussalidis to come forward.

Mr. Michael Proussalidis: You did a very good job with the name. Thank you.

The Chair (Mr. Pat Hoy): Good afternoon. You have 10 minutes for your presentation. There could be five minutes of questioning, and if you just state your name before you begin, you could begin.

Mr. Michael Proussalidis: My name is Michael Proussalidis. Thank you very much for hearing from me today. I've been a community pharmacist serving the residents of Ontario since 1993.

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I see that Bill 16, the Creating the Foundation for Jobs and Growth Act, amends many acts, but today, as a pharmacist, I will speak to you about the impact it will have on pharmacy in this province.

As you well know, the Ministry of Health and Long-Term Care, under the direction of Minister Deb Matthews and the executive officer of Ontario drug programs, Helen Stevenson, has proposed to amend regulations in order to reduce drug expenditure by the province. To receive the intended saving of, by the ministry's count, $500 million, generic drug prices are to be slashed in half. It has been stated by the ministry that this can be achieved if the professional allowances conceived of by the same provincial government in 2006 be eliminated.

As I understand it, the Ontario Drug Benefit Act, 1986, provided for a fee to be paid to cover the pharmacist's professional services and all operating costs. Back then, Ontario paid $6.47 per prescription for those covered by the program. It was only in 2003, some 17 years later, that the fee increased a net amount of seven cents to $6.54. In fact, by 2003, senior citizens and others had already been paying a portion of that. Some seniors today pay the first $100 a year themselves, and then they're asked to pay $6.11 for each prescription. Other seniors and those through Ontario Works and disability pay $2 per prescription. Thus, the province only actually puts in, at most, $4.54. Three years later, that fee increased to $7, again with the province footing, at most, $5. For many seniors, the government only puts in 89 cents. This is the lowest fee in Canada. Is this not indicative of what the government estimates that pharmacists' professional services are worth? How can the ministry continue to defend such low fees that do not fulfil, the intent of the act, to cover all operating costs?

An independent study in September 2008 concluded that the median cost for dispensing a prescription in Ontario was $13.77. This includes things such as rent, hydro, computer systems, as well as wages. The difference between $7 and $14 is a gap in funding that has been going on for well over 20 years. The band-aid solution to this gap has been the rebates from generic companies—rebranded as professional allowances—that the province has permitted until now. There already was a shift in the cost burden from government to seniors and those on welfare with the introduction of deductibles and co-payment amounts in 1997. The government was happy at the time to have pharmacists seek funding from private industry and encouraged the practice, as it meant that they would not feel the pressure to pay their fair share.

All of that came to a head in 2006 when this government wanted a share of the pie. In the name of greater

transparency, they rebranded the rebates as professional allowances and began the process of limiting the allowances and dictating generic prices. In the meantime, they legislated the means to receive rebates themselves from the brand name companies. They even provided for their rebates to remain secret. This is what the Transparent Drug System for Patients Act, 2006, created.

Let me say this: I am all for the elimination of professional allowances, but you must understand that these allowances were defined by the government, regulated and monitored by the government, and encouraged by the government. To have them come now, after a nine-month process where solutions to the government's fiscal woes were brought forth on a silver platter and tossed aside, and say that professional allowances were misused, the system was abused, and this is why they want to eliminate them, smacks of disingenuity.

Yes, reduce generic prices. I'm all for that as well. But where is the integrity in the system? Who in government today will say, "Help us deal with our fiscal issues and work with us to improve the system," rather than, "Well, those proposals were nice thoughts, but we prefer to unilaterally announce our plan and to take steps on our own since we really do not want to partner with pharmacists"? Because eliminating professional allowances without replacing them, without reassuming the responsibility to adequately fund the system, would be like ripping a Band-Aid off with a festering, open wound beneath.

One must provide for an alternate solution to this funding gap. A $1 increase in the professional fee, as has been proposed, will not bridge the $7 gap. A $1 increase will result in forcing community pharmacies, big and small, to bridge the gap where? On the backs of citizens and voters. Some will close, no doubt, and likely some communities, especially in northern Ontario and rural locales, will be left without a pharmacist. These are draconian measures, despotically imposed, if you will.

In the nine months of negotiations that pharmacy has had with the government, comprehensive proposals that would have saved $1.3 billion over three years, as we have already heard, were offered and rejected. These proposals worked toward providing a foundational improvement in the provision of front-line health care in Ontario, something that would benefit the government, would benefit pharmacy and, most importantly, would benefit the end-user. After all, it is the end-user—the patient, citizen, voter—whom we're talking about. Whether it's the 89-year-old widow on a fixed income, the middle-aged factory worker with reasonable health benefits through his union, or the single mother who has no one to turn to but the provincial health care system, each one at some point will need the services of front-line health care workers, as we pharmacists are.

I recently spoke with one pharmacist who explained that he is the only community pharmacist in 300 kilometres and that the proposed changes will bring him to his knees. What will those patients and voters do then?

As a pharmacist and pharmacy owner myself, I am pleased to hear that the ministry is seeking to keep its fiscal house in order. After the billion dollars that was spent on the eHealth initiative did not yield a workable product, it seems suspect that this government is able to achieve just that: fiscal responsibility. And while I do not believe that the Ontario government has set out to harm the province's economy and make war on small, independent pharmacies such as mine, that will be the unintended and unfortunate result of the elimination of the band-aid solution that professional allowances are to the funding gap.

If this bill's purpose is truly to create the foundation for jobs and growth, then I submit that pharmacy jobs will be lost and the economy will not grow. Unemployment in the pharmacy and pharmaceutical sector will rise and the fiscal house, in the end, will not be in order. Patients will have a more inefficient system to deal with. It is utterly disgraceful that such an integral part of the health care system is left to ruin for no good reason.

To summarize, the ODB Act provided for a fee to cover pharmacists' professional services and all operating costs. Operating costs exceed the fee by at least $7. Up to now, the government-regulated professional allowances made up for the government's shortfall. Now the ministry is trying to eliminate professional allowances without bridging the gap. That's all that I am asking for—that the government of Ontario meet its responsibilities with respect to pharmacy funding.

The Chair (Mr. Pat Hoy): Thank you. For the committee's information, I understand that the official opposition and NDP will swap their rotation, so it will be Mr. Tabuns.

Mr. Peter Tabuns: Mr. Proussalidis, thank you for coming in and making that presentation. If in fact Ontario was to pay $14 per prescription, what would that cost?

Mr. Michael Proussalidis: What would that cost? To whom?

Mr. Peter Tabuns: To the province. If it's looking to save $3 billion, let's say that, in exchange, it gave pharmacists $14 per prescription. What would that extra cost?

Mr. Michael Proussalidis: As an independent pharmacist, I can tell you what it would do in my store, but as to what impact it will have on the rest of the province, it would probably be best to ask an economist. I really don't—

Mr. Peter Tabuns: Is it in any way comparable to the amount that you're receiving now from the generic drug companies as the professional fee?

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Mr. Michael Proussalidis: Yes. That's the whole point: that over 20 years of lack of funding increases as costs have increased, when we see that the costs have increased at a far greater rate than what the reimbursement has been, we came to a point where there was this gap. The professional allowances bridged that gap adequately so that we are able to provide all of that blister-pack compliance packaging for patients, answer those questions that they have on the phone and provide services where we don't end up charging people, because we are funded elsewhere.

Mr. Peter Tabuns: If you were paid $14 per prescription and the professional allowances were eliminated, would that provide a savings to the government or would it cost them more?

Mr. Michael Proussalidis: In the end, it would provide a savings, I believe. I don't have any numbers, and that's not a calculation that I've made.

Mr. Peter Tabuns: Okay; fair enough. Earlier today we were told about the whole question of utilization. Can you tell us a bit about what you've seen with over-prescription or prescription of brand name as opposed to generic when you've dealt with patients who have come to see you?

Mr. Michael Proussalidis: Sure. Patients see me every day. I was even at the store this morning, at the pharmacy, dealing with patients while I was trying to prepare all of my comments.

There is a lot of waste within the system. We see it all the time, because seniors, for example, if it's not going to cost them very much, if at all, will say, "Sure, go ahead. Ninety-day supply, 30-day supply—go ahead; fill my bag," almost as if it's trick-or-treat time.

Without it hurting their pocket, which is not something that anybody would like to do—

Mr. Peter Tabuns: That's right.

Mr. Michael Proussalidis: Without them understanding the cost of these things, there is a lot of waste within the system. If we were able to go ahead and educate people and help them understand that, "You've got 12 things on your list here. You only really need three. Let me call your doctor. Let me work with you and see how we can reduce all of this," that would be a tremendous saving to the system.

The Chair (Mr. Pat Hoy): Thank you for your presentation.

Mr. Michael Proussalidis: Thank you all.

MS. RITA WINN

MR. FARID WASSEF

The Chair (Mr. Pat Hoy): Now I call on Farid Wassef and Rita Winn to come forward.

Mr. Frank Klees: Chair, if I might, while they're coming forward: I wonder if we could have legislative research provide a report to the committee that details the rebates that are being paid to the government by the brand companies on a line-by-line basis for the drugs for which they've contracted with the government. I think Mr. Proussalidis has made a very important point. In the interest of transparency, it's important, I think, for this committee to have that information. If we could have an undertaking from legislative research to have that report, I'd appreciate it.

Mr. Norm Miller: Mr. Chair, if I could make that request on behalf of Mr. Klees, please, it would be appreciated.

The Chair (Mr. Pat Hoy): Do you need that in writing?

Mr. Larry Johnston: I'd like it in writing.

The Chair (Mr. Pat Hoy): Could you make a short note for that?

Mr. Frank Klees: Okay, will do.

The Chair (Mr. Pat Hoy): Very good.

We'll proceed again. You have 10 minutes for your presentation. There could be five minutes of questioning. I'd ask you to identify yourself, and then you can begin.

Ms. Rita Winn: Thank you. Good afternoon, Mr. Chair, committee members, committee staff and fellow deputants. My name is Rita Winn. With me today is Farid Wassef, who is a community pharmacist in Stouffville.

My name is Rita Winn. I'm a practising pharmacist and the general manager and COO of Lovell Drugs in Oshawa.

Like my colleagues here today from King City, Kincardine, London, Kitchener, Stouffville and throughout the GTA, Lovell's pharmacies are first and foremost about delivering primary health care. Ninety-three per cent of our business comes directly from safely and efficiently filling our patients' prescriptions and providing over-the-counter medications.

With roots dating back to 1856, Lovell Drugs is the oldest drugstore chain in Ontario, and we are still run by the family that helped to found the company, the Lovell family. We operate stores in Whitby, Oshawa, Kingston and Cornwall and employ 150 people, including 25 pharmacists and 35 pharmacy technicians.

When I entered the profession of pharmacy 29 years ago, there was a clear understanding of what was expected of a pharmacist, and that was pretty much reserved to the "lick, stick and pour" activities that we're all familiar with. Then, about 15 years ago, so-called "drugs by design" started hitting the shelves, treating such things as ulcers, hypertension, cholesterol, depression etc. At the same time, we baby boomers started getting older, and pretty soon there was an explosion on our hands. Pharmacists were being called on to be the drug experts to those patient populations that are taking more and more drugs.

Today, the government says it will spend the savings it realizes by slashing generic drug prices on listing new drug therapies. Thousands of new drugs have come to market since I began practising and have made our lives better and longer. This has meant, though, that many of us, particularly in our advanced years—not that I'm in advanced years, but I'm moving towards that—will be taking four or five medications, each offering its own set of side effects and possible adverse reactions. "Lick, stick and pour" has become a lot more complicated, time-consuming and, frankly, it has become risky. The need for pharmacists and for our pharmacy services is increasing, both driven by the demography and also by the avalanche of new drugs that are coming to market.

The question before you today is: What kind of pharmacy system do Ontarians want? What do we want and what do we want in the future? What kind of system would you like to have? Today I would argue that we have an enviable pharmacy infrastructure that is as good as or better than any other developed country in the

world. I think that patients can expect and do receive medications and advice in a timely and very convenient manner. When needed, medications are delivered to patients' homes and are packaged so that they take the dosage at the right time. Pharmacists themselves have invested in systems and tools to keep track of patients' adherence and to flag possible adverse drug interactions, therefore improving patient health and keeping people out of hospitals and doctors' offices.

It seems like ancient history, but also recall the smooth distribution of anti-virals during the H1N1 pandemic for Ontarians and the part we play in educating the public on flu prevention and treatment every year. Do you know that pharmacists in Ontario collectively took 90,000 calls each day during the peak pandemic period? Ninety thousand calls. We didn't get paid for one of those calls.

These activities take time, energy and money, and we are pleased to do them. I think Ontarians who rely on their pharmacist know that they are fortunate to have them. Ontarians are fortunate to have pharmacists who are passionate about their profession and solve all kinds of problems for them without making much of a fuss. Perhaps that has been to our detriment, given the kind of cataclysmic change that we're facing in Ontario.

Is it the cheapest pharmacy system in the world? Probably not. But I think it's a Volvo: durable, reliable and safe. It's there when you need it; not the most expensive and not the cheapest; good reputation, good value. That's what pharmacy offers.

But all this is about to change. Excising $750 million annually from the pharmacy system, as you have heard, amounts to $300,000 per pharmacy. The brutal, inescapable fact is that $300,000 is roughly equivalent to three pharmacists' salaries. To put that in perspective, I employ 25. That means that there are none of my pharmacists, including myself, left. There's nothing left.

If we, Lovell Drugs, were to have to let go three pharmacists per store, you can see the math: It doesn't work. If these regulations are passed, programs that we are involved in that enable community living for thousands of Ontarians will be jeopardized. Our home infusion program in Kingston will be gone. Our public health methadone program will be gone. The 150-some clinic days we offer patients on topics such as osteoporosis screening, heart health risk screening and asthma education—gone, and the list goes on and on. Many of these programs benefit very sick people and very old people. Many interact with us and count on us each and every day. We wouldn't have built these programs and services if there wasn't a demonstrated need for them, and let me tell you, we won't for one minute delight in their demise.

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But what about the fees that pharmacists will not receive from the government for providing services that were previously self-funded, you will ask? My view, as a community pharmacist, is that services need to be conceived and delivered locally if they are to work, so the prospect of delivering centrally planned services for an undetermined fee to patients who may not need or want them is frankly unappetizing to me as a community pharmacist.

Where I come from, you don't pull down your old house before you've got another place to live. Let's take the time and care to improve our enviable pharmacy system for today and also for tomorrow. I'm asking that there be a reasonable pace of change, a reasonable approach towards a new model of services and funding that gives government the cost containment it wants and protects the pharmacy services that patients need. I'm asking you to extend the consultation period of the regulations, delay third reading of Bill 16 and stop the cuts. Thank you.

The Chair (Mr. Pat Hoy): Thank you. There are about three minutes left.

Mr. Farid Wassef: Okay. If I could have five, that would be good, but I will talk fast.

Good afternoon, Mr. Chair, members of the committee and guests. My name is Farid Wassef. I am one of 13,000 pharmacists who provide health care services to nearly six million residents in Ontario. I've been a community pharmacist for over 20 years. I'm carrying on in my father's legacy, who was a pharmacist for over 50 years. We owned and operated a pharmacy in Stouffville for 36 years.

In 2006, when Bill 102 was passed, I experienced extreme financial hardship and was forced to close down. Ironically, later that same year—something I'm very proud of—I was honoured as the 2006 Canadian Pharmacist of the Year for my excellence in patient care.

I was able to find employment, with a stellar resumé, in Stouffville at another independent pharmacy. My wife and I and our two young children love Stouffville. We wish to remain there. We call that home.

Stouffville is located in York region, which is rapidly growing and has a population of over 33,000 now. However, we remain underserviced: There are not enough doctors.

It is unfortunate that members of the public see images of hands sliding pills across a tray and this is their understanding of pharmacy, so please allow me the opportunity to educate the committee on what I do and what we do in the community.

Many seniors who live alone wish to remain independent, so they rely upon our pharmacy to provide customized drug packaging and delivery of their medications and groceries, as well as working closely with their doctors. We provide methadone to chemically dependent individuals and help them become productive members of society. We help people quit smoking. We make sure that addicts and alcoholics—and that's a population that's on the rise in my community—get the care they need. We help cancer patients control their pain. I am the last resort when they can't get a hold of the specialist at the hospital. We help them manage their pain and manage the nausea. We counsel patients on cardiovascular disease, on asthma. In the 1980s, when the government came to us, we had the highest rate of asthma in the world at 30%. People were dying of asthma. We rolled

up our sleeves and we found out why: People were overusing certain inhalers and they weren't being maintained properly. We got engaged, we were allowed to help, and we have reduced that now. There are fewer hospital visits and fewer doctor visits. We have now controlled asthma effectively, safely and cost-effectively, I might add. We educate women on the importance of maintaining adequate nutrition throughout pregnancy. Again, we are the first and last resort. We help care for their infants, we help manage their colds and flus, and we make sure that antibiotics are appropriate when prescribed. We hold screening and education clinics. I provide my cellphone and my home phone in a small town because people need me when they need immediate care. Physicians call me after hours to discuss difficult cases. We meet for lunch and we collaborate.

All of these things I just mentioned, I don't get paid for. My employer is able to hire me because he has been receiving professional allowances.

Twenty-one years ago, I want to make it known, when I became a pharmacist, I took an oath to advocate for my profession and my patients and to always do what is in their best interests. Today I stand before you—I didn't realize I was going to be sitting; I'm usually standing on my feet—fulfilling this oath. I am not against the government's removal of professional allowances, provided that adequate funding is given to dispense medications, counsel patients, consult with doctors—they need our help; they call us, they rely upon me—and provide these vital services I just mentioned. Without adequate funding, I am deeply concerned that if Bill 16 and its regulations pass, pharmacists' hours will be reduced and relegated to counting pills. Patient care services will disappear and pharmacies will close.

Bill 16 and its regulations trigger drastic funding cuts—and you've heard that today—which are far too fast and very troubling for my small town. I am worried sick. I haven't slept in nine months because my patients' health is at risk. I am taxed and tired of answering phone calls: "Is it true you're receiving kickbacks?" I have to appear, because of all of this insanity, at the community centre next week to answer these calls. All day long, we answer these calls about what's written in the media about us.

I am humbly asking the committee today to delay third reading of Bill 16 until a full examination of the regional impact—I want to be able to go back to Stouffville and let them know that these services will continue. That's why I'm here today. I am also asking the Legislature to request that the Minister of Health and Long-Term Care please outline the services she expects us to do and to deliver, and what that fee will be. Thank you.

The Chair (Mr. Pat Hoy): Thank you. The questioning is to the official opposition. Mr. Klees.

Mr. Frank Klees: Thank you, Ms. Winn and Mr. Wassef, for your presentation. It seems that both of you and others are asking one thing, really, of the government, and that is to put the brakes on to provide for a reasonable transition period to work with the industry to come up with a reasonable resolution here. I heard the passion in your voice in terms of the branding of these professional allowances, now being called kickbacks. It's interesting that we all know—although the government's not willing to tell us what their rebates are, which they're getting from the brand companies. I've asked for that report through this committee. It will be interesting how much we have to go through to actually find that out. I don't think they want to call them kickbacks, but they certainly are doing that on your backs.

I'd just like to know from you, as a professional—and perhaps both of you can quickly comment on this. As a professional in the community, to have these allowances, which were once branded as professional allowances by the same government, now being branded as kickbacks, what does that do to you and to your profession?

Ms. Rita Winn: It's very troubling, and I'm personally offended by those remarks. Pharmacists don't want to talk about money; we don't. When our patient comes to the counter, money is not what we're focused on. There are a hundred things going through our minds about how the patient is doing. We see what they look like, we're looking at their medications, we're thinking about the condition they have. Did we make sure that they're taking it properly? Did I remember everything they need to know? Are they okay? And I don't want to talk about money. To have put the idea that I, as a professional, am taking something dirty—kickbacks, nefarious, whatever words have been used in the media. I'm personally offended, deeply offended.

Mr. Frank Klees: Mr. Wassef?

Mr. Farid Wassef: What it's done for me—I think it's temporary. I'm hoping I will recover, and I think I will once this dies down, but temporarily, it has lessened my reputation.

It has occupied a great deal of my time trying to explain this to the average public. They trust me, but they're confused by what they hear, number one. Secondly, they're very anxious and worried and scared about what that means. I have had many people phone me because they live in the city and they drop their elderly parents off in Stouffville to live and retire. They're saying, "Are you going to be able to deliver mum's prescriptions for free? Are you going to be able to check on mum? Are you going to be able to continue to call her doctor?" And I said, "We will, we will," when I darn well know the math doesn't add up and at some point my employer is going to have to start to charge for these things quickly if no funding comes from the government or no detailed picture of how we can access this pitiful $100 million that was offered to us. It really is, when you sit down and you look at the math. That's what I, as you can detect, am angry about.

1510

Mr. Frank Klees: Well, if I can just assure you that certainly those of us sitting here in the official opposition think it's a reasonable request that you've made, that the government take a pause, that they get back to the table with the industry, that the discussion takes place in terms

of how we can get from here to where I hear the government wants to be and I hear you want to be, too.

Ultimately, if professional allowances are not what the government wants, you're willing to work with them. The reduction of the cost of drugs, the common purpose is there. I think what I'm hearing from you is, let's put the patients first and ensure that they're not hurt in the meantime, that their services are protected, that patients are protected. By ramming this thing through there will be unintended consequences, and the unintended consequences will be throughout the community.

We'll stand with you on that and we're hoping—and maybe we can get a comment from the parliamentary assistant as to whether he would be willing to support that kind of deferral, that kind of pause, to ensure that we can find a proper resolution here.

Mr. Parliamentary Assistant?

Mr. Wayne Arthurs: I think you'll find the process we have—as you well know, today we're hearing from witnesses. The time for our debate and discussion occurs a week from now.

Mr. Frank Klees: I was just hoping that maybe you personally would be able to support that.

The Chair (Mr. Pat Hoy): Thank you. We appreciate your presentation. Thank you very much.

MR. NAYAN PATEL

The Chair (Mr. Pat Hoy): Now I call on Nayan Patel to come forward, please. Good afternoon. You have 10 minutes; there could be five minutes of questioning. Just state your name, and then you can begin.

Mr. Nayan Patel: My name is Nayan Patel.

Dear members of the standing committee, I wish to thank you for this opportunity to speak to you regarding changes proposed in Bill 16 as they affect pharmacies.

I am an independent pharmacist, serving the people of Stouffville, Ontario. At 12 p.m. on a Wednesday afternoon, a patient walked into my pharmacy. She told me that her doctor was at lunch and she came here because she was out of breath. I got her to sit down and started to review her current medications and her chronic conditions. This process took me about five minutes.

I realized that her doctor had recently increased the dosage of her pain medication called Duragesic. This medication is very effective for pain, but at high doses could cause respiratory depression, displayed by shortness of breath. After confirming her pain was under control, I asked her to remove her Duragesic patch. Within 15 minutes, her breathing started to improve. I then contacted her doctor and explained to him what I did. He agreed that what I did was beneficial to the patient and thanked me for my work.

This entire process took me 30 minutes to complete. I was able to provide this service since I was allowed to use professional allowance funding to pay for the time to intervene on the patient's behalf.

At 11 a.m. on a Sunday afternoon, I received a call from a patient covered by the Ontario drug benefit plan who was feeling dizzy and had some rashes develop on her skin. I looked up her medication profile on my computer and realized that she had just started a course of ciprofloxacin antibiotics and Tylenol 3 for pain. I asked her how her pain was and she said it was mild. I explained to her that it could be the codeine in the Tylenol 3 causing the dizziness and itching. I asked her to stop taking her Tylenol 3 and switch to extra-strength Tylenol and continue with her antibiotic and to call me later on that evening. She called me at approximately 4 p.m. and told me that she was feeling much better.

This entire process took me 10 minutes. This is an example of a recommendation that should be covered by my professional fee; however, it is not. The Ontario drug benefit fee is $7 and my average cost to fill a prescription and to provide the required support and advice to the patient is approximately $14 per prescription. This is where the professional allowances have covered the gap in funding.

Dear members of the standing committee, do you think that these are valuable services that I provide to my patients? Please explain to me how I am going to provide this valuable service if the government removes over $750 million of funding to pharmacies and only returns a small fraction of this funding to pharmacies. The services that I have mentioned above would have to disappear if I were to attempt surviving these funding cuts.

When speaking to my representative in government, my MPP, I was asked, "What does a pharmacist do?" This is the explanation that I provided: I provide advice to my patients when they are ill and, in many cases, I help them avoid physician visits and visits to emergency departments. I proactively educate patients on a wide variety of disease states. In most cases, I engage them in learning how to control, improve and manage their ailment, and, based on personal knowledge of that particular patient, I tell them what diseases they are more susceptible to contract and how they can proactively manage their health to minimize their effects.

I solve drug-related problems, such as detecting drug interactions. I resolve barriers to patients being able to take their medications properly and ensure that no harm comes to them from these occurrences. I conduct approximately 15 to 20 seminars per year on high blood pressure, diabetes, nutrition and many other conditions. I follow up with my patients to see if they are following my advice and suggest alternatives, if they are not able. And the list goes on and on.

Just from being asked this question alone, I realized that the government drafted this legislation without knowing what a pharmacist does, without realizing how integral the pharmacist is in the health care system, and without realizing how the pharmacist is able to deliver these services with the funding model currently in place.

We agree that the people of Ontario deserve to have lower drug prices, which should include both generic and brand name medicines. We agree that a new funding model, which does not have pharmacies rely on professional allowances to cover the current funding gap, is

necessary. Removing professional allowances without addressing adequate replacement funding will leave many patients in a compromised situation.

Decades of government underfunding for pharmacy services led pharmacies to seek alternate funding. The government was quite content in the past with not having to pay pharmacies for the actual cost of providing a service to recipients of the Ontario drug benefit plan. The Ontario government negotiated prices with manufacturers directly and not with pharmacies. Now, the Liberal government is portraying pharmacists as the villains for the high cost of the Ontario drug benefit plan. This system was created by the government and the government should take responsibility for fixing it properly.

Professional allowances are used by pharmacies to provide direct patient care in the communities that we work in, and we follow the guidelines designed by the government. To suggest that 70% of the professional allowances received were used inappropriately is an irresponsible statement and does not stop short of slander.

In good faith, pharmacists began a negotiation process with the government many months ago. Our proposal included a reduction in generic drug pricing and maintaining the support and services offered by pharmacists in our community. However, this was totally ignored by the government.

I have to wonder if submitting comments both orally and in writing during this consultation process is just a show. Our experience shows that in the last four years, the result of this process is that none of the recommendations are accepted and it's more a process designed to provide the perception of enabling stakeholder and public feedback. How do we know that this time someone will actually read and listen to us?

The Liberal government says that they appreciate and understand pharmacists, but we know that they do not. The government needs to spend time in an actual store to see what a pharmacist does and to understand that no matter how cheap a drug is, it may not work properly or be harmful to a person if they do not take it appropriately. A good portion of our services are not covered by the fees we collect. They are only possible due to the professional allowances we are able to collect.

1520

Unfortunately, the professional services, in many cases, are directly tied to the prescription dispensing process. You can't simply cut the funding to dispensing and expect professional services to take place.

There are numerous functions that a pharmacy provides for a patient that cannot be covered by separately billing for extra time. For example, if an elderly patient forgets my recommendations or I encounter a patient who does not speak English well, they require a little bit more of my time. Should I charge them extra? My fee is an average cost of what it costs me to provide medication and related information to the patient.

My store has been recognized for the outstanding level of service and care that it provides. The readers of our local newspaper voted our store as the best pharmacy in Stouffville in 2009 out of the five stores in our town. Our store was named the most outstanding Pharmasave store in Ontario in 2009 out of over 150 stores. Our customers write about us. I have provided you with a copy of an article from Drugstore Canada to illustrate what our store does and the care that it provides. Make sure you have a box of tissue nearby when you read this article.

I can compete with the large drugstore chains because of my focus on service and care that I show my patients every day. I focus on health care. If Bill 16 is not drastically changed, I will lose money on providing prescription services. I do not have a cosmetics department to subsidize the cost of filling a prescription and I do not have deep pockets to see if the government will change its mind after they realize that too many pharmacies have gone out of business.

The Chair (Mr. Pat Hoy): You have about a minute left.

Mr. Nayan Patel: With increasing health care costs, you need pharmacists to work with you, now more than ever. We help the government deliver public health, from telling patients about West Nile virus to dispensing Tamiflu to control H1N1 outbreaks.

The government needs to empower pharmacists to save money in our health care system, not create barriers. The government needs to ensure that we are there when they need us.

I hope that my comments will be listened to and acted upon by the government. If they are not, then I fear that my patients will not get the services that they need to maintain their health, and we will see health care costs rise in other areas of our health care system.

Thank you.

The Chair (Mr. Pat Hoy): The rotation goes to the government. Mr Arthurs.

Mr. Wayne Arthurs: Mr. Patel, thank you so much for being here. I certainly heard your comments, a variety of them, and the concerns about whether or not the processes that you've been engaged in, and presumably will continue to be engaged in, do have any impact. From my perspective, I can broadly provide assurance that these are important processes. Whether or not at a given time you see a direct outcome or not, the absence of the kinds of inputs that we have in these processes would do us all a disservice. I want to thank you for that, in spite of the frustration you'll feel or have felt along the way.

As a small pharmacist—we've heard now from three or four today. I think one had a number of stores, but for the most part we're talking about independents. How does volume impact you? How does your business model have to adjust to presumably reflect a smaller volume of activity than, let's say, a large chain operation? You mentioned cosmetics and the like as part of that business model. Presumably your business model has to operate somewhat differently if it's going to provide those services than an operation with a very large volume, which might be able to absorb some of that into their business. Not every client or customer that you have will require the level of service—at least I'm presuming, from

my own personal experience—that you articulate here as necessary for seniors or those with very specific medical needs.

Mr. Nayan Patel: Definitely, volume can play a difference. Like I said, I don't think that I should have to branch out into cosmetics and food to subsidize the costs of providing a prescription service.

Not every patient requires the same amount of time. We find that we do spend a lot more time on the elderly. They have more complex drug conditions, as opposed to someone who may be in their 20s.

The fee that we charge is an average. I don't think it's in our best interests to sort of count the minutes and charge patients accordingly. I think that a flat fee is the best way to go in terms of eliminating the extra paperwork.

Mr. Wayne Arthurs: One of the challenges, I guess, potentially will be that the professional allowances will be removed in stages, the first one being the publicly funded portion of that. With the other professional allowances being in place for a period, I believe, of three years, how immediate is the impact, and what are the implications for you in the context of a phasing out, over a period of time, of those other allowances? Obviously, in the absence of government support, the implications are that it would be even more significant—I'll say severe; I won't even ask you to do that—if those allowances were removed all at one time.

Mr. Nayan Patel: I guess what you're asking me is if I would like a quick death or a slow death. I think that the government really needs to step up to the plate and, as professional allowance funding is removed, they need to add more to it so that there is funding for these professional services and they are maintained. I can tell you for sure that customers will suffer, patients will suffer, and I think that a lot of these costs will be downloaded onto the patient. Hopefully, they can pay for it.

Mr. Wayne Arthurs: When you ask a question, as I did, you have to expect an answer. Thank you.

The Chair (Mr. Pat Hoy): Thank you for your presentation.

Mr. Nayan Patel: Thank you.

MR. PETER MERAW

The Chair (Mr. Pat Hoy): I now call on Minden Pharmasave to come forward, please. Good afternoon. You have 10 minutes for your presentation. There could be up to five minutes of questioning. I would ask you to state your name, and then you can begin.

Mr. Peter Meraw: My name is Peter Meraw. I am a pharmacist at Minden Pharmasave. It's a great honour for me today to be given the opportunity to speak to this committee about Bill 16 and the potential implications it may have for direct health care in this province, on my profession of pharmacy, and for the rural community of Minden Hills township, which is my home.

I want to start off by telling you a little bit about myself. I grew up in Bowmanville during the 1970s, went to Catholic schools and attended Bowmanville High School. My father worked at GM in Oshawa and my mother was an elementary school teacher. We had a typical southern Ontario working-class upbringing, and a lot of advice from Mom and Dad: "Peter, if you ever want to make something of yourself, you have to stay in school." It was good advice, so I set my sights on a career in pharmacy and pursued that goal in the faculty at the University of Toronto.

Since becoming a pharmacist, I've worked in a number of positions. I started as a Shoppers Drug Mart staff pharmacist in Peterborough for two years, then joined Oshawa Lakeridge hospital as a staff pharmacist, and worked in psychiatry, oncology and the renal care clinic. Two years later, I joined Janssen-Ortho's medical information department, and for the next 10 years held a number of positions as a sales rep, medical education manager and brand manager. In the evenings, I worked towards a master's of business administration at Schulich School of Business at York.

I believe that, like the proverb of the five blind men describing the elephant with their up-close perspective, my experiences, broad as they are, give me a better view of the big picture of what this is all about, and perhaps what's the most important part.

In 2006, my lifelong friend Richard Smith and I had the opportunity to purchase the Minden drugstore, or Minden Pharmasave. It was a big risk and involved substantial business loans and relocating our young families to rural Ontario. Providing health care in Minden has involved some unique challenges, and I'll share some of these with you today. But before I do, I want to tell you that neither my family or I have regretted our move for a minute. The experience over the last four years has been great. It's hard work, but the community has been wonderfuIly supportive. We have a great staff of about 20 employees who treat us like family. Ours is a busy store. We provide many specialized services, including methadone dispensing, long-term-care management, diabetes education and blood pressure monitoring. We answer questions for our community non-stop, all day long. It can be quite exhausting, but rewarding just the same.

Running a small-town pharmacy has reminded me that being a pharmacist is about serving the community, and I feel that this is what the present debate should be about as well. It's about our sick, our elderly, our parents and our grandparents. It's about government; it's about responsibility. It's about society, small towns, media and, at the centre of it, the patient—in Canada's largest province, in defence of our most vulnerable people and our most vulnerable communities.

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In order to show you why I believe this legislation is a step backwards for health care in this province, I'd like to talk to you about some of the challenges we face in providing health care in Minden.

We are a proud community of 5,500 full-time residents known for beautiful forests and freshwater lakes.

Our people are rich in spirit, welcoming and friendly, but economically deprived. The median income is well below the provincial average. In fact, using information from census studies, Haliburton county residents earn less than anyone else in Ontario at $39,450 per household. The provincial median is $70,806. Minden is an elderly community; 25% of our population is over the age of 65, compared to 14% province-wide. The average age in our town is 50, the provincial average is 39. Due to its natural beauty, Minden's summertime population swells by 20,000, as tourists flock to the area's waterfront cottages and beautiful parks.

I want to pause for a moment and I want you to consider these dynamics: the age of the community, the income level, the sparse population, the spread-out geography, the influx of tourists and the chaos this can create in providing services, in particular, health services for the elderly. To face these health care challenges, Minden has one full-time family doctor and one full-time ER physician. This is typical of many rural communities in our province.

How is a community like ours able to meet its rural health care challenges? In no small part because of the services my staff and pharmacy provide. In rural communities across Ontario, pharmacies take on a hugely important role within the health care model. It's the hub. We receive orders from nurses, caregivers and physicians. We service patients' needs. We clarify dosing, check costs and formulary issues. We recommend substitutes when drugs are not on formulary or are not affordable, and we counsel and support our patients. We treat addictive disorders and depression. We counsel on weight loss. We act as a triage for the local ERs and urgent-care clinics. We recommend over-the-counter meds. We are the most accessible person in the system and we provide a highly trained and professional service free of charge, seven days a week. Our service may not be appreciated by this current provincial government, but it certainly is by our patients in Minden. Our service is particularly important in communities that are aged and lack sufficient doctor services: rural communities, geographically isolated communities—communities like Minden.

Last week, I spoke with Olive Hamilton. She came to me with stomach pain and she was under stress. Olive is moving into a nursing home. She and her husband Jim are in their 80s and can no longer manage on their own. She gets her medications in compliance-style blister packaging, which helps her to remember to take her medications at the correct time and in the correct dose, a service that is provided free of charge thanks to professional allowance funding. In reviewing her meds, I noted that Olive was on meloxicam. She tells me she cannot get in to see her physician soon enough. Meloxicam is what's called a non-steroidal anti-inflammatory. It's used to treat arthritis but, like every drug, it has side effects and sometimes these can be dangerous. On meloxicam, patients can develop stomach ulcers, especially elderly patients. If left untreated, stomach ulcers can become stomach bleeds. Patients can die—patients like Olive.

I asked Olive to bring me back her meds. We removed her meloxicam. One of our dedicated technicians spent 15 minutes working on her meds; I spent 10 minutes checking them. The service was provided free to Olive, who cannot afford extra fees on a fixed income. This pharmacist-initiated intervention will save the ODB approximately $260 per year going forward. I also gave Olive a $7 antacid and told her to use it regularly for a few days, then as needed. Olive returned a few days later, telling me she felt much better. In this case, the service saved the province a potential visit to the ER. ER visits cost money. I'm not sure how much but I'm quite sure it's more than $7.

Consider now that two thirds of people over 65 take five or more prescriptions. There are Olive Hamiltons all over this province.

In order to know how this bill impacts pharmacists and their staff, the communities in which they work and, most importantly, patients like Olive, we need to take a look at the math that underlies our business and how this bill changes that math.

You've heard that it costs us $14 in expenses to dispense an ODB script. The province pays us $7. That's right, the government pays us half of what it costs to fill a prescription for the most vulnerable patients in our province. If I walked into a grocery store, picked up a $4 bag of milk, flipped the cashier a toonie and walked out, I'd get arrested. For the government of Ontario, this has been standard procedure for the last several years.

So given that 70% of the prescriptions we fill are ODB prescriptions, how do we pay our staff and continue to provide services? In 2006, George Smitherman, the health minister, created the Transparent Drug System for Patients Act, TDSPA, effectively creating a legal subsidy for ODB. Because of chronic underfunding of pharmacy services, the generic industry stepped in and financed half the cost of pharmacy care for seniors in this province. Depending on your perspective, you may consider that pharmacists made a deal with the devil or, like many European health models, that TDSPA created an innovative private/public partnership which both enhanced service quality and saved the province money. But whatever your opinion, the government made it legal. They've audited us for the last four years and they've regulated the funding.

This professional allowance funding pays for the expenses of Olive's packaging, the technician's time, the materials, the equipment and the pharmacist's time. Bill 16 makes this funding illegal for pharmacists to accept. The Premier says he's not cutting funding, but Ontario seniors, I will tell you the truth: Bill 16 cuts health care funding in this province.

This issue really is this simple. The government necessitated these professional allowances by chronically underfunding the ODB. By making this funding illegal, without actually paying pharmacists what it costs us to fill a prescription, they're making it impossible to provide the level of health care services that our seniors and low-income patients rely on. To claim, as this gov-

ernment is doing, that they haven't cut funding simply because they haven't increased their level of neglect of ODB is disingenuous and cynical. I'll say it again so there's no mistake: Bill 16 cuts health care funding in this province.

The Chair (Mr. Pat Hoy): You have about a minute left.

Mr. Peter Meraw: Okay.

There are other important issues to consider. Drug expenditures are skyrocketing. We need to rein them in or we won't have ODB for our children. We have to control the deficit.

What's interesting is that a year ago, the federal government tried to pass a balanced budget. The opposition parties considered the issue so serious that they threatened to form a coalition to "bring Canadians a government that cares about them in a crisis." We need stimulus spending, they said. So under opposition pressure, the federal government came back with $60 billion of deficit spending stimulus. Now, a year later, in Canada's largest province, we need to rein in the deficit in our most important economy—health care.

I want to also consider another important issue: sustainable, environmentally friendly, small, rural towns. In Minden, on our downtown main street, our pharmacy is one of the hubs of economic activity. We are a family. We know our customers by first name. It's a pleasure to serve them and they like to visit us. We invest in our neighbourhood merchants. We sponsor local charities. We look out for each other. Bill 16 has taught Richard and I just how much our community goes to bat for each other when they sense injustice. We are humbled by the support we've received. We'll remember it for the rest of our lives.

We need sustainable, vibrant, small-town economies like these, not empty main streets with two-hour daily commutes to larger centres. It's bad for our environment and it's bad for society.

Rather than being clear with the people of Ontario about the impact of this bill on physical and economic health, we've engaged in a campaign to discredit pharmacies and distort the facts. The first fact that I want to clarify is the statement that this bill will bring down the cost of drugs for patients in Ontario. Let's examine that claim. ODB patients pay a fixed co-payment of $2 or $6.11. With private insurance plans, they usually pay a fixed price also, or a percentage. Sometimes the co-pay is the dispensing fee or a percentage of both.

So where are the savings to the patient? Will large insurance companies pass on those savings to the end customer? History tells us that this is unlikely. As an example, you only need to look as far back as July 2008, when the provincial ministry gave exclusive priority listings for brand name manufacturer GlaxoWellcome's stomach pill Zantac and Merck Frosst's pill Vasotec in exchange for volume discounts: Kickbacks paid to the ministry in quarterly instalments worth hundreds of millions of dollars. These two brand name pharma companies received exclusive priority listing in the ODB formulary in return for paying a rebate back into the ODB. In these first two examples—

The Chair (Mr. Pat Hoy): We're going to have to move to the questioning now.

Mr. Peter Meraw: Okay. The price in those two examples did not change. It was $2 or $6.11 before and $2 or $6.11 after. So what this really means is that it saves insurance companies money, not consumers.

The Chair (Mr. Pat Hoy): Thank you. The questioning goes to the official opposition. Mr. O'Toole?

Mr. John O'Toole: Yes, thank you very much to Peter Meraw and your partner, Richard Smith. I know that your family and your parents would be very proud of you today, with what you've accounted for in an unambiguous manner.

I read an article recently in the Toronto Star that sort of said that there are more pharmacists per capita in Ontario than in some United States states. How would you treat that kind of characterization by the Toronto Star of that number of pharmacists?

Mr. Peter Meraw: I think it's an interesting point because I believe the author spun it as if it were somehow evidence that we had too many pharmacies. I think McGuinty commented at one point that he needed to put a few of us out of business.

I would say that if you look at the percentages of consumption between the two countries in tablets consumed annually and you also consider the volume of drugstores per capita, if you do the math it tells you that our system, which is still a 51% small owner/operator high-service model, and their system is leaning toward a large-style department store, low-service model, high barriers to entry, high capital investment. So I think what is missing here is the fact that, is that better for patients, like all of Hamilton? Is it better for seniors? Is it better for communities like Minden?

1540

Mr. John O'Toole: A very straightforward question.

I'd also openly ask: The description you gave—maybe you could expand on that—that seniors over 65 actually don't pay directly; the government pays. So the government is paying. And persons who have a benefit plan: Their benefit plan is covering it. But the rest of the people are paying out of their wallet. How would you say this change will impact not necessarily your business but the consumers generally? These changes are taking money out of the system. How do you think that this change is going to affect, at the end of the day, the three types of patients I've mentioned: seniors, the ones on benefits and—

Mr. Peter Meraw: Seniors will typically pay $2 if they're low-income or $6.11, but they receive a number of services free of charge, so I think that the co-payment is not expected to change. As I said earlier, what this does is, it saves insurance companies money, but it doesn't necessarily save seniors money. In fact, previously free services that they relied upon in order for pharmacists like ours to stay in business, inevitably, we're going to have to increase our fee—probably—

and/or increase fees to services we provide. So at the end of the day, what it really does is it takes fixed-income seniors and it downloads extra fees to them, and the benefactors of that are insurance companies. To me, that is an injustice, when fixed-income seniors are offloaded fees so that insurance companies can profit. I think you see where I'm going with that.

Mr. John O'Toole: Absolutely, and I guess it's very clear that the choice, then, is that they're actually—this is really about consumers, at the end of the day, paying more and getting less. That's how I see it. They're either going to be paying more or getting less or both. Which do you think is the worst possible outcome?

Mr. Peter Meraw: Well, if you consider a community like mine—and what I'm hopeful for, at the end of the day, from all this is that we have strengthened amendments for rural communities, because our patient mix—actually, if you look at our third party private payers and ODB, we're a heavy senior population; we have 10% of patients who are actually cash-paying customers. If you consider that this bill only affects 24% of the overall expenditure pie and 76% are brand name pharma companies that are unaffected—in fact, Pfizer, I think, two months ago, increased their prices 4% or 5%. So 2.4% of my prescription transactions will go down, but at what cost?

We need change here that is evolutionary, not revolutionary, because—I don't want to be too melodramatic—with revolution you can achieve change faster, but there are often consequences and casualties and, in some cases, body bags and concentrations of power that are not necessarily benevolent.

The Chair (Mr. Pat Hoy): Thank you.

Mr. John O'Toole: Thank you very much for your presentation.

MS. ROSANNE CURRIE

The Chair (Mr. Pat Hoy): Now I call on Pellow and Lucknow Pharmasave to come forward, please. Good afternoon. I noted that you've been sitting there for some time but I'm compelled to tell you that you have 10 minutes for your presentation, and there'll be five minutes of questioning. If you state your name, you can begin.

Ms. Rosanne Currie: Thank you. Good afternoon, Chair, and members of the standing committee. My name is Rosanne Currie. I'm a community pharmacist and owner of two rural pharmacies: Pellow Pharmasave in Walkerton and Lucknow Pharmasave in Lucknow, Ontario. Both of these communities serve a large proportion of seniors and are struggling due to the current doctor shortage.

Twenty years ago when I graduated from the University of Toronto, I had a vision of how I wanted to practise patient care in community pharmacy. This vision came to fruition with creating a competent pharmacy team that takes care of the technical aspects of preparing a prescription, freeing up the pharmacist to be available to meet the increasing health care demands and needs of our patients.

The reality is that this massive funding cut to health care will affect the level of patient care I will be able to provide to my patients. The government has underfunded my pharmacy services for over 20 years, in which time I have received a 56-cent increase. Independent studies show that the cost of providing a prescription is $14, while the government has paid me only $7. Yes, I have received professional allowances, which, as regulated, have been reported to the government. These professional allowances have been used to help support the patient care activities I offer in my pharmacies and to assist with the payment of my pharmacists' salaries.

Using my professional allowances for my pharmacist salary is the most direct form of patient care. It is ensuring that a pharmacist is available to speak with our patients. There has been a huge funding gap—a gap that we've had to fill in order to keep community pharmacy viable. Professional allowances have filled this gap in the past and allowed us to provide care and services that have made us the most trusted health care professional, as voted by patients.

Community pharmacists provide valuable services on a daily basis for which there is no direct funding. I know that with a pharmacist's involvement in providing care to patients, their overall health is improved, resulting in direct savings to the health care system.

For example, let's look back at May 2000, when our community was facing the E. coli crisis in Walkerton. Pharmacists in our community played a crucial role in the provision of advice to patients, young and old. We kept current with the advisories from public health and disseminated the information to the public. I need to highlight that these are the challenges we face. Crises come up in our communities. Pharmacists respond to the challenges and are not directly reimbursed. Or this past fall, when we fielded many calls and visits from patients asking our advice regarding H1N1. I was tracking over 30 calls per day.

What about the patient who recently had a stroke and was not only was dealing with a loss of independence, but was suffering from severe insomnia that resulted in several visits to his doctor? This frustrated patient, thinking that taking more of his prescribed medication would surely solve his problem, is lucky enough to spend more than 30 minutes talking with my pharmacist, Tracy, providing reassurances and coming up with solutions to meet his health care needs.

What about the patient with an average blood sugar of 11 millimoles per litre who was recommended to go on multiple daily injections of insulin by his doctor, and he refused this course of treatment? The patient told me how upset and angry he was with his doctor. I took the time to find out what his concerns were. He operated heavy machinery and was concerned he would have low blood sugar with multiple dosing, and he couldn't afford to miss work.

I educated this patient about the benefits of this therapy, and he was in agreement to initiate this therapy

in the winter when he was laid off. I communicated this to the physician, and I set up the patient on this new system in the winter. His blood sugars are now within the desired range. I note that this patient is 60 years old and has many more years of being a diabetic ahead of him.

What about the MedsCheck program, which is also an underfunded program? Most seniors require much more than 30 minutes of our time as they are on a larger number of medications and have multiple health conditions. Many problems are detected during these sessions, and it would be unethical as a pharmacist to identify the problem but not solve it. This takes time—time that is not directly funded.

What about the emergency departments and doctors' offices who routinely refer patients to us to provide advice and recommendations for patients who cannot be seen? We are more than happy to assist, despite not being reimbursed for our time. However, what will be the impact on local health care when I refer these patients back to the emergency department because I don't have the staff to support my pharmacist services?

What about the patient who said, "My pharmacist, Rosanne, has been with me on my health journey. She has always taken the time to meet with me to listen to my problems, flush out the obstacles that are keeping me from moving forward, providing contacts in the health care community to assist me, works with me on a plan of action, including setting goals and coaching me with regard to self-esteem and self-confidence issues. I have been referred to a bariatric clinic, and Rosanne took the time to assist me in the completion of the questionnaire that the clinic sent prior to my first appointment"?

What about our patient who arrived back in Lucknow from London, sick, tired and in pain, just before closing, with a prescription to be filled? There was a problem with the prescription, but Dionne, our staff pharmacist in Lucknow, took the time to get it fixed, even though it took her until well after closing to ensure that the patient received the drug she desperately needed—or the time I drove over 30 minutes to another community after hours to pick up a medication that a patient required from a hospital discharge in London?

What about the patient who was on Plavix after a stent who suffered extensive nose bleeds that doctors could not control? The patient said, "I was informed I would have a major heart attack in less than a year. My doctor was out of options and told me to consult my local pharmacist, Dionne, with the purpose of finding an alternative drug. After several meetings with her, she came up with a different drug. I am not being dramatic, but feel she saved my life."

What about the patient who did not want to start insulin until he talked with the pharmacist first, or the patient who could not promise me "she would be safe" because she was suicidal whom I drove to the emergency department?

As you can see, many of these interventions are not attached to a prescription, and that is the problem with the current system. If we are forced to cut services, we will not have the time to discuss these issues with patients. This could mean that patients may prolong starting a life-altering drug treatment or may start a medication without proper education. Both of these situations could lead to serious health-related effects and ultimately increase costs to the health care system.

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Those are just some of the examples of the huge impact we have had as community pharmacists in the lives of our patients. In addition, we provide other vital health care services on a daily basis that have been funded by professional allowances, including:

—free delivery;

—faxing doctors' offices for renewals of medications;

—advancing medications;

—splitting medications;

—providing monthly wallet cards with the most current, up-to-date medication list, which are extremely important in emergency situations and can prevent serious adverse events;

—overlap of pharmacists to allow for medication reviews, chronic disease state management and patient education;

—medication and syringe disposal;

—empowering patients and teaching patients how to self-manage their chronic conditions, such as diabetes, high blood pressure, obesity and depression;

—advice on over-the-counter medication, herbals and vitamins;

—answering phone questions from patients who may not even be our regular patients;

—training on various devices, such as blood glucose monitoring, blood pressure machines and CoaguChek machines;

—and, of course, blister packaging and community seminars.

As you can see, these are all important patient care services that would have serious effects if they were either no longer offered or the patient could not afford to pay for them out of their own pockets.

In addition, there are many other aspects of our daily job as pharmacists that we do not receive direct funding for. These activities include: patient counselling, assisting with drug coverage issues, consulting physicians regarding potential drug interactions or inappropriate therapy choices, dose adjustments when patients are renally compromised or simply clarifying incomplete or incorrect prescriptions.

Every day is different in the world of pharmacy, and that is what I love about it. We are the most accessible health care professional, especially in our rural setting, and as such are called upon for anything and everything when it comes to the health care needs of our community.

The concern I have with Bill 16 is not the removal of professional allowances; it is the lack of proper transition time for my pharmacies which will compromise the care and services my patients receive. I want us to be able to keep my business viable and employ my dedicated team so that I ultimately can continue to provide these valuable

services to my patients. The amount of professional allowances that are being removed will largely impact my ability to do this. My pharmacy is one of those average pharmacies, and the average loss will be $300,000 per year.

To remain viable, what do I need to do? In less than 10 days, the Legislature is expecting our entire pharmacy model and model of care to be transformed. This is impossible. As a result, I need to find ways for my pharmacy to remain viable, and I need to react quickly. This means charging patients for services they have been accustomed to receiving as a service at my pharmacy for no charge. In addition, there will be no overlap of pharmacists. I will need to reduce technician hours, which will result in increased wait times, and the pharmacist will no longer be available or accessible to answer questions or address concerns in a timely manner. This causes great concern.

For many of our senior customers, we are their lifeline. Many of them do not have family close by to assist them and cannot access timely health care in our rural setting due to issues with distances and doctor shortages. Who will they go to when they have questions or concerns or simply need clarifications?

Make no mistake, I agree that the system is flawed. I would much rather be paid directly for the services and the interventions my pharmacists and I make on a daily basis that saves the health care system money—thousands of dollars.

I am also a certified diabetes educator and spend a great deal of time with my patients, discussing not only their medications but also trying to engage my patients to take an active role in the self-management of their diabetes. Whether the interaction is 60 minutes or five minutes, there is value.

Studies show that these mini-interventions have an impact in creating behaviour change. Keep in mind that a diabetic visits a pharmacy, on average, 46 times per year. That's almost once per week, so there are many opportunities to assist patients in achieving better management of their chronic condition, and there are many times when teaching can occur.

It's very frustrating that the McGuinty government does not appreciate or value my role as a community pharmacist. Premier Dalton McGuinty goes on to say, "It's not the government's job to ensure the survival of smaller pharmacies who say the changes will force them to close their doors." By saying this, the Premier is saying that it is not his job to ensure that my patients have accessible, front-line health care in my communities.

Thank you.

The Chair (Mr. Pat Hoy): Thank you very much. You had a lot of words there and went through them well. This rotation will go to the NDP. Mr. Tabuns.

Mr. Peter Tabuns: Rosanne, thanks for the presentation today.

You say that you don't have difficulty with the professional allowances going but you need a transition period. What do you mean by a "transition period"? What, concretely, should we be thinking of when you use that term?

Ms. Rosanne Currie: Well, I think what we're talking about here is that this bill is thought to go through on May 15. In this short period of time, a large, reckless amount of money is being removed from our system that we have relied on—the professional allowances that have allowed me to provide these services to my patients. If you remove that, what am I going to do? How am I going to pay my pharmacists? How am I going to continue to provide these services?

What we need to do is evolve. We need to evolve to a new model that will actually separate things into two things. There are those costs and those things that are associated with the direct filling of a prescription, and then there are those other tangible things that we do on a day-to-day basis, as I gave in my many examples of what we do on a daily basis as health care front—

Mr. Peter Tabuns: I'm going to go back to a question I asked some people earlier in this process. If you were paid $14 for filling every prescription, would that cover the gap in revenue that you would lose with the professional allowances gone?

Ms. Rosanne Currie: I think it's a really good start, but again, we've got to take a look at the two functions, right?

Mr. Peter Tabuns: Yes.

Ms. Rosanne Currie: We already know that the cost to provide a prescription is $14. The government is only paying $7. Yes, if you bring that up to $14, that will certainly cover the one part of our business. But what about those other professional services that we're providing, those things that I mentioned that have impacted people's health, those things that aren't directly related to the product? I think there needs to be improvisation for those direct fundings as well.

Mr. Peter Tabuns: Can you talk about the utilization issue? That's something that I've asked others about. Do you see circumstances where doctors are prescribing brand name drugs where they could be prescribing generics and saving money? If you see that, do you see that in large volumes?

Ms. Rosanne Currie: Absolutely. In every practice, we see that. There is no doubt in my mind that there is influence by the big branded pharma in terms of the choices that are prescribed. Definitely, you can pretty much tell that a rep has been in to see a prescriber, because you can certainly tell by the patterns of the prescriptions as well.

Yes, we do have a role to play in utilization. I'm a huge advocate for that and do it daily in my practice.

Mr. Peter Tabuns: The reality is—and this has been expressed by a number of pharmacists—that you will have people coming in for a large number of drugs, where you think that the volume of drugs that they're using could be substantially reduced.

Ms. Rosanne Currie: I think what we have to keep in mind is that probably we are that last link for the patient.

We're the ones that kind of keep track of everything that's going on. Sometimes, when patients go to a physician's office, oftentimes doctors only have time to address one issue—right? Or two issues. There are even signs posted saying you can address two things. As a result, a lot of things go by the wayside and oftentimes there isn't a critical review of the whole picture. As pharmacists, we can take that critical assessment of a medication profile. Maybe a spouse died 10 years ago and maybe that patient doesn't need their antidepressant anymore. But we can only find out those things by engaging in conversations with our patients.

Mr. Peter Tabuns: Okay. Thank you.

The Chair (Mr. Pat Hoy): Thank you for your presentation.

MR. HAIDER MEGHJEE

The Chair (Mr. Pat Hoy): I call on Haider Meghjee to come forward, please. Good afternoon. You have 10 minutes for your presentation. I would ask you to state your name before you begin.

Mr. Haider Meghjee: Sure. Good afternoon, everybody. My name is Haider Meghjee and I'm the owner of Guardian Pharmacy in King City. I'm here to talk about how this bill will affect my store.

My pharmacy is a small, independent pharmacy and has served the city of King for over 30 years. I bought the store about three years ago and I have a 10-year business loan to pay. I employ eight staff. This includes two part-time pharmacists, two assistants and four part-time cashiers.

The professional allowance I get is approximately $130,000 a year. This amount is reported to the Ministry of Health and is on my income statement as well.

This bill will remove about $130,000 from my store, and a small store like mine cannot sustain such a huge loss.

What will I do to survive? I will have to lay off my staff—some of my staff, at least. Both of my pharmacists will be laid off. Right now, I collect about $5,000 a month in terms of source deduction, CPP, employment insurance and taxes for the government. Most of this will be lost because I will have to lay off the majority of my staff. My pharmacists, who have never collected EI, have told me that they will collect EI with pride. Not only will the government lose in taxes that I collect, but they will also have to pay EI to some of my staff.

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The second thing that I will have to do is charge for services that we provide, or redirect patients to walk-in clinics or telehealth. Forty per cent of my patients are senior citizens and are highly dependent on my pharmacy for advice and for managing their medications. Right now, the professional allowance pays for the medical advice and issues handled in the pharmacy. If removed, I will have to either start charging for advice or refer my patients either to a walk-in clinic or telehealth. The cost of one phone call to telehealth is about $39. The cost to visit a walk-in clinic is about $35. By removing the funding from the pharmacy, the government will end up paying more towards other services. They will not be saving much money.

I am not against cheaper drug prices. Both generic and brand name drug prices should be lowered. After all, the brand names are responsible for about 75% of the drug cost. This bill is removing professional allowances without replacing them with a fair fee for the services that we provide, and this is where the problem lies. As you've heard here, the average cost to fill a prescription is about $14, and the government pays us just $7. How do you expect us to provide these services for free? These services save the government a lot of money, yet I am not being paid fairly.

In conclusion, I would just like to say this: In these tough economic times, why is the government destroying an industry that's employing people? This bill will force every single pharmacy to lay off people. This will have a ripple effect on the economy: jobs lost, less taxes collected, more unemployment. It just doesn't make any sense.

That's all I have to say. Thank you.

The Chair (Mr. Pat Hoy): Thank you for your comments. The questions go to the government. Mr. Arthurs.

Mr. Wayne Arthurs: Haider, thank you very much for being here this afternoon and describing your particular business. Tell me, if you can, though, just refresh me on your comment; I'm not sure I gathered it correctly. You referenced about $130,000 in professional allowances which you will lose if this legislation gets implemented. Is that the portion from the Ontario drug benefit plan or is that the full amount—

Mr. Haider Meghjee: That's the full amount.

Mr. Wayne Arthurs: That's the full amount. So presumably, at least initially—I'm not arguing your numbers—you wouldn't see that impact when the Ontario drug benefit portion is removed because the phase-in for the other would still be in place.

Mr. Haider Meghjee: I will lose about half of it at least.

Mr. Wayne Arthurs: About half of it would be the number that you're working with initially.

You, like others, have indicated that there's no disagreement that we should be doing things to bring down the cost of generic drugs. I have no expertise in drugs; I only work from some examples that are provided. Maybe I can just give you one; you can let me know whether I'm even in the ballpark. As I understand it, anyway, Ramipril, which I believe is a high blood pressure drug: Currently, the cost on an annual basis might be in the range of about $256. With the removal of the rebate structure, it could be down to about $87, probably saving about $170 on that particular drug. Would you be familiar with that?

Mr. Haider Meghjee: I'm not familiar with the exact numbers, but about half of it at least.

Mr. Wayne Arthurs: Okay. So it would certainly be substantive at that point for that.

Mr. Haider Meghjee: But a bigger saving is achieved by cutting down the prices of brand name drugs, which the ministry hasn't even touched.

Mr. Wayne Arthurs: Okay. All right. Mr. Chairman, I believe that Mr. Colle may have a question in our time allocated.

Mr. Mike Colle: Thank you for coming here today and expressing your very sincere concern. I'm not quite sure how this professional allowance works. Is it on every prescription that the generic drug company sends you the allowance? How does that work?

Mr. Haider Meghjee: No. We get a volume discount. So let's say you buy $100 worth of generic. You get a discount, okay? I buy my generics from Drug Trading, so there is an average discount of about 36%. For every $100 worth we purchase, we get $36 of discount.

Mr. Mike Colle: So it's a discount, basically, the way it works.

Mr. Haider Meghjee: Yes, it's a discount. People have called it a kickback; people have called it rebates. The government decided to call it a professional allowance.

Mr. Mike Colle: Then, on the comparison side, on the brand name pharmaceuticals, which you mentioned, their prices are also very high. Do they give you any kind of reimbursement or discounts of any kind?

Mr. Haider Meghjee: No.

Mr. Mike Colle: They don't.

Mr. Haider Meghjee: No, they don't.

Mr. Mike Colle: So they essentially make their money by their high price and the advertising they do of their—although they don't advertise, except you see all those American television stations with all those ads. I'm not sure if that's for Vitalis and all of those. I don't think they—

Mr. Haider Meghjee: They promote their products through doctors, so they advertise with the doctors.

Mr. Mike Colle: Do the doctors get a discount from Big Pharma?

Mr. Haider Meghjee: I don't think so, no, but I'm sure they get trips. They get other benefits from there.

Mr. Mike Colle: Yeah, because how does a pharmacist or a doctor know which drug is suitable? In other words, there are many different competing producers and, therefore, how would they connect with doctors to let them know that this drug is better than another drug by another company? These are the questions I get asked as an MPP from my constituents, and I sometimes find it difficult because there are so many complexities to it.

Mr. Haider Meghjee: It all depends on the company and how much advertising they do and how many doctor visits they do. The more doctor visits they do, the higher chance of getting that prescription.

Mr. Mike Colle: So the Big Pharma salesmen go see the doctors.

Mr. Haider Meghjee: Salesmen go to the doctor, yes.

Mr. Mike Colle: Thank you. I appreciate the help.

Mr. Haider Meghjee: You're welcome.

The Chair (Mr. Pat Hoy): And thank you for your presentation.

MR. ROB ROGERS

The Chair (Mr. Pat Hoy): Now I call on Rob Rogers to come forward, please. I'm pretty sure you know how it goes here now.

Mr. Rob Rogers: Yeah, I've got the idea. I've been here three hours or so.

The Chair (Mr. Pat Hoy): You have up to 10 minutes, and there will be five minutes of questioning. Just state your name, please.

Mr. Rob Rogers: Okay. My name is Rob Rogers. Good afternoon, Mr. Chairman and everyone on the committee. I'm a pharmacist and store owner of two pharmacies up in Bruce county: Gordon Pharmasave in Kincardine and Wardrop Pharmasave in Port Elgin.

My stores are independently owned and operated by myself and two partners, both located in southern Ontario. My stores are businesses that have been operating in their respective communities for generations—long-standing traditions. We serve a large clientele of both young and senior alike, but more to the senior side. Both stores have a long-standing tradition of top-notch quality and accessible health care. Both stores are small, well under 5,000 square feet, but they are anchor stores for their downtown cores, which in these days is very important. The downtowns need all the drawing power they can get in rural Ontario. Prescriptions make up 90% of our business. Pharmacy is our bread and butter, our passion and our reason for existing. Our front stores can't possibly make up for any shortfall in the pharmacy.

I'm here today to share with you the impact of eliminating professional allowances from the system, which was designed by the government through Bill 102 in such a short span of time without proper consideration for the consequences for both patient care and the viability of a vital service in the community.

Our pharmacy business has a mix of roughly 55% government prescriptions and 45% private. Removing professional allowances from the system will mean a huge financial blow to the pharmacies. If allowances are taken away completely, both stores will lose a large amount of money per month. The allowances allow us to pay the expenses that ensure that pharmacy care and services are accessible to our community .

Due to the extremely low margin on government prescriptions, we actually lose money on them to the tune of $7 per prescription. We are operating on a dispensing fee that has only increased 56 cents in 20 years. What business could possibly operate on a 1990s revenue while paying 2010 expenses? Pharmacist rates have gone up, technicians are needed now for increased workloads, and all other overhead costs have gone up.

Our pharmacies provide many extremely valuable services to the community. We compliance-pack seniors' and disabled people's meds to allow them to avoid dangerous errors in taking their meds. A good example

is, we provide compliance packaging to two local group homes that care for mentally challenged individuals. The caregivers at these homes are lay people and they don't have the knowledge to dispense these medicines unless they are properly packaged in this manner.

Due to the fact that these people have very little income, we do not charge them any blister-pack fees on these prescriptions. Because some of them are not on many items, this results in some of them actually resulting in a loss for the pharmacy. This is a very expensive process, compliance packaging. It requires a lot of products, but more so, a lot of manpower.

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Another example is a senior man we have who is extremely deaf; he can't even hear on the phone. He's an alcoholic and he's very confused, yet he's on very important medication. We've had to actually go to the extent of delivering him one strip of pills per day, every day, and of course at no charge.

We counsel people not only on their medicines and how to effectively take them but also on their disease states, but we do not get reimbursed for this counselling. We have one patient in particular with whom we spend at least an hour per week on the phone talking about all of her pain issues. She is a greatly troubled woman with whom myself and my fellow pharmacists show a great deal of compassion and patience. We spend a lot of time researching treatments for her, phoning the doctor on her behalf, getting her refills, advancing her pills etc. Currently, there is no direct compensation for this.

We counsel people on how to treat ailments with over-the-counter medicines and non-medicinal treatments, thus keeping people from going for a very costly emergency room visit. Hundreds of times I have given people a simple over-the-counter antibiotic drop to treat bacterial conjunctivitis, commonly known as pink eye. This cures the infection, usually within a couple of days, with no cost to anyone but the patient. If this person were to go to the emergency room, then the taxpayers would be on the hook for both the emergency room visit and possibly a much more expensive prescription that the doctor would prescribe. We solve all kinds of medicine-related issues: interactions between drugs, wrong doses, wrong drug for the ailment etc.

About a month ago, I had a man and wife come in. The man was taking his blood pressure at our in-store machine. His wife asked me if high blood pressure could cause such things as for him to slur his speech and make incomplete, incoherent sentences. I recognized this immediately as a sign of not high blood pressure but something much more serious: He was having a stroke. I sent them to the hospital immediately. The man's wife called me the very next day to thank me sincerely as the early intervention by the hospital saved the man from severe damage and possibly even death.

We take bags and bags full of waste medicines and needles back from people and dispose of them properly, getting them incinerated, keeping them out of the local water supply. This is very costly for us. This isn't cheap to send these things away. I checked my bills; it costs us about $150 a month to send these away, but no funding for that.

All of these services are provided on a no-appointment basis by the most accessible health care professionals in the system. I can't think of any other professional whom an Ontario resident can access simply by walking in and getting quality health care so quickly, and at no direct expense to them or the taxpayers.

Several times weekly, we teach patients how to properly use blood pressure machines and blood glucose meters. These devices are key elements to monitoring disease states such as high blood pressure and diabetes—very serious disease states. When they're used properly they're very important, but when these devices malfunction, people don't go to their doctor or their hospital; they come to the local pharmacy. Dealing with this is very time-consuming, and manpower is expensive. These services all happen in conjunction with dispensing medicines and cannot easily be separated out and paid for.

The abrupt loss of the allowance without proper alternative funding mechanisms will mean a rapid and shocking change to the public's quality of front-line health care. I'll be forced to dramatically increase the dispensing fee on the non-government prescriptions by $4 to $5 per, as I can only count on a $1 increase for government prescriptions. I'll have to eliminate overlap of pharmacist shifts, which will translate into longer wait times and a lot less time for counselling patients who really need the help. I will have to cut a full-time technician in each store, meaning yet longer wait times. I will have to at least double the cost of compliance packaging for the people who can least afford to pay it. I will charge for expired medication and needle disposals. Many people will probably just throw them in the garbage.

Pharmacists realize that there are budget issues and a need for a more transparent system. That's why the coalition provided a plan to reduce generic prices, lower allowances and save the government $260 million. Taking $750 million or $300,000 per store out of the system does not cure the problem but forces it out in another way onto the taxpayer. It will be a lot more noticeable for them, in that case.

The Chair (Mr. Pat Hoy): Thank you, and the question goes to Mr. Miller.

Mr. Norm Miller: Thank you, Rob, for your presentation. Most of the pharmacists that have come before us today said they're in favour of lower generic drug prices and they're also in favour of, with a gradual transition, doing away with the professional allowance. I get the impression that you'd much rather be paid the real cost of a dispensing fee, which has been estimated at $14, versus half the cost of the dispensing fee, which is what you're paid currently, the $7. You're nodding your head, so I guess that means you agree with that.

Mr. Rob Rogers: Yes. Definitely, it would be much easier than the other way around.

Mr. Norm Miller: But my question is, we have the Canadian Association of Retired Persons, CARP, coming

later on this afternoon, and they've come out and made statements in favour of the government's plan, I think mainly on the basis of reduced generic drug prices. What would you tell them about what it's going to mean for seniors in your community and the patients who you deal with? Frankly, I'm surprised that CARP is supporting this, because from what I've heard today, certainly, it's going to mean a lot of services that will have either extra charges for seniors or services not provided to them.

Mr. Rob Rogers: I'm surprised too, because seniors, as someone before me mentioned, pay either $2 or $6.11 on their government prescriptions. The fact is that a generic price change isn't going to affect them out of their pocket at all, but it will affect them if we start charging them for compliance packaging, for delivery and for counselling on their disease state. That would cost them, because currently we can't bill directly for it. So those are things being subsidized.

The other thing is that a cheaper, generic price won't help if they're getting brand-name prescriptions. Seventy-five per cent of the budget is the brand name medicines, not the generics. It's attacking the smaller percentage of the problem rather than the larger side of the problem. As people have said before and as I know for a fact, doctors prescribe these brand name medicines over the generics often, and it has a huge influence on the sales force.

I, myself, have gone to the doctor, recently diagnosed for blood pressure. The doctor asked, "So what do you want to go with?" She knows I'm a pharmacist. I threw out a couple of generic names. "Well, no. No, I really think you need this brand name stuff instead." She was actually arguing with me, a guy who knows drugs, wanting to give me a brand name. I think that speaks a lot about just how potent this promoting of the brand name medicines is.

Mr. Norm Miller: So what would you say to CARP, this organization that represents seniors? What would your message to them be?

Mr. Rob Rogers: I would have to assume they don't fully understand the system. Pharmacists know the system inside and out, and we know where money can be saved. As almost every pharmacist up here has said, drug utilization is huge and it could save millions and millions of dollars. If you can get somebody off Crestor and put them on simvastatin, that's a huge savings, but—

Mr. Norm Miller: And these changes are going to hurt seniors?

Mr. Rob Rogers: Yes.

Mr. Norm Miller: Okay, thanks. I think Toby wanted to ask a question.

The Chair (Mr. Pat Hoy): Mr. Barrett.

Mr. Toby Barrett: The government has indicated they're looking at a larger dispensing fee for rural pharmacies or remote pharmacies to compensate for losing the professional allowance. I don't know whether you can shed any light on this. What would be the government's definition of "rural"? We had a definition of rural for doctor recruitment, and they changed that. Some rural areas are no longer classified as rural.

Mr. Rob Rogers: Well, whenever you talk to anybody from Toronto or young people, it's always, "Where I live in Bruce county is rural"; I've even heard the word "remote." I'm from Saskatchewan, so that just makes me laugh my head off, because it's a great place to live. To me, an hour to drive to a large city is nothing, but to people out there, it is remote, and we have to pay extremely high prices for pharmacists in our area, higher than any of the major metropolitan centres by probably a good 10%, 15%, 20%. So I have to pay a high price.

We can't get doctors because it's remote. We have a severe doctor shortage in Kincardine, which only makes us all the more valuable. We had a doctor who went through a crisis about a month ago—a family crisis—probably the biggest writer in town, the most popular doctor. He was basically out of commission for two to three weeks. We had to scramble, we had to find other doctors. We had to fax, we had to loan people pills. What would happen if the pharmacy wasn't there to fill in for that? I mean, people have to wait a month to get in to the doctor.

Mr. Norm Miller: Thanks for your presentation.

Mr. Mike Colle: A question, Mr. Chair, of the research?

The Chair (Mr. Pat Hoy): Very good.

Mr. Mike Colle: I wonder if research could compile some kind of data information in terms of the protocols used by doctors to prescribe brand name pharmaceuticals over generic pharmaceuticals, the rationales they use for prescribing a brand name over generic, given the cost differential, what their rationale is and the protocols that they use, and if there is any government oversight of this; and maybe some data on how much is prescribed and the cost of these prescriptions of these brand names, to give us some examples so maybe, as Mr. Rogers—that used to be the name of my drugstore, Mr. Rogers', but I'm sure there's no relationship. Perhaps we could get a couple of commonly prescribed brand name drugs, like for high blood pressure and other common ailments, two or three of them, not too many; I know you don't have that much time. But if you could give us a bit of a breakdown on that to get an idea, if the government has any of this data available.

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The Chair (Mr. Pat Hoy): Thank you. Mr. Colle is subbed in to the committee, so he can put the question.

Thank you for your presentation.

Mr. Rob Rogers: Thank you.

MR. MURRAY BERMAN

The Chair (Mr. Pat Hoy): Now I ask Murray Berman to come forward, please.

Mr. Murray Berman: Thank you, Mr. Chairman, lady and gentlemen, for the privilege of addressing you. My name is Murray Berman. I am a retired pharmacist. I had two stores. I retired in 1977. I have no financial

interest in a pharmacy whatsoever. I should point out that I'm a senior. I'm going to be 78 in October.

Interjection: You may sit down, sir.

Mr. Murray Berman: Yeah, I'd rather stand. As a pharmacist, I never sat down. I stood up all my life and I'm still standing.

Anyway, I did serve six years as an alderman in the city of Chatham and three years on the board of education after I got out of pharmacy and got into another profession to help people. I was also on the provincial flood plain review committee.

I would like to just throw in one thing: I notice, from store to store when I go shopping, that Walmart is now up to $9.49, and I'm sure some of the other superstore chains are climbing up too.

What I'm here for today is to give you a history of the fee for pharmacy service to replace the archaic system of markup and profit for filling a prescription.

In 1956-57, the final year of four for pharmacy students at the college of pharmacy, U of T, led by Professor Fuller, the class undertook to survey the then-current system utilized to cost prescriptions as formulated by the College of Pharmacy of Ontario to dispense drugs. Several class members—I was among them—who worked in pharmacies did a breakdown of 200 prescriptions, each dispensed during a given period. The breakdown was to determine the actual cost of the medication and the resulting fee or profit. Utilizing the Ontario College of Pharmacy schedule, the cost of a drug was marked up by a formula, a percentage markup of 40%. This was like the retail system in use then, and in use today, for sales by merchants of food, clothing and hardware. The survey showed that should a fee system be implemented using the actual cost of the drug plus a fee of $2, this would result in the final price being almost exactly the same as the current system in place. I believe all pharmacies of the day believed that this system was unacceptable to them.

As a result, the pharmacists operating at the time could not accept that they could not get the 40% markup on the high cost of the new drugs coming out every day and only make $2. They also failed to realize that a prescription for 100 phenobarb or similar type of low-priced drug with a cost of about 25 cents would only return a very low total price of, say, $1.50 or $1.75 for 100, or something like 85 cents for 24. They would not accept that a prescription for Achromycin, for example, a patented brand name, would only reimburse them $9.17—cost—plus $2, when they were charging $15.27, a markup or profit of $6.10.

In 1960, nobody knew the generic names of brand drugs. Everyone used the brand name. There were some very cheap medications like phenobarb, ASA, codeine etc. that used a generic name. No one used generic-named drugs.

It was determined from the surveys across Ontario that these high-priced prescriptions were very few in number and that the majority of prescriptions were in the low end and not the high price range.

The students reasoned that counting and dispensing 16 tablets at a cost of 10 cents was just as much a professional endeavour as dispensing 16 antibiotics at a cost of $9.17, and that the professional fee did not depend on the cost of the ingredient, but the professional service required. We were pharmacists, not merchants.

That was 1957.

In May 1959, I opened my own small store in Chatham, and in January 1960 started dispensing utilizing a $2 fee. My average prescription price was about $2.96. In about 1960 or 1961 I distributed a list of generic drugs with their patented names and advised the physicians in my area that if they had patients who they thought would not get their prescriptions filled because of the cost, then they should use the generic name and this would cut the cost of the prescription by at least 50%—at least in my store, using a $2 fee with generic drugs. I guess I upset my confreres, and so the College of Pharmacy ordered me to appear in Toronto before the infringement committee to explain why I was acting in such an unprofessional manner. The drug manufacturers also sent me letters condemning me for using their patented names without their permission and warned of impending lawsuits.

I also instituted an answering machine, for which I sent letters to the doctors that if they wanted faster service for prescriptions after hours, they could record the prescriptions verbally and I would act on it fast. Again, the Ontario Pharmacists' Association condemned me and demanded that I provide an explanation to them and the college in Toronto for my rogue behaviour in utilizing an answering machine.

These actions by authorities appear outrageous by today's standards.

I also put "Poison" stickers on all my stock of cigarettes, and down came the tobacco companies to stop my mutilation of their products, but that is another matter.

Which brings us to the main point that I want to make. It has been 53 years since the class of 1957 originated the fee of $2 on the cost of the drug—no markup—for the quantity of drug for a course of treatment or a 30-day supply and, in many cases, a maximum of 100 tablets. You couldn't give them two months' supply for $2; it didn't make sense. In those days, most drugs were packaged, exceptions being for antibiotics, which were packaged as a course of treatment, a pack of 16 or so.

It was not until later in my career that larger bottle sizes appeared, such as 500s or 1,000s. This small price advantage to the pharmacist was removed at the hand of government. The cost price was the larger size cost, not the accepted price previously determined earlier based on the class-of-1957 calculations that we had used to determine the fee. The provincial government, then, determined the cost of the drug for us, regardless of what it actually cost the pharmacy. They determined our costs, not us. For example, the cost to a pharmacy in Wawa or Sault Ste. Marie was obviously higher due to transportation costs and other factors. Yes, there were what one might call meetings held with the ministry, but never

truly negotiations as far as we pharmacists were concerned.

Pharmacists now lost the benefit of larger-size buying. Any modest fee was stagnated, with no consideration of the cost of living or inflation, as with almost every other body of workers in a democratic, free society. Pharmacists, being nice guys, never, ever went on strike or held the public captive, as we have seen over the years in some allied health professions with work stoppages, work to rule or strikes.

In the current May issue of Reader's Digest, you will find a survey of the most trusted professionals in Canada. Well, pharmacists were number three as the most trusted professionals. Where were others, you may ask? Nurses were number five; doctors, number six; politicians, 39, just one above car salesmen at 40.

How can you strap pharmacy with this terrible mockery of your best friends in the health care field, with a fee of $7 in this time frame, 53 years later? If you recall the fee of $2 in 1957, also recall that bread and milk were 19 cents each, and gas was 24 cents a gallon. That works out to about five cents a litre. Taking inflation into account, I am told by someone who did some calculations and had access to an amortization schedule that the fee should be closer to $14.35 or more, an honest fee. I'm surprised to hear that the figure $14 came out several times today.

If the province had played fair with the pharmacies of Ontario long ago and negotiated a proper and reasonable fee in past years, then this furor over so-called professional allowances, coined as such by the ministry—there would not have been this quagmire we have today.

I personally am no longer practising my chosen profession that I, as a child growing up, wanted to become. The government had more fingers in my pie than I did, so I sold out and quit. The policies of this Liberal government, if put forth, will unfortunately force hundreds of stores and pharmacists to do the same: quit. It is archaic economics and logic to believe that by reducing the sheer number of pharmacists practising, Ontario's drug costs will be contained. Similarly, the idea to reduce the number of medical school graduates in the 1980s did little to reduce health care costs but did create an enormous doctor shortage and poorer health care for decades to come.

Long-term solutions must reign. Ontario is not immune to the large demographic shift that will increase demands on health care dramatically in the near future. A smart, creative and industrious government would see that working with pharmacy, as the most cost-effective provider of health care, would be the wisest, most economical and innovative direction the cash-strapped government could undertake.

What if the government got what it truly wanted? What if tomorrow every pharmacy in Ontario said that there's just no way financially to continue to service patients under this government reimbursement policy? Does this government truly believe they could create and fund a public system that services the great citizens of Ontario at even close to the level that takes place today—

The Chair (Mr. Pat Hoy): You have about a minute left.

Mr. Murray Berman: Okay. I'm here to advise you, the legislative committee, to take heed, and the pharmacies of Ontario to take heed of the following and not lie down as we have in the past.

The medical profession have an OMA schedule, updated regularly, of fees that they utilize to assess their patients for services not covered. The pharmacists of Ontario should adopt a similar system as well, and start now. The resultant costs would be charged to the patients of Ontario. It would be on your heads to explain why they now have to pay the charges, just like they are asked by the medical profession, when it was free before. Pay it piecemeal for service or a lump sum payment every year. Nothing is free today, except pharmacy services. I supplied you with the OMA schedule of fees. You can pay $95 a year personally or $195 for the family—something like that.

If a doctor charges $12.13 on the OMA schedule for a phone call to the pharmacist, using only one example, then the pharmacist should charge the patient as well for the actions they take every day: calling doctors for repeats and for errors in prescriptions, inaccurate dosages, drug-drug interactions and many more.

The pharmacist is the last hope for patients to ensure that there are no errors or drug interactions and that they understand the directions and instructions from the doctor, which they seem to forget soon after they have left the office.

If you examine the list of services the medical profession ascribes to, then the pharmacists should charge for so many other extras. Let the doctors check their own prescriptions for incompatibility. We should charge for all the advice we give for everything dispensed, for all the information on over-the-counter drugs, and for the counselling for all the drugs we are responsible for in our stores, instead of sending people to the hospitals and walk-in clinics. We should stop acting as intermediaries for doctors and hospitals. One only gets what one pays for. Pharmacists counsel patients to not buy something or to not take a drug as often as they suggest a drug to relieve a problem, even though this does not add to the bottom line.

Thank you very much.

The Chair (Mr. Pat Hoy): Thank you. I did let you go over because we're shortly going to be called for a bell, or potentially could have a bell, for a vote, and our questioner in this round is not here. Thank you very much for your presentation.

Mr. Murray Berman: Thank you.

The Chair (Mr. Pat Hoy): I'm just going to wait and see if members—they're calling to see what would occur. We'll just pause for a moment.

Okay, we will recess until after the vote, and then we'll come back.

The committee recessed from 1634 to 1646.

The Chair (Mr. Pat Hoy): The standing committee will come back to order now. Before we start with our

next presenter, I'm just going to let the room know that we are going to forgo questions in order that we can be done on time. There will be no questions, but we do want to hear your presentation. It's partially my fault; I gave people more time than 10 minutes and I gave questioners more time than five minutes on occasions, and now we're behind—plus the vote we just had.

MR. AKIL DHIRANI

The Chair (Mr. Pat Hoy): I'd ask for Akil Dhirani.

Mr. Akil Dhirani: Good afternoon. My name is Akil Dhirani. I have a little store in Scarborough at the corner of Victoria Park and Finch.

I'll give you a little background about myself. I started practising in a hospital setting in Windsor at Salvation Army Grace Hospital and then moved on to Hôtel-Dieu Grace, where I was the director of both sites. Finally, when Mr. Rae was through with the hospitals in Windsor, we had the amalgamation of the hospitals and we ended up with two hospital sites in Windsor. This brings back some memories, in the sense that we went through some of these things in a hospital setting a few years ago.

I'll walk you through my little presentation. I hope everybody has got a copy of the handout. The first page is a little pictorial of the clinics that we do on a day-to-day basis. In this particular case, we have Nurse Millie here, and we're going through the MedsCheck program as well as cholesterol, blood sugar and blood pressure monitoring. Then on page 3 of the article, I thought that rather than me telling you what it is that I do, I'd ask a couple of people who come to me for my services on a daily, weekly or monthly basis.

I remember one of the members—if I remember, it was the honourable MPP Miller who asked a question: What would you tell the representative from CARP? I believe it was yourself. Well, I got a little answer for you here. This is from Mr. and Mrs. Marjeram. If you look at paragraph 2—I'm going to the middle of the paragraph: "No request is too small or difficult for him to administer. I had occasion to request him to fill a prescription while I was out of the country and he was fully acquainted with the implications of mailing" my prescriptions "to me in the United States and he willingly undertook the request," and my prescriptions were received. This would be something that I would tell the honourable member from CARP.

If memory serves me right, I think there is a member of CARP from Windsor who had actually come out and said the exact opposite, as far as the support for this program goes.

In addition, if we go to page 4, this is a letter from a lady who's 90 years old—she looks 60. Again, somewhere in the middle of the thing: "At times, he has taken time to explain to me things about my medications that doctors have not taken time to do." That's something else that I would tell the member of CARP, who hopefully will be coming in after me.

Lastly, on page 5, is a letter from Mr. and Mrs. McMullen. Again, the middle paragraph: "Mr. Dhirani has proved to be a most helpful liaison with the doctors who prescribe these medications. We are more frequently in touch with Mr. Dhirani than our family physician."

I hope this suffices to answer your question. As far as what I would tell this member of CARP, these are some of the things that we may think about twice before we embark on mailing our prescriptions to the United States, visiting a 90-year-old or liaising with a senior's physician.

If you go to page 6, this is a letter from a physician. This patient was totally out of control. She was a psych patient, and this is a physician writing me a letter, saying, "I want to thank you" personally for supporting the management of this patient. Hopefully this is enough as far as answers and information on what we as pharmacists do. Again, this is not in my words. I'm sure you folks have heard a lot of words today, so hopefully this is a little different.

Then we go to page 7, and here what I'd like to do is bring in my hospital experience and talk about therapeutic substitution. We've had numerous questions about brand name drugs. Member Colle asked research to look at prescribing habits for brand name drugs. I bet you, if you look at research done in the United States in the 1990s—they looked at the prescribing habits of emergency interns. What they found out was that it was dependent on which company had brought in lunch the day before. Hopefully you can still find that research.

I had just graduated; then I joined Salvation Army Grace hospital. At that time, my job as director of pharmacy was to look at the drug budget. Guess what? Drug budget, yes—the drug budget at Hotel-Dieu Grace Hospital which exists today. There, one of the things we did to curtail the drug budget was to form two committees. One is found in any given hospital; it's called the pharmacy and therapeutics committee. If you look at the roles—and hopefully research can do that for you folks—of a pharmacy and therapeutics committee, one of the things it does is it controls the drugs that are permitted to be prescribed in the hospital. Guess what pharmaceutical companies will do? They will approach the physicians directly and ask them to prescribe their third- or fourth-generation drugs in the ICU or emergency room settings. My job, or any clinical pharmacist's job in a hospital setting, would be to go through the P&T committee and educate these physicians that just because something has been around for a while doesn't mean it doesn't work anymore. Hence, we get into issues of anti-microbial resistance, where we have such things as superbugs. Why do we have superbugs? Because you have drugs that are used that are not necessary, like broad-spectrum antibiotics.

That leads me to the other committee that we formed at the hospital, again talking about how we look at the usage of drugs. One of the committees was an anti-microbial review committee. Hopefully you folks can guess what this committee did. It looked at the anti-microbials that were used in the hospital setting, particularly in the ICU and the emergency room settings. These are some of the things that I looked at.

I want to embark on—and hopefully I can conclude with this—the talk about therapeutic substitution. Again, I heard there was discussion about how a doctor chooses a brand name drug and how pharmacists come in. Well, if you look at any hospital pharmacist, you'll find that their job will be to go on those units and hopefully, when the doctor is prescribing, say, "Well, Doctor, this is not in the formulary, but this is."

I got you folks three real-life examples. We've had numerous questions. I'm glad you can't ask me any questions, so I can get away with these numbers. I've got three examples here, and hopefully if you guys have any questions you can ask me later on or email me.

The first one is an antimicrobial. In all three examples, on your left will be the generic version; on your right will be the brand. The cost—I'm going to simplify this. On your left, for the pharmacists behind me, is biaxin clarithromycin. What do these brand name drug companies do? Guess what: If my patent's expiring tomorrow, I'm going to put an SR, XL, CR or what have you and make it a better drug, and go tell these doctors that this drug is better. You folks are talking about reducing the cost of generics? Well, guess what: It's barking up the wrong tree. You folks have heard that 75% is brand names, right? But it doesn't really matter. We're going to reduce the cost of generics? Well, these folks will put an XL, SR or what have you and go tell the doctors, "This is a better drug."

This is an antimicrobial for upper respiratory infections, Biaxin. The 10-day therapy is on the left: $38.96 is circled; the 10-day therapy on the right—hopefully you folks can read the $59.31 and do the math. We dispense that; we lose $1.36 on every prescription.

The Chair (Mr. Pat Hoy): You have about a minute left.

Mr. Akil Dhirani: Okay. The same thing with the next one, Actonel. It's for bone density. We've got an Actonel 150. The 35, which is used four times a month, just became genericized. Guess what? The 150 is out. The majority of their patients are on 150. Guess what's going to happen?

The last one is Lipitor, the world-famous cholesterol-lowering drug. Again, the math is right there. The cost for one month on the left is $33.84 for the generic simvastatin; on the right, it's $58.91.

Page 10: These are the losses that I would suffer—hopefully you folks can read that—if these cutbacks or what have you would go through. Lastly, page 11: We're not against lowering the cost of generic drugs; we're all in it together. We're in to look for solutions. Let's look at solutions—

The Chair (Mr. Pat Hoy): I'm going to have to end it there because we are really pressed for time, but thank you very much, and we will look for it.

MR. HESHAM ABDELSAYED

The Chair (Mr. Pat Hoy): Now I would ask Hesham Abdelsayed to come forward. Good afternoon, gentlemen.

Mr. Hesham Abdelsayed: Good afternoon, and thank you, Mr. Chair and members of the standing committee on Bill 16. My name is Hesham Abdelsayed. I am an independent pharmacist from London, Ontario and I have been a practising pharmacist for 25 years. I own several pharmacies across Ontario. With me today is Mr. Michael Nashat. He's a new pharmacist who has just recently entered the profession.

I appreciate the opportunity to comment on this bill. My comments, endorsements and concerns will focus on how this bill will impact the pharmacy. I hope that what I and what other stakeholders will say today will be examined, studied and acted on. Unfortunately, I do have my doubts.

As you may be aware, Bill 16 amends the Drug Interchangeability and Dispensing Fee Act and the Ontario Drug Benefit Act. Regulations have been posted on the Ministry of Health's website for comment. The deadline for comments on these regulations is May 8, 2010, yet the regulations are to be enforced on May 15—that's five business days. How can comments that are received be expected to be analyzed, examined or even looked at, or changes implemented to them, if at all, within five business days?

The committee should recognize that this is unacceptable in a process that is meant to be transparent and accountable. The comments and concerns of all parties should at least be considered to ensure that the changes we are putting through are in the best interests of the Ontario population, the taxpayers, the elderly and those with chronic disabilities. Ontario's pharmacists are considered one of the most trusted professions in Canada.

My first request is to delay implementation of the regulations until we have fairly addressed the concerns and comments. As a taxpayer and business owner who supplies his employees with health benefits, I welcome changes towards a system where drug prices will be lower and more transparent. The reductions and possible elimination of professional allowances that have been set up, regulated and audited by the current government is also a welcome move.

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However, it is very important to be known that in Ontario the pharmacy has only seen an increase of 56 cents in dispensing fees over the past 20 years. The current cost of dispensing, by an independent University of Toronto study, is $14—and I have supplied you with a copy of the study itself—for the average pharmacy. This fee covers salaries, overheads, insurance, software and packaging costs, along with many other costs.

For the past 15 years, the cost of operating a pharmacy business has doubled: pharmacists' rates from $28 to over $50; technicians from $10 to $11 to $18 or $19 and even as much as $20; delivery from $2 to $5 per package; hydro, gas and everything.

You can see that we have a gap in funding between what we are paid by Ontario drug benefit, which is currently a $7 fee plus markup of 8%, for a total of $9.80 on an average prescription.

A $1 increase in the dispensing fee as proposed will not be enough, especially because this $1 actually translates to be a 60-cent increase in funding. The lowering of generic prices by 50% saves $500 million and will mean a reduction of $40 million in markup funds, which works out to be 40 cents over all prescriptions, brand name and generic.

Having made some points so far, certain things need to be established as I go forward with my comments.

Helping close the gap in funding will create a stable, transparent and sustainable system. As a professional pharmacist who operates his own store, I can assure you that I will continue my services under any circumstances. It is both my moral and professional obligation. It is also required of me as a pharmacist to follow the standards of practice and code of ethics as set by the Ontario College of Pharmacists. If I am not able to provide these services, I will not be able to perform my duties as a pharmacist, which means I would have to close. I will not hold my patients hostage or grant them services that are suboptimal and not up to the expected standards of the profession. This means that our options are limited to closing if we can't provide the same level of service.

How we can reach a sustainable goal that can save the government money? According to the government's account, there will be $500 million in savings and, in return, the government will invest back $124 million in dispensing fees and $100 million for professional services, resulting in a net savings of $276 million.

However, I suspect that the real savings will be over $800 million, considering savings that will come from the following scenarios: $500 million from the 50% cut in generic prices; $40 million on the markup savings due to decreased costs; and $270 million when Lipitor, which is Ontario's most expensive drug, goes generic this year, and the government will immediately start saving $270 million plus $2.4 million in the difference of markup for that product. This amount will result in total savings of $810 million. If you increase funding of the dispensing fee by $3 per prescription, which will cost the government $300 million, the ODB program will still save $500 million.

We are supporting elimination of the professional allowances and the reduction in price of medications, but we expect the government to reimburse pharmacies fairly and transparently so that they can safely provide patients with their medications and provide the services that our most needy population—which includes the elderly, the mentally ill, brain-injured patients and those with disabilities and chronic conditions—require. I wish to continue to service these patients, and the proposed regulations, as currently written, will not allow me to do that.

I ask with all sincerity that the government increase its dispensing fee to a level that is more realistic with what the Ontario population expects from their pharmacy.

As a business owner, I am also concerned about the hastiness of this implementation. The regulations immediately drop the price of generic medications. Aside from being a pharmacist, I have to purchase the medications and sell them. These medications come with a price, and the drop in prices overnight means I will be selling my entire generic inventory at a loss. As a business owner, this is unacceptable. As the Standing Committee on Finance and Economic Affairs, I hope you see that I can't buy and keep an ODB product at $50 and receive reimbursement at $25 for it when the price reduction comes into effect May 15. A process needs to be in place to allow pharmacists to adapt to this new model. There needs to be a phase-in where we can obtain lower-cost inventory. Thank you for your time.

The Chair (Mr. Pat Hoy): And thank you for your presentation.

MR. SCOTT HANNAY

The Chair (Mr. Pat Hoy): I would call Scott Hannay to come forward, please. If you state your name, you can begin. You have 10 minutes.

Mr. Scott Hannay: I'm Scott Hannay. Thanks for spending the time today. I know you've had a lot of talk from pharmacists. I'm an independent pharmacist. I'm a co-owner of two pharmacies in Kitchener.

If you think you've heard a lot about drugs, I'm just coming from the Ontario Pharmacists charity hockey tournament, and there's one topic of conversation that's been going on for the last two days—

Mr. Wayne Arthurs: And it's not Montreal.

Mr. Scott Hannay: There was a lot of that last night. Just as an aside for Norm Miller, my wife used to work for you, and she has always spoken highly of you, as we were fortunate enough to get up to that part of the country. It eases my anxiety to put a face to the name, I guess.

Mr. Norm Miller: I'll speak to you afterwards.

Mr. Scott Hannay: You helped dig my car out one time, actually, too.

So to give a context to my point of view, I'd like you to know that I'm a co-owner of two independent pharmacies. My father was a community pharmacist, and I grew up learning by his example of providing excellent patient care.

Our stores serve an equal mix of retail customers and long-term-care-home residents. My days are pretty typical. I have my staff and myself set the example by helping customers—that's always the main focus. I don't get breaks or meals. I'm on call 24 hours a day, seven days a week for the homes or patients who need to reach me, and I do it all because I love pharmacy. I love the profession. It's something I thought I could do until I retire.

With that in mind, here are my comments, which I hope to follow up with some suggestions for going forward.

The first one is, pharmacists are a large group of dedicated individuals like myself. What is being proposed is a massive change in thinking for us. We've been given one side of the equation, which we see as all the bad stuff, and there's a vague indication of what will be added back in. We know that there will be a huge

shortfall in revenue, and that scares us. It scares us for ourselves, for our families, and it scares our staff as well. Everything we've known about running a successful business and differentiating ourselves through service seems to be off the table. We're still reeling from the regulation changes in 2006 and again in 2008, and they've already caused a steep decline in our profitability. We're somewhat in disbelief that the government, in a democratic and free society, can set rules to mandate how a private business operates. So we're worried and we're confused.

Then we see a publicity campaign by the government that pits us as the bad guys. If you think Ontario pays too much for generic drugs, doesn't it make sense for the government to acknowledge that they set both the purchase and retail prices of these drugs, and those prices are published on their website? The fact that we have received professional allowances from generic companies, we don't see as having anything to do with high prices. It comes from the manufacturer to us; if we didn't get it, they would have it. We don't feel there's anything abnormal, illegal or immoral in what was happening. We were doing what anyone in private business would do. It was good business.

In 2006, the government decided to legislate the amount of allowance flowing to pharmacies, and made a law that we had to justify that every dollar we received went toward patient care. It was a horrible and inefficient process. I was supposed to know that when I was counselling a patient on medication, that time could qualify. If I was calling their drug plan to sort it out, that time didn't qualify. If my technician was filling a dosette for compliance, that would qualify, but the delivery to the person's house wouldn't qualify. And twice a year, we had to tally all this up and come up with a figure that would meet or exceed that amount of allowance that we received or else, in theory, we could be fined or whatever the other consequences would be. It was a lot of effort, and I think any reasonable person who could see our side of things would see that it put an unreasonable onus on the pharmacists.

The minister, Deb Matthews, has repeatedly been quoted speaking of abuses in the system related to inaccuracies in this reporting and widespread unaccountability. My point is, it was a bad system and not bad people that led to the inaccuracies, and I'm pretty sure of this. I don't think you can separate out what is and isn't patient care in a community pharmacy. I don't think salaries, rent, utilities, inventory and even profit can be seen as not integral to providing patient care. I was thinking that until we have volunteer pharmacists working outside, it's all part and parcel of running the business. We know this, and we know that the government knows this, so it's frustrating when I see the tactic used of talking of abuses in media releases. It's just a point of frustration among my colleagues and me.

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I was encouraged that Minister Deb Matthews correctly said that "pharmacists want to provide" patient "care to their patients, and if they are fairly compensated for that, then they will do that.... Independent pharmacists are particularly well positioned to embrace the new model in Ontario. They have a closer relationship, typically, with their customers." That was letter she sent to the Ontario Pharmacists' Association.

Unfortunately, we have to balance this observation with the Premier's statement that it's not his "job to ensure the survival of smaller pharmacies" in Ontario. How is that supposed to make me feel? It's my life, and I hear the head of my province saying he isn't concerned that pharmacies like mine could close. How can anyone running a small business, which I believe to be the backbone of a vibrant economy, be sure that the Premier won't decide to regulate their industry? Certainly we pay more for pretty much everything than other provinces and the USA pay. It's expensive to do business here. I've yet to speak to anyone in business whose purchases aren't tied to some sort of rebate or loyalty program or volume discount—call it what you will.

To take it further, you could say that the Ontario government is the biggest purchaser, I'm sure, of a lot of things: food, gas, pens—you name it. I'm sure there'd be public support for the government to lower the price of those things, too, but I don't think it's the role of government in a free economy.

Pharmacists know that the high cost of drugs in the system is not the generics; it's not because of the professional allowance. We feel the government should be doing everything to support the use of generics and the generic companies that bring the less expensive medications to market.

Unfortunately, when a drug is genericized, its use falls off. The speaker—two ago—kind of stole my thunder with the drug Actonel. I did an analysis of one of my stores and, like you said, there was a new strength that came out. Starting last July, the new strength went from zero use to—last month I had 73 tablets dispensed. Over that same period of time, I went from 206 of the older strength down to just 55 last month. To sum it all up, in the prices he quoted, that one drug in my one pharmacy is costing the government an extra $12,000 a year right now, because the drug was just genericized last week. What's unknown is how much of a rebate our government is getting from Procter and Gamble, the maker of Actonel. It might not be as big a savings as I'm saying or what I think it is; it's an unknown. But the difference between the price of the generic—which, under the new regulations, would go down to $11—and the price of the new strength at $45: I would hope that they negotiated at least a $34 rebate for every tablet; otherwise they've done us all a disservice.

Those are my issues, and now I'm going to give some solutions that I think will make things better for me and hopefully some others. We need to see the other side of the equation. Without the professional allowance, how can we generate revenue to stay in business? We know about MedsCheck; we've tried to embrace it where possible. Based on an evaluation I did in my store, we'd

have to do one initial MedsCheck every half hour, eight hours a day for 125 days each year to make up for the shortfall in funding due to the proposed regulation changes. I'd have to do that without adding any extra salary.

The actual fee I collect from the government, on average, for an ODB prescription is $4.10. This was based on our 2009 sales data. The break-even point for us is $14, and the professional allowance is what makes up the difference there. We serve approximately 550 seniors in retirement homes in Kitchener, Waterloo, Hamilton and London. The demands from the homes and by the residents and the staff at the homes are no different than licensed long-term-care homes, but ODB reimburses us one third of the amount. The professional allowance makes up the rest. Elderly seniors in those homes use a disproportionately large percentage of generic drugs, as they're older and they've been on the drugs longer and those drugs tend to be generic. This has always made servicing retirement homes properly—giving them medication reviews, medication carts, computers, compliance packaging, audits, in-services for the staff—affordable and even profitable.

The Chair (Mr. Pat Hoy): You have about a minute left.

Mr. Scott Hannay: Okay.

Eliminating professional allowances on top of all that makes it difficult for me to predict what the outcome would be without it. You'd certainly see an increased demand in nursing time, and medication errors. If the retirement homes can't afford extra nursing time, it can increase costs for residents or push them towards placement into long-term-care homes.

The fact is that as they are run now, there's a lot of overlap in the type of resident in a retirement home and nursing home, and pharmacies should be encouraged to offer these people the service they need to stay out of long-term care.

There are a lot of people I see fall through the cracks in our welfare and support systems. My one pharmacy is a few doors down from a community outreach mental health clinic. The clinic has explained that their patients are at risk of non-compliance with their medications if they have to pay even a $2 co-payment on drugs through the welfare or disability programs. We've agreed to waive the co-pay for these patients. We package their medications in dosettes, provide them free delivery, often multiple times because they tend to be transient and not home, on a weekly basis.

As it stands now, we likely do this at a financial loss. Under the system put in place in 2008, we get paid a fee twice a month for this service. If we decided to charge these people $2 for prescriptions, they likely wouldn't pay and wouldn't take them. I'd like to take an educated guess that no other pharmacy would be lining up to provide these services under the proposed changes to the act.

I will stop there because I don't think I'll finish the rest. Thank you.

The Chair (Mr. Pat Hoy): Thank you very much for the presentation.

ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Pat Hoy): Now I would call on the Ontario Hospital Association to come forward, please.

Good afternoon. You have 10 minutes for your presentation. If you'd just introduce yourselves first, and you can begin.

Ms. Janet Davidson: Thank you, Mr. Chairman. I am Janet Davidson. I am president and CEO of the Trillium Health Centre, but I'm also second vice-chair of the Ontario Hospital Association. This is Greg Shaw. He's the OHA's vice-president of strategic human resources management services.

Thank you for the opportunity to comment on Bill 16. As you know, Bill 16 includes a number of provisions that affect the health sector, including mental health. We've provided the clerk with a written submission that comments on these provisions, and we'll focus our oral presentation on the aspects of Bill 16 that address the compensation of hospital employees.

I'd like to state, though, for the record that the OHA strongly supports the government's pharmacy reforms. We believe that hospitals are likely to see a 15% to 20% drop in the cost of extended health premiums for their employees as a result of these reforms.

As you know, schedule 25 of Bill 16 would create the Public Sector Compensation Restraint to Protect Public Services Act, which effectively freezes current compensation plans for non-union public sector employees for two years. This group includes thousands of front-line health professionals such as laboratory and radiation technologists, as well as registered nurses at some hospitals. As drafted, Bill 16 specifically excludes employees who are represented by trade unions. Approximately 75% of hospital employees in Ontario are unionized.

The government of Ontario has stated that all existing collective agreements in the public sector will be honoured, and that as agreements are renegotiated, they will work with their transfer partners and bargaining agents to seek agreements of at least two years' duration with no net increase in total compensation. The government's fiscal plan does not contemplate compensation increases for future collective agreements.

The OHA supports the intent of Bill 16. Salaries and benefits constitute approximately 75% of hospitals' operating costs. We believe that a two-year pause in the growth of health sector salaries and benefits is a reasonable step as Ontario grapples with a $21-billion deficit. Many hospitals have already implemented pay freezes for executive and management employees, so from a principles perspective, Bill 16 is consistent with those hospitals' actions.

However, we are very concerned that Bill 16 will create significant inequity between unionized and non-unionized hospital employees in the short term and possibly over the long term. I'll outline two actual examples of what I mean by this.

Markham Stouffville Hospital has two sites. Registered nurses are unionized at one site but not at the other. On April 1, 2010, the unionized registered nurses received a 3% increase in salary as per their collective agreement, and it is possible that they will receive another similar increase next year. Bill 16 would freeze the compensation for non-unionized nurses for two years, causing their wages to significantly fall behind their otherwise identical but unionized counterparts and creating an inequitable situation within the same employment category and within the same hospital.

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Mount Sinai Hospital has unionized lab techs, who, on April 1, received a 2.5% increase in salary. Bill 16 would cause a non-unionized equivalent to these lab techs—for example, radiation techs—to have their compensation frozen for two years. This example demonstrates how Bill 16 would create inequitable situations across similar professions within a particular hospital.

Bill 16, however unintentionally, could pose significant challenges to compensation equity within Ontario's hospital sector in the years ahead, and also to its smooth operation, unless ironclad certainty is provided that unionized salaries will be rebalanced against non-unionized salaries in the near future.

Greg?

Mr. Greg Shaw: Thank you, Janet.

For example, non-union professionals will be more likely to leave their current hospital to work in one where their job is unionized, thus avoiding the effect of Bill 16 while receiving union-negotiated wage increases.

I would like to note that at the Hospital For Sick Children, the legislation in its current draft has already played a major role in CUPE's drive to certify the hospital's non-union employees. The union has touted the fact that unionized employees are exempt from the legislation and are not subject to the two-year wage freeze. The vote to unionize or not is scheduled for tomorrow.

Hospitals may have difficulty recruiting new employees for non-unionized positions at lower rates of compensation than those offered at neighbouring, unionized hospitals, thus exacerbating existing hiring shortfalls.

Finally, managers who have had their compensation frozen—in some cases, prior to the introduction of Bill 16—could see their compensation actually fall below the level of their unionized employees.

At least one health sector union has already indicated that they're not prepared to accept a compensation freeze once their current contract expires. This fact, coupled with the hospitals' expected inability to pay higher compensation in the years ahead, has forced this union and the represented hospitals to binding arbitration. This pattern will likely be repeated as other agreements expire.

Hospitals are bound by the Hospital Labour Disputes Arbitration Act, or HLDAA, which places all disputed items arising during negotiations into the hands of third party arbitrators. While these arbitrators are required by HLDAA to consider the ability of the employer to pay and possible reductions in services in rendering their decisions, history suggests that arbitrators are unlikely to pay sufficient credit to these criteria and typically do not provide concrete reasons for their decisions, as they're not compelled to do so.

The OHA believes that the goal of maintaining equity within and across hospital-based health care professions is very important and that there is more than one way to achieve this goal.

One way would be to amend Bill 16 to include all unionized hospital employees within its scope once their current collective agreements expire. This would ensure balance in compensation across the hospital sector and, in doing so, maintain equity for identical or similar employees. We recognize that this path is unlikely.

An alternative is to extend the life of the existing collective agreements with unionized hospital staff for a period of two years, with a freeze in total compensation over this period.

Another alternative is to amend HLDAA to clearly define the limits of an arbitrator's decision-making authority, especially with respect to the prevailing economic circumstances and the organization's ability to pay. For example, when a budget speech has clearly stated that funding will not flow where increases are negotiated, arbitrators should be required to sufficiently consider the HLDAA criteria, such as ability of the employer to pay and possible reduction of services, and provide detailed rationale for their decisions, at a minimum. This would strengthen the ability to achieve a contract that is equitable.

The OHA believes that HLDAA reform should proceed alone or in tandem with any other measures the government may take regarding Bill 16 or broader public sector compensation.

To conclude, the OHA supports the principles underpinning Bill 16. We're looking forward to working with the government as it explores the various options available to it in order to protect compensation equity amongst our valued health care professionals and to meet its other public policy goals.

That's the end of the submission. We'd be happy to answer any questions that you may have.

The Chair (Mr. Pat Hoy): Thank you very much for the presentation. We're not having questions at this point. We're trying to get through everyone here today. But we do appreciate your presentation very much.

Mr. Greg Shaw: Thanks very much.

LAW SOCIETY OF UPPER CANADA

The Chair (Mr. Pat Hoy): Now I call on the Law Society of Upper Canada to come forward. Good afternoon, everyone. You have 10 minutes for your presentation. If you have a speaking role, I would ask you to identify yourselves for our Hansard. You can begin.

Mr. Malcolm Heins: Good afternoon, Chair and committee members. Thank you for the opportunity to

discuss the Law Society Act and the amendments to it in Bill 16.

I'm Malcolm Heins, chief executive officer of the law society. With me I have Tom Heintzmann on my left, who is chair of the governance task force; Sheena Weir, on the far left, who is manager of government relations; and Jim Varro, who is our policy counsel at the law society.

Interjection.

Mr. Malcolm Heins: I was going to say this is not about drugs, generic or otherwise.

We license and regulate, at the law society, 41,000 lawyers and 3,000 paralegals in Ontario. In December 2009, convocation, the law society's board, approved reforms to our governance structure in response to what we thought was a need for increased effectiveness, transparency and accountability.

We're here today to thank the government for moving so promptly to implement the reforms through the amendments to the Law Society Act in Bill 16.

We believe that good governance of Ontario's lawyers and paralegals is key to the law society's successful and credible regulation of lawyers and paralegals so that the public has confidence in our work.

We consulted widely with respect to these reforms before debating them and recommending them to the government. Our consultations made it clear that we needed to make some changes to modernize our governance structure.

These amendments will assist us in being more efficient and effective, and exhibit responsive leadership now and in the future to both the public and our other stakeholders.

One of the key concerns about our governance structure was the size of our governing body. It was large and growing, particularly with respect to the unelected ex officio component, some of whom had voting rights.

Ex officio benchers, who are our directors, include former treasurers, who can vote at convocation, former attorneys general, and individual benchers or directors who had served 16 years and called themselves life benchers. We currently have 31 of those directors. By next year, we were going to have 41.

Our convocation size, our board size, which is currently 83, including those people, was going to move into the 90s. If we looked out a few years, we were going to be larger than the Ontario Legislature. We really felt we had to move and do something. Not that there's anything wrong with the size of the Ontario Legislature; we just didn't think we needed to be that big to regulate who we had to regulate.

The amendments that are contained in Bill 16 will end the office of ex officio bencher for the former treasurers, life benchers and former attorneys general. The core of convocation will then be its elected component, together with the eight lay benchers that are appointed by the Attorney General.

Over time what we will see happening is that even though we're going to grandparent the existing ex officio benchers, who are the life benchers, former treasurers and attorneys general, those numbers will decrease so that we will return to what I would call a more normal size for a body of our type.

The other thing that we're doing is we're looking to impose a term limit on the elected benchers. I hesitate to say that in this room, but I think we have slightly different parameters when it comes to our governance.

Term limits are very common in regulatory bodies. Until now, we have not had one at the law society. We think it's important because it formalizes renewal of the board. It's an effective way for us to bring in new ideas, new people, and it provides for a regular introduction of new energy, new views and different skill sets. It also allows more people to participate. It's clear to us that those individuals who are incumbents have a significant advantage when it comes to our four-year election process, and we think we should allow, as I said, others to participate.

1730

I would conclude, before Mr. Heintzman makes his remarks, by saying that these reforms will allow us to focus on the governance of lawyers and paralegals in the public interest and fulfill our regulatory mandate. We strongly believe that it will make us more efficient, given the size reduction that will happen at our board of directors, or convocation, as we call it.

The act itself, which was amended just a couple of years ago, actually requires us to operate efficiently and transparently, and in fact our governance review was in view of that mandate under the act to look at our own governance structure. These are the recommendations that we've come forward with.

Again I want to thank the government for acting so quickly.

Mr. Thomas Heintzman: Thank you, Malcolm, and thank you to each and every one of you for having us here on this hot afternoon to talk about the amendments to the Law Society Act. My name is Tom Heintzman. I am a bencher, or director, of the law society and I'm here to represent convocation and the treasurer this afternoon. I am the chair of the governance task force, which has been bringing forth governance reform to the law society, something that I think all regulatory bodies have to go through and address on a periodic basis. I'd just like to talk to you for a few minutes about how we got here and the views of other legal organizations about the reforms that we're making.

First of all, how did we get here? We consulted broadly with the legal profession and among our fellow benchers for over three and a half years. We first had a workshop of our board of directors to make sure that we were getting their input and consultation. Having done that, we then consulted right across Ontario, from Thunder Bay to London to Ottawa, meeting with over 100 lawyers in that process, and paralegals as well, whom the law society now regulates. Thirdly, we spoke to key representatives of the legal profession who have an important view about how lawyers are regulated in Ontario.

That's the process that we followed. What we heard was that the law society did need to renew its governance, did have to pay attention to the voices out there that wanted to be heard in the law society and weren't being heard, and that we did have to make ourselves a more effective and efficient governing body.

That's what we've adopted. Convocation has approved those changes and we're here today to ensure that the Legislature has our views and can implement these reforms.

I also wanted to bring to your attention the views of other bodies within the legal profession about these reforms. They've been universally praised by other organizations. The Advocates' Society, which is the body of trial and appellate lawyers, supports these reforms. They've said that they support the progressive reforms set out in the recommendations. "They will modernize the law society's governance model and help to foster renewal and new ideas." That's an important voice in our profession.

The Ontario Bar Association, which represents lawyers—we're a regulatory body; they represent lawyers—has said, "As with many organizations over the past year, the law society has undertaken a much-needed governance review to ensure that it will continue to serve its members in the most relevant, appropriate and representative manner. Change, while sometimes challenging, is essential in all aspects of our profession, including the governance structure of its regulator." That's what the association representing Ontario lawyers has to say.

The County and District Law Presidents' Association represents the associations of legal organizations across the province. They've said, "We applaud the law society's adoption of key governance reform initiatives recommended by County and District Law Presidents' Association. Such changes introduce a framework for a more accountable and transparent self-regulatory legal industry in Ontario."

I'd like to close by echoing the words of our treasurer, who said, "These reforms demonstrate the law society's leadership as a modern regulator protecting the public interest."

Those are our submissions to you today and thank you very much for enabling us to be here.

The Chair (Mr. Pat Hoy): Thank you for the presentation.

Committee, you can plan many things as Chair, but you cannot plan that the next presenter would not be here. We'll recess until they arrive.

The committee recessed from 1733 to 1739.

CARP

The Chair (Mr. Pat Hoy): The committee will now come back to order. Now that we're back to order again, we have our next presenter, CARP. I would ask you to identify yourself for the purposes of our recording, and then you will have 10 minutes for your presentation.

Ms. Susan Eng: Thank you very much, Mr. Chair. My name is Susan Eng. I'm vice-president, advocacy, for CARP. We have presented before. You will know that we have members across the country, of whom some 200,000 are here in Ontario.

We are in support of the government's proposals to eliminate professional allowances, represented in Bill 16, and the proposals elsewhere to regulate generic drug prices. We support these proposals because they are expected to reduce the cost of generic drugs for everyone, including seniors, whose drugs are covered under the Ontario drug benefit plan. We believe that the changes will expand professional services provided by pharmacists, which will now be covered by the province. With the savings, we expect that there will be new drugs put on the formulary that will, again, assist our members.

Some of our members and others have been told that their pharmacy services will be cut or that they will have to pay for them. They are understandably confused and upset by these messages, which may be found in ads purchased by the pharmacists and on behalf of the pharmacists and drugstore chains as well as in notices sent home with the patients.

The province has announced that many of those services that are being threatened will, in fact, be compensated for on the basis of direct billing by the pharmacists, and that there is therefore an opportunity for them to recoup some or most of the money that will be lost to the rebates. We understand that this will not be the case for pharmacists who are not providing such services or who do not intend to provide such services.

We've also heard from pharmacists, including one or two who happen to be CARP members, who believe that eliminating the professional allowances will force them to cut services or even to go out of business. They take no account of the promise to compensate for the professional services that they say they provide. This is not surprising, since the messaging from those opposing the generic drug pricing proposals has not mentioned this compensation for professional services. We've raised with the Ministry of Health the need to be more forthcoming and more precise about the professional services and, of course, the amount that they will pay for them, especially as they have set specific dates for the cuts but have not brought forward any definitive proposals for the compensation.

Further, we have heard from the pharmacists, and we would certainly support some special consideration for the truly independent pharmacists who are taking the business risks themselves, especially those in underserviced areas, where a number of our members live, including ensuring that the compensation structure provided for them will permit them to maintain a reasonable level of service for their patients.

We're supportive of reasonable charges for professional services actually provided, and we'll continue to press for more urgency in providing the detail of the proposals as well as the special consideration.

The reduction in drug prices, whether generics or brand name, will benefit our members and other patients,

and CARP will continue to resist attempts to pressure them with incomplete information or misdirected advocacy.

As members who have seen me come before you before will know, I rarely come without a poll. We did, in fact, do a poll on the generic pricing proposals. We were quite detailed, and I have included that in the package that I've left with you. Just to make it clear, the poll goes across Canada, and we teased out the Ontario numbers so that they would be directly relevant here, but I can tell you that the trend lines are exactly identical. People in other provinces recognize that these changes may come to their province, and their responses to the questions are identical, if not—the people in Ontario are a little bit more emphatic in their support for the proposals.

You will find, as you look through it, that:

—92% agree with eliminating the rebates;

—60% agree very strongly;

—85% do not like the idea of generic drug companies paying the rebates at all;

—70% agree with the government that rebates inflate drug prices, versus 6% who buy the pharmacies' arguments that they will have to close stores, cut hours or charge for delivery and consultations;

—90% approve of the plan to ban rebates in both the public and private market;

—76% think it is fair to use the savings to pay for consulting and other services actually provided by the pharmacists and to support rural pharmacies;

—76% blame the drugstore chains for threats to close the stores and to cut services, and so far they make a clear distinction between the drugstore chains and the pharmacists themselves—only 9% blame the pharmacists for these problems;

—90% say the drugstore chains are being hypocritical when they say that vital services will have to be cut, because they know very well that consulting services were being covered by the rebates and are now still proposed to be compensated for, but based on proof that actual services were provided;

—89% say the government has no responsibility to guarantee the profit levels of the drugstores;

—77% support the government regulating drug prices for all consumers, not just those on the public health plans.

The interesting thing, however, is the issue of the free services that the messaging has been saying will be cut. Only 19% of our members, and they live across the country and in rural areas as well as the major cities, say they use these services at all, and 81% say they rarely or never use them. Of the list of services that could be covered, the medicine reviews had the most support, at 52%.

That's a flavour of what our members are thinking about the proposal, in fairly significant detail, with full knowledge in front of them. Some 2,100 people responded to this poll, most of them overnight. This issue has gathered a lot of knowledge and a lot of focus in Ontario, as you can well imagine, but clearly, from the point of view of supporting our members and other patients, the net reduction in costs finds full favour with them.

The Chair (Mr. Pat Hoy): Thank you for your presentation.

Ms. Susan Eng: Thank you for your attention.

The Chair (Mr. Pat Hoy): I was advised during the recess that Mr. Murray had a couple of questions for research, so if you want to put those?

Mr. Glen R. Murray: Just a couple of things that came up.

One of the issues that came up from about five delegations, if I was keeping track, was that a pharmaceutical product was being reissued at a higher strength that had some significant implications for the cost of generics or their re-branding of it. I was wondering if we could get some information that would describe that to us and what, in fact, is happening.

The second issue that I would like some information on is the $14 dispensing fee real number. It seems to me, having grown up in a family that was a manufacturer's agent that supplied pharmacies with all kinds of supplies for 30 years, that it's a rather abstract idea in the sense that $14 depends on what the volume of your business is and how much drug dispensing you do and what percentage—how reliant you are on it. A small pharmacy that may do 10 a day is different than a Shoppers Drug Mart that does several hundred. I'm just wondering if we could actually get an analysis, a more sophisticated breakdown of what real dispensing fees are, if that information is available.

I'll put a proviso on it: I realize that those are more complex questions. If there is research on that, that would, I think, be good for the committee to have. If it's not possible, I would certainly understand that as well.

The Chair (Mr. Pat Hoy): Okay, thank you.

If there's no other business, we are adjourned.

The committee adjourned at 1748.

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