PRINCE EDWARD ISLAND LEGISLATIVE ASSEMBLY

Speaker: Hon. Francis (Buck) Watts

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Standing Committee on Health and Wellness

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SUBJECT: BRIEFING ON THE CATASTROPHIC DRUG PROGRAM

COMMITTEE:

Hal Perry, MLA Tignish-Palmer Road [Chair]
Dr. Peter Bevan-Baker, Leader of the Third Party
Hon. Richard Brown, Minister of Communities, Land and Environment
Kathleen Casey, MLA Charlottetown-Lewis Point
Darlene Compton, MLA Belfast-Murray River
Hon. Sonny Gallant, Minister of Workforce and Advanced Learning (replaces Hon. Chris Palmer)
Sidney MacEwen, MLA Morell-Mermaid
Hon. Pat Murphy, Minister of Rural and Regional Development (replaces Hon. Jordan Brown)

COMMITTEE MEMBERS ABSENT:

Hon. Jordan Brown, Minister of Education, Early Learning and Culture
Hon. Chris Palmer, Minister of Economic Development and Tourism

MEMBERS IN ATTENDANCE:

none

GUESTS:

Health PEI (Denise Lewis Fleming, Grant Wyand)

STAFF:

Joey Jeffrey, Clerk Assistant (Director, Corporate Services)

Edited by Hansard

The Committee met at 1:30 p.m.

Chair (Perry): Good afternoon ladies and gentlemen. I'd like to welcome you all to the Standing Committee on Health and Wellness. I'd like to call this meeting to order.

First, we're going to start with some substitutions that we have. We have Sonny Gallant substituting for Chris Palmer and we have Pat Murphy substituting for Jordan Brown. Welcome.

Mr. R. Brown: Great substitutes.

Chair: Number (1) line on our agenda is the adoption of the agenda. Everyone had an opportunity?

Ms. Casey: (Indistinct)

Chair: So moved; Kathleen, thank you very much.

Number (3) is we have a briefing regarding the Catastrophic Drug Program, and other drug programs available to Islanders, which was scheduled for our previous meeting, but we had run over time. Our presenters were so gracious to say that they would come back and this is our next scheduled meeting we had. We want to apologize for having them sit, last time, and wait, but we do appreciate the fact that they came back into talk about this program to us today.

At this time, I'll ask our presenters to come to the floor. I'll ask if each of you could, for Hansard, state your name and your position, please.

I'll start here with the minister.

Mr. Mitchell: Robert Mitchell; Minister of Health and Wellness.

Denise Lewis Fleming: Denise Lewis Fleming; Chief Operating Officer for Health PEI. Part of my portfolio is the Pharmacare programs.

Grant Wyand: Grant Wyand; Manager, PEI Pharmacare with Health PEI.

Chair: Thank you very much, and welcome. We're going to have you do your presentation. We'll withhold questions until the presentation is complete. At that time, or during this time, I can compile a list if you just give me some notice and I'll put your name on it, for questions.

With that, you can begin.

Mr. Mitchell: Thank you very much, Chair.

Again, it is a pleasure to be back. I think it was two weeks ago that we were here ready to go with this presentation last week. Thank you for the opportunity to come back.

This is a very in-depth presentation that Denise and Grant will provide for us today. As you mentioned, Chair, if questions could be held until the end that would be wonderful. There's a lot of things packed into the presentation, some of the questions may get answered further out through, although they may trigger questions early on. With that said, I'd like to turn it over to, I believe, Denise you're going to lead off today?

Thanks for the opportunity to be here.

Denise Lewis Fleming: Thank you very much.

The plan for this afternoon is, I will walk us through the briefing on the Catastrophic Drug Program and some other drug programs. Then, as we take questions, Grant is here. I'll call him our subject matter expert. He has great depth of knowledge in all of our programs, so he will also be available to assist us in responding to any questions that you may have.

What we outlined for a briefing for the committee is; we're going to do some highlights on the Pharamcare Program, give the update on the Catastrophic Drug Program as requested. Then, go through a few of the other commonly used drug program, because we believe there's interest in understanding or being aware of those. As well as, speak briefly on the public drug formulary because it is a core underlying piece, and, I think, a good place to also create some understanding about what is on that, or those particular pieces.

Mr. MacEwen: Chair? Sorry, Denise.

I have seen this stuff before. It is complicated. Could we get copies of the presentation so that we can makes notes as we go?

Chair: Just a moment. Do you have copies prepared with you, Denise?

Denise Lewis Fleming: Don't have copies with me.

Mr. Mitchell: Would soft copies suffice, hon. member, if we sent it after the presentation? We could have that.

Mr. MacEwen: I'm thinking as we go. If you want to take a break I can go out –

Chair: Well, I'm sorry, we don't, generally, you know, you knew they were on the floor, so I guess you could have requested it before we came in and they could have had that prepared. We don't normally ask our presenters to come in with that. They usually give us a copy of it afterwards.

Mr. MacEwen: I asked at my other committees, but I guess I have to ask at this committee, too.

Chair: (Indistinct)

Mr. MacEwen: Do you mind if I have a copy and I can go and photocopy it right out there? I can make seven copies, eight copies.

Chair: Do you have one available that we could photocopy?

Denise Lewis Fleming: No –

Mr. Mitchell: Actually, I can give him mine.

Chair: Okay.

Mr. Mitchell: (Indistinct) hon. member (Indistinct) keep this copy.

Mr. MacEwen: I'll be right back.

Mr. R. Brown: Now, that's cooperation.

Chair: We're going to continue on with the presentation.

Denise Lewis Fleming: That's great.

Just at a high level, a lot of people refer to Pharmacare and Pharmacare is the division within Health PEI that we manage all the public drug programs that are offered to Islanders.

These drug programs are intended to help Islanders access medications by providing financial assistance towards the cost of eligible medications. There are a lot of key terms in there. Eligible medications, what that assistance is and we'll hit some of those pieces as we get a little bit later into the presentation.

As some of the hon. members may be aware, currently, in our Pharmacare division there are 26 drug programs on PEI. Yes, that is a large number; we do realize. They are designed on various different factors such as; disease state, for example diabetes program. They could be based on income level. Some of our programs are designed that way, for example; financial assistance. For those that are clients of the financial assistance program of the province. Some are aged-based. The one that is most commonly known, of course, is the seniors' program.

Islanders do pay different amounts depending upon the parameters of each program. When I say pay different amounts; that is the amount that the Islanders are required to contribute at the cash register in the pharmacy whenever they go in to get their prescription filled.

These drug programs provide approximately 49,300 Islanders with access to support for – so that's nearly a third of Islanders are receiving support. What you'll see on this table here, you're actually to add up the registrants, it comes to nearly 70,000 people. That reflects that an Islander can be enrolled in multiple programs. When we go to unique individuals it's approximately 49,300 Islanders that do receive or gain access to benefits.

As noted, seniors are the highest utilization group, so people ages 45 to 64 are our next highest group. There's approximately 10,000. You'll see in our seniors program, we have nearly 27,000 people registered or just over, and nearly 25,000 actually receive support for their claims that they have submitted. That just means their claims were

not denied, the other seniors, they just may never have had prescriptions during that year that they required support for.

You'll also see a list of our other most commonly-used programs. The Generic Drug Program, which I'll speak to later, diabetes, financial assistance, which I had mentioned earlier, of course the Catastrophic Drug Program, high-cost drug is our accumulation for what started out as our multiple sclerosis program, but then was expanded to include other high-cost disease states that required support. And the Family Health Benefit and opioid replacement, (Indistinct) conduct – or sorry, comprise the vast majority of what our programs are. You can see it's nearly $28 million of our $34 million are those programs that you see listed.

Each year, those programs that I just noted provide nearly 1.1 million prescription supports to Islanders. As I mentioned a third of Islanders and about 1.1 million prescriptions flow through public drug programs each year.

To focus on the Catastrophic Drug Program, this is an income-tested program. It will support any individual or family whose eligible drug costs are affecting their household's ability to maintain life essentials. People may remember that from whenever the program was launched. That is the intent of this program.

The eligibility criteria; you must be a permanent resident of PEI, you have to have filed your taxes in the previous year, because we do require that information in order to assess your income levels, and you need to have a valid PEI health card. Anyone on the Island that meets those three criteria is eligible to apply.

The other piece I really wanted to highlight to the committee is that the annual application is required. This is a program that's assessed each year, because, of course, your income may change, and quite often does change every year. For the committee to note is the plan year runs from July 1st to June 30th. That was chosen on purpose because it gives three months leeway after the end of your tax filing requirement for individuals to be able to get their notice of tax assessment back if they wanted to bring in their paper documents. So, it was an intentional piece about why do we have a plan year that's different from, say, for example, the province's fiscal year?

Now, under the Catastrophic Drug Program the client or the individual pays out-of-pocket expenses for eligible prescriptions until they hit what's referred to as their household cap. Then, the program pays the remainder of the eligible costs for the remainder of that year. Basically, once you hit your threshold, you no longer have to pay anything at the cash; the program picks it up.

The household caps are calculated based on your household income. There are four income bands in this program. Your cap, if you're in the income range of zero to $20,000 is 3%, which would mean, for individuals in that group for households, that your maximum annual payment for your prescriptions would be $600. Beyond that, so if you paid – if $1,000 in prescriptions is what you needed, you would pay $600, the plan would pay the remaining $400 and that's spread out, potentially, over the remainder of the year.

It ranges there, and you can see then we jump to 5% for incomes between $20,000 and $50,000. That means that in that income range the cap can range from $1,000 per year to $2,500. That just works all the way through. As noted below, the maximum cap for the first income level is $600.

Quite often, we get the question where people want to understand: what is a household, because household income is what drives your assessment. Household income is a single person, which is what we list there as an adult, age 19 or over, unless, you're in a post-secondary institution and you're still attached to your parents' household. It's a couple. It could be a single parent with children, or it could be parents with dependents. Those are the four different categories that really are listed up there.

The income of the adults in the household is what is used to assess your income household gap, or sorry, income cap. I do want to note – it's not noted on the screen here for the committee – that we do make deductions from your income in determining

what your household income will be. We take what your gross taxable income is and we deduct off for split pensions. This is why your notice of assessment is needed for your child care expenses and for your support payments that you may need to make. Then, we determine that's your household income amount and determine your cap based on that.

I think it's also – while that's being handed out, worthy to note that if an individual is 18 years or older still living with your family and you're not in school, so while you're still in the same house, you're not considered part of the household. You file your own application because you are an adult over the age of 19 and you're not in a post-secondary institution. We could have two applications from the same house, and they would be two separate households.

Think out-of-pockets expenses relatively easy for, I would say, most of the committee members and anyone that happens to be listening, to understand: it's what you pay at the cash register for an eligible prescription after all of your other coverage is applied. This notes that you can be in private insurance and still be part of the Catastrophic Drug Program. Your private insurance pays its portion first before it flows through to the Catastrophic Drug Program. You could be in other public drug programs, for example, in the seniors' program or you could be in the financial assistance program. It will flow through that first before coming and being considered here. We always do all of those checks.

An eligible prescription is quite often our next biggest question. They are the drugs, which are listed for coverage on the provincial formulary. Now, these eligible prescriptions, they include all the prescriptions, or all the prescription drugs listed for each of the other 25 programs. As I mentioned earlier, there are 26 programs in total. This Catastrophic Drug Program formulary includes all of those drugs that are listed on every other program with one exception. It excludes non-prescription medications that are covered under the financial assistance program and under the nursing home programs. Under those programs we do have a few over-the-counter drugs that are covered. For example, Tylenol or Aspirin and a few pieces like that; they are not part of the Catastrophic Drug Program. It's just eligible prescription drugs.

As I mentioned earlier, you can be enrolled in the Catastrophic Drug Program while you have private insurance. You can also be enrolled in the Catastrophic Drug Program when you're in the seniors' program, when you're in the Generic Drug Program. That's perfectly allowable. What would happen, in a senior's case is a senior in the catastrophic drug would have their co-pay under the seniors' program applied to their household cap. As some committee members may be aware when a senior – I'll say on July 1st – walks into the pharmacy and they have a prescription to fill; I believe it's 15.94, I got it right, that they would pay for their prescription. That's the maximum amount that they would pay. That 15.94 would then count towards their household cap in the Catastrophic Drug Program is how it works. Even though they had to pay under the seniors' program it counts towards your household cap.

The other thing we thought the committee would be interested in is just how much is the Catastrophic Drug Program being used. The program did begin in 2013, in October, 2013, I believe. In the first year, we had just over 1,500 Islanders register. That's the light blue bar that you'll see on this chart. The dark blue bar reflects how many households reach their cap in that year. So, 390 households in the first year reached their cap and for the remainder of that year had their prescriptions paid by the Catastrophic Drug Program.

By the fourth year, the previous fiscal year that was just completed, 2016-2017, we've grown to just over 4,800 Islanders registering for the program, and just over 1,000 households reached their cap and then received assistance for the remainder of that year. It's tripled in the first four years that the program has been in place.

That is the high-level briefing on the Catastrophic Drug Program. I'm going to touch on a few of the other key programs that we had highlighted earlier. The Seniors' Drug Program, it is for individuals that are aged 65 and older. It's important for, I believe, all the committee to be aware and the public, is that enrollment is automatic.

So long as you have a valid PEI health card, your enrollment is automatic at age 65. Islanders pay $8.25 towards the drug cost and they pay the first $7.69 towards the pharmacy dispensing fee.

Just to pause on that for a moment; prescriptions that are issued to individuals have a variety of components in their cost. Part of it is the drug cost and that may include some mark-up fees for making sure you get it delivered to the store, and then you have the pharmacy dispensing fee. Sometimes you have a compounding fee if you need to put a couple of products together. But, a senior only pays the maximum of those two amounts.

As I mentioned earlier, $15.94 is the maximum combined total. However, you can have a lot of combinations. For example, if a pharmacy only chose to bill an individual or bill the province, I would say, $7 for their dispensing fee, then the senior would only pay the $7 plus the $8.25 for their drug program. That's why it's split into those two pieces. As we noted here; of the approximately 27,700 eligible seniors, nearly 25,000 received benefits from the program last year. That reflects approximately 530,000 prescriptions that were covered for seniors in the fiscal year 2016-2017. So, if you remember the number I gave earlier that all of our programs together are 1.1 million prescriptions per year, the seniors program accounts for just over half of all the prescriptions that we provide.

Diabetes Drug Program is another one that's well used by Islanders. There's different co-pay, depending upon the medication. Oral medications, they pay $11. As you can see, insulin vials; it's $10 per vial. The cartridges are a different amount. Now the test strips, they are for insulin dependent Islanders only. It's $11 for 100 strips every 30 days. Now, I will note that just over the last year we have increased the test strips that are provided to women with gestational diabetes. There's an extra 120 strips a month for those individuals. Now, that portion is managed through, actually, the public health nursing because they support mothers with challenges during their health, in particular gestational diabetes and also nutritional support pieces like that.

As we note here, nearly 8,700 Islanders benefited from the Diabetes Drug Program last year. If you also think of the number of Islanders we have, that's just over about 6% of Islanders with diabetes are the ones that we're really concerned about making sure we have support for.

This program that we want to highlight next is the Family Health Benefit. I don't believe it's very well known, but it is something that I think it's important for Islanders who are struggling to be aware of. It's referred to as the Family Health Benefit and it does provide financial support to low-income families who have children under the age of 18, or under 25, if you have full-time students. There is a maximum income threshold for that particular program. The client will pay a maximum amount on the dispensing fee. They're only responsible for covering the dispensing fee cost. The program would pick up all the drug costs. We had nearly 490 Islanders benefit from the program last fiscal year.

Financial assistance, I briefly mentioned that earlier. We cover the cost of approved prescription and non-prescription medications for clients who are receiving social assistance. Approximately 4,900 Islanders utilized that program in the last fiscal year. I believe this program; we actually have a zero dollar co-pay. When you're on financial assistance, we don't require the individual to make a co-pay because their funding is coming from another department within government so that would just be an artificial shift of cost between two departments. They do have a zero dollar co-pay on their drug program.

High cost drugs; this assistance level is based on income as well. What I wanted to note for the committee is that for this particular program there are 50 income bans on which – that we use in order to assess an individual. It starts for people with income less than $14,000 who are not on financial assistance. Their co-pay would be $7. People that are on financial assistance and have a high-cost drug requirement, they also sit in this program and their co-pay is $2 under this particular piece. The increments for the High Cost Drug Program are $2,000 income increments. So, then we go from $14,000 to $16,000. That's one income ban; $16,000 to $18,000. I think the committee

can then envision it all the way up to, I think, more than $180,000.

Next is our Generic Drug Program and this, I think, is fairly commonly known. People are used to having a maximum cost of $19.95 for eligible generic prescription drugs. You cannot have private insurance and be eligible for participation in this program. It is our only program that does have a requirement that you have to be without private insurance. It was intended to provide support to those Islanders who didn't have access to private insurance, and also take advantage of the good generic drug pricing that we have been able to negotiate over the past five years. Approximately 15,700 Islanders registered last year, and nearly 8,700 of them claimed a medication through the program.

What I take from this particular piece is that there are a number of Islanders that are actually using this like their insurance program. They register just in case they need it and if they don't, that's great, for their generic drugs. If they do, it is there and it's already in place. Grant staff always encourages individuals who contact the office that they really should be putting their application in, provided they have no private insurance, and you just have it there in your back pocket.

To give people an understanding, we cover a pretty exhaustive list of generic drugs with a couple of exceptions; diabetes drugs, because they are covered in the diabetes program and the co-pay under that program is actually less than the Generic Drug Program so that's why it's not covered here. The other exception to the Generic Drug Program is any generic narcotics, controlled, or targeted substances. This is due to the health and public policy issue. This is something that we wanted to make sure it adheres to any special authorization or limits on a supply that we choose to put on those in order to manage that.

Now, the next is a program that I would say has become a great support to a number of individuals on PEI, is the opioid replacement therapy. It does assist Islanders who are being challenged with opioid use disorder and addiction. Clients who are eligible for this program are the ones that go through the Health PEI clinical addictions team program that is centered out of the provincial addictions treatment facility in Mount Herbert. It also has satellite offices in Summerside, and I believe there's another up further in West Prince. It does cover both methadone and Suboxone. The coverage for Suboxone was expanded last April in that particular piece, and it's still under this particular program, eligible clients have zero dollar co-pay for their methadone or their Suboxone.

I did want to highlight for the committee that while we have this specific opioid replacement therapy that is tied to the PATF addictions program, coverage for methadone and Suboxone is also available under other public drug programs. For example, it is listed under the Catastrophic Drug Program, financial assistance, the seniors' program. There are some individuals who choose not to go through the provincial addictions treatment centre in order to do their treatment. They may work directly with their own primary care doctor that has had training to do that. We still do provide them with support, but then they're subject to the rules of those other programs as far as what their co-pay would be for those pieces. I just wanted the committee to be aware there's more access than what's actually provided just solely under this particular program.

To give everybody a little feeling for it, here are the other 18 programs that are listed that we didn't go into detail about. You can see they range from support for people with communicable diseases; AIDS, Hepatitis C, Tuberculosis.

We also have supports for smoking cessation, meningitis. We do have supports for our public and private nursing homes; children-in-care is another group that we also provide. We do provide supports to those who have had transplants. There are a few others there. The palliative care, I will note for the committee, is highlighted because it is still classified as a pilot project, but that is tied into the Palliative Care Program for people who are choosing to spend their last days at home. It's tied to that particular piece.

Getting down, as you may recall, this was the last piece on the program, I'll say, we set for today, is talking a little bit about the drug formulary. Now, the Pharmacare Drug

Formulary, it's a list of all eligible medications for each of our public drug programs.

We do have a Provincial Drugs & Therapeutics Committee that provides advice to the administration of Health PEI and to the department on new medications to be added to the formulary. It is a multi-disciplinary committee. It's comprised of physicians, pharmacists. It has nurses on it. It also, on our physician-side, it includes generalists as well as specialists.

New medications that are being considered for listing must have been reviewed by nationally recognized advisory bodies. For a little bit of clarification or just education to the committee, national bodies that we require to have our medication requests be considered by; first, Health Canada, of course, it has to be legal for use in Canada. CADTH, so that's the Canadian association for drugs and therapeutic health, they have two particular committees, the Common Drug Review, CDR, and they have the pCODR, the pan-Canadian Oncology Drug Review committee. They take a look at the committee, or a look at all the new drugs that are coming in and look at it for, both efficacy and cost-effectiveness and make recommendations to all the provinces as a whole as to whether or not they believe the drug should be listed, or if it should be listed with restrictions or if it should not be listed at all based on the current price, or the efficacy and the research they see coming through.

Since this will be available to the committee and, I believe, it's also shared publicly, we did put the website address there if anybody does want to go on and look at the formulary. It's at healthpei.ca/formulary. I will say, it can be a little challenging sometimes to read the formulary because it uses letters to identify which program each drug covers. I'd encourage everyone to make sure you read the index at the beginning of the formulary and keep it in mind as you go down through it.

In conclusion, nearly a third of Islanders, just over 56,000 Islanders, I believe, receive benefits from the program. About 1.1 million prescriptions per year are – received support from the public drug programs and we provide coverage for over 5,600 medications.

Now, I will also make a quick note to the committee that that 5,600 medications, some of them may be the same medication, but different dosage strengths. For example – and I'm not going to presume anyone sitting in the committee here – but if anybody is on blood pressure medication, you could be on a five milligram or a 10 milligram strength, each of those have a different drug identification number, or what we refer to as a DIN. If you had a five milligram and a 10 milligram that's considered two medications; it's two DINs.

With that, we'll open the floor to questions, and if anyone does want to follow-up or reach out to us the phone number to reach the Pharmacare office and talk to any of our staff: 902-368-4947, or they can go onto the website and there's actually a place for the drug programs, just look for the provincial Pharmacare program.

Chair: Thank you very much for your presentation. The floor is now open for questions. I do have a list started. If anyone else wants to get on the list, just give me an indication.

We'll start with Richard Brown.

Mr. R. Brown: Thank you, Mr. Chairman.

How close are we to a universal drug program? Like, if we took all of these programs together, took all the resources that we put into all the different programs, how far away would be away from a universal drug program?

I'm looking here –

Mr. Mitchell: Are you talking about this national universal –

Mr. R. Brown: No, no –

Mr. Mitchell: – drug program that's discussed in our –

Mr. R. Brown: – just our own, like –

Mr. Mitchell: – federal government, now?

Mr. R. Brown: Catastrophic Drug Program, when it was introduced and everything, and I – and I'd say a lot of Islanders would say: well that's only for cancer drugs or for some drugs that, you know, I'm just getting some –

Ms. Casey: Out of (Indistinct), (Indistinct) reach –

Mr. R. Brown: Yeah. And the interpretation of that, I think, a lot of Islanders aren't going for it because of the title. I think the title is wrong. I think the title should be changed because it's a program that's, by the looks of it, is what the federal government is trying to do in terms of a national drug program.

Mr. Mitchell: Hon. member, when you speak about Catastrophic Drug Program, and yes, I agree, it is confusing. We've had this discussion. Catastrophic does not mean high-cost.

Mr. R. Brown: No.

Mr. Mitchell: It does not mean life-saving. What it means – catastrophic means financial health for your household. If you're paying an exorbitant amount of dollars in drugs, then this is the program that kicks in, so that you pay a capped amount and then the program picks up the rest.

I do agree, it's very confusing on a descriptor of it. But when you look at all the programs and you know, obviously there is discussion currently within the department right now of looking to bring that from a number of 26 programs down to some other number of programs. It is a little bit difficult or difficult to work with because some pay, you know, there's zero payments, like the opioid program, the diabetes program. There's particular co-pay. Some are income. It's really hard to massage it into one defined plan. At the end of the day, it would still be a one-to-five plan with a lot of different methods in the inside of it.

Obviously, the federal government are looking at some kind of a national program for Pharmacare. As a province, we're watching all of that; we'll be part of that. I believe, maybe the premiers have indicated, they want that to keep continuing to move on.

There's no – I'll let Denise add to it, too. I know they really would like to see some other number, a reduced number, so there's not 26. You can kind of streamline the process. It's difficult to work with and I'll let her reference work that they've been doing inside the department.

Denise Lewis Fleming: Some of the other challenges we've identified, we have a number of income-tested programs but the income levels are different across each program. It would great to those particular pieces.

Getting to a universal program, or even for PEI, universal means, I would say, different things to different people. If it's getting to listing all drugs that have come through, I'd say we're still quite a ways off from that. Getting to a common – or supports for and harmonizing these programs, I don't think we're that far off from it.

The challenge will be some people will be impacted. You know, that if you have a zero-dollar or a $2 co-pay, while others, currently, for example, like seniors, have a $15.94 getting – where do you bring the level up to? Do the people that are currently paying zero have to come up to the 15.94? Or if you're bringing the 15.94 down, then there's a significant increase in cost to the program. That's what would be some of the factors we'd consider.

Mr. R. Brown: You know, I think the biggest gap, and I think the feds are on the right track here. The biggest gap is, right now, is families, people who work part-time. People – I have a lot of constituents that work part-time, they don't have a drug insurance program. They've got to go through the winter – or, you know, under a lot of issues. Now, that I see the Catastrophic Drug Program, I will be telling them that this is the program.

It's a wrong name. I'm going to tell you that right now.

Mr. Mitchell: For the family that your referenced there, the Generic Drug Program will pick up a lot of the drugs that they would use. Like, a child with some condition or two children, and the parents needing particular drugs. A lot of the generic drugs will cover a lot of the needs that that

family may have. They're paying 19.95 cap there. But each of those, I believe, that that cap would still add to the household cap.

Denise Lewis Fleming: It does.

Mr. Mitchell: So, if they did, you know, find themselves in a situation where they needed significant dollars for other drugs, they could access like, two and probably three programs, even if it was a diabetes drug, too. There's such an array of programs that they could access. The important part is that they are aware of what they could be getting into.

Mr. R. Brown: I'm not sure of that. When I was with the city, we have the casual workers and then the permanent workers. The permanent workers would have year-round coverage and the causal workers would be off-coverage for when they're off work. We came up with a plan that said, you know: We will deduct from you a year-round coverage. Blue Cross at the time or whoever it was said: Yeah, okay, we can work with that plan that while they're not working they paid into it to cover it right through.

You know, that was a big thing to a lot of families, a real big thing. So, and that's – are we sure, like I'm not sure we're catching – are we catching everybody under this program?

Mr. Mitchell: One thing that – and these (Indistinct) –

Mr. R. Brown: Yeah, but I'm not sure that people –

Mr. Mitchell: – when we did bring the generic program in and we analyzed the data, I suppose we thought uptake would be bigger. So it leads to believe that a lot of PEI families are already on insurance plans.

Mr. R. Brown: Yeah. Do we know (Indistinct) –

Mr. Mitchell: (Indistinct) which is good. That's –

Mr. R. Brown: Do we know how many families would be on an insurance plan?

Grant Wyand: Would we have a –

Mr. R. Brown: Like, you know –

Denise Lewis Fleming: (Indistinct)

Mr. R. Brown: – DVA, the federal government, the – you know, cities, universities, must be a lot of people on a plan.

Denise Lewis Fleming: So I can't speak to how many people are on specific particular plans, but we can – and I'll let Grant speak to it – we do have stats of those who participate in the public drug programs. The pharmacies are actually required to provide us with how much private insurance pays, so we do have stats for how many people in public programs have private insurance. I'll just let Grant share that.

Grant Wyand: Yeah, I think the number that we've come up with is seemingly about 30% of Islanders have some sort of private insurance.

Mr. R. Brown: So we're dealing with the 70; and on the eligibility stuff, the first 600, that 600 would be tax-deductible or that would be a deduction on my income tax.

Denise Lewis Fleming: Yes, you could use –

Mr. R. Brown: Yeah.

Denise Lewis Fleming: – that as your health care (Indistinct) –

Mr. R. Brown: So if I'm making $100,000, I can deduct that extra amount I'm paying for the fees on my income tax, so I'm getting a break there also.

Denise Lewis Fleming: Well, I haven't practiced tax in quite a number of years. Whether you can use the amount to determine if you'll be eligible to deduct your health care expenses, but your – you have to meet a certain threshold under the tax rules to qualify them as a deduction.

Mr. Mitchell: To actually use it, yeah.

Mr. R. Brown: So how many Islanders do we think, with all the programs that we have – I'm just amazed by the Catastrophic Drug Program. I still think it should be renamed. I'll be asking that time and time again now,

because this is – I look at this as the universal drug program right here if we can tweak it a bit.

If we can do little tweaks – like, how many Islanders are without a drug program without – you say 30% of the Islanders have a drug program. How many Islanders are taking these programs, net? I'd say we're really, really close.

Mr. Mitchell: Yeah. With that first slide, I think you added that up kind of thing for you there.

Denise Lewis Fleming: I believe Grant has some numbers to share with us. I mentioned earlier on an annual basis, under the public drug programs; there are about 1.1 million in prescriptions that flow through public drug programs.

Our drug information system – so as the committee may be aware, we have a central database that all community pharmacies have to send the prescription information to. In the same fiscal year, about $2.2 million in prescriptions were reported to that database. That means about 50% of Islanders who required prescriptions had their prescription flow through the public drug programs. So, about 50% of Islanders who used or needed prescriptions did not come to the public drug programs. It's really –

Mr. R. Brown: Yeah, but they might have went through the private programs.

Denise Lewis Fleming: Exactly.

Mr. R. Brown: Okay, so –

Denise Lewis Fleming: And never came near any of the public programs.

Mr. R. Brown: Could we do an analysis? I think we're really, really close to a universal drug program, and if we can think of combining or doing something instead of having 64 programs, you know, bring it down, and I think that's what the national government's trying to do.

I just look at this and I think we have a national program here. I don't know how many we're missing. I'd like to know how many we're missing and why we're missing them.

Mr. Mitchell: I think the key, hon. member, is the points that were alluded to a little earlier. If you try to make some kind of a new program, you're going to have to make adjustments. So who – like, is it fair to raise somebody up, or is it fair to drop somebody or they're income-testing amounts. So to get that consistency of what you would consider universal comes with other measures.

Right now we're able to fit everybody's needs into a program. Yes, there are 26 of them; yes, it is a little cumbersome; and yes, it is hard to kind of figure out which ones you can be part of, but it works and it works well, and if you're in a particular income, that meets those needs, if you're in a program where it should be a zero-co-pay, that's being met. If you try to fiddle around with those, there's going to be somebody that will be affected by that.

Is that the right thing to do? We can spend more time to figure that out and have those discussions, either on the floor of the Legislature or in standing committees or committees of the whole or whatever. There is work to do, but you're right, we're very close; but if you continue on to figure that out, there will be changes and each program will look a little differently to those that are using them today. I guess that's the fair assessment of it.

Mr. R. Brown: I'm not going to give up on this, Premier or – Premier.

Chair, I just think if we could work this – I think you should be going to the federal government with this, because the Catastrophic Drug Program, I think, the one they introduced in the budget, they're looking for something like this.

There are a lot of people without a program that don't have insurance, and I feel sorry for these people. In the United States, you got all the congressmen and the senators and everybody are all covered, but they don't care about the rest of the country. This is the difference between us and the US, I think. I just think we're so close to it that it's time we take a look at it and see what adjustments can be made because –

Mr. Mitchell: And you know, we –

Mr. R. Brown: – being a Liberal means being fair to everybody here.

Mr. Mitchell: And we can work on that, and we can bring back at some point in time some level that says, you know, you think this works. It may fly and it may die, depending on situations of people that we know and who, you know, whether it would affect them positively or negatively; but there will be outcomes of that.

To try to strike something that's even across the board, people will be left out and people will be coming on.

Mr. R. Brown: Yeah, but I'm a Liberal. I don't want to leave anybody out.

Mr. Mitchell: (Indistinct)

Mr. R. Brown: And the ones that can pay should pay. That's my philosophy.

Now, just one more question, Premier.

Chair: Sure.

Unidentified Voice: Premier?

Mr. R. Brown: Sorry. I don't know. I must be looking at a picture and looking at you.

Since the Catastrophic Drug Program, has any drug plans been saying: Go on to the Catastrophic Drug Program and forget paying the fees.

Grant Wyand: Not really with the catastrophic program, but we've certainly seen that with other programs such as our High Cost Drug Program. The insurance companies started to say: You can get it through the province, so we're no longer going to cover your high-cost drug for you. So they're pushing the cost to a satellite. The catastrophic, we haven't really seen any changes with the insurance plans.

Mr. R. Brown: Yeah. So on the Catastrophic Drug Program, are we sure that we're controlling the cost? You know that story in the United States where that young fellow bought one drug and went from $37 to $5600 a pill. That fellow should be put in jail.

Unidentified Voice: He is.

Mr. R. Brown: Good. I want to make sure that the drug companies are not reducing their cost and putting them onto the public system, and especially if they're not reducing the cost of the person that's on the plan, saying: You go to the catastrophic, you go to the high-cost drug program, and we'll reduce your plan by a certain amount of money. Are we ensuring that's not happening?

That's it for me, Chair.

Denise Lewis Fleming: The challenge with that particular piece is it's actually insurance plans or trustee plans that control that. It's not the drug manufacturers per se, just to create a little bit of distinction there.

We currently have no legislation that mandates that an insurance company must provide insurance, or that you can't de-list a drug once it comes onto the public drug formulary. I know other provinces have attempted, in order to maintain a private insurance component to their system, to mandate that employers provide private insurance to that level. It's been of limited success, in that it stands for any amount of time; and that particular piece, I think it's been withdrawn in all jurisdictions except for Quebec that have tried it.

Mr. R. Brown: Thank you.

Chair: Pat Murphy.

Mr. Murphy: Thank you.

I was just wondering about promotion of the programs. How are they promoted? Like, if somebody visits their doctor and the doctor tells them they need a certain drug, how do they find out what's available for them?

Grant Wyand: Since the start of the program there were a number of mail-outs sent out to all the pharmacies across PEI hoping that they would participate, let patients know when they do come into the pharmacy that programs are available to them.

Within the hospitals, all of the nurses and physicians should be certainly all well aware. We get calls from them quite often asking about coverage for patients, so they're aware programs are out there. They

(Indistinct) from us but we certainly provide that.

As well, we get requests from special interest groups quite often within Pharmacare asking if we can go and do some presentations on the programs to their members or anybody that's taking in the meeting. That's really how it's working right now.

Mr. Murphy: Is there a phone number like that a –

Denise Lewis Fleming: There is.

Mr. Murphy: − person could just call and say: This is what I need, how do I get –

Grant Wyand: Yeah.

Denise Lewis Fleming: The phone number we provided there on the slide deck and it is also included on the website so anybody that does have Internet access and they go to healthpei.ca and they click on Pharmacare programs, this contact information is there. They will get directed to one of the staff at the office. They can ask questions, share their circumstances. Staff can give them advice on what potential programs would be best for them, to make sure they enroll in.

Mr. Murphy: Are there posters up in the drug stores and that sort of stuff with that number on it?

Denise Lewis Fleming: We do circulate them periodically at the provincial pharmacies – or sorry, at the community pharmacies. They do have our number and they'll either provide it to the individual or direct them towards our office. Usually if they leave the pharmacy, they leave it with our number.

Mr. Murphy: (Indistinct)

Grant Wyand: Any mail-outs that we actually do from our office, if it's for another program or perhaps there's somebody who has requested special authorization access to a certain medication, staff will usually put a little card in there letting them know about the Catastrophic Drug Program and how to enroll in that if they aren't already.

Mr. Murphy: Oh, okay.

Chair: Pat Murphy.

Mr. Murphy: Richard just asked me one there too, so I'll ask it.

Mr. R. Brown: Thanks.

Mr. Murphy: Could it be retroactive if they've been buying – paying for a drug themselves and then a year later they find out that they qualify for the program? Could they get reimbursed for the money they spent on the –

Mr. R. Brown: (Indistinct)

Mr. Murphy: − because of the lack of –

Denise Lewis Fleming: Under the Catastrophic Drug Program, they can apply in any year. So as I mentioned, it starts on July 1st. If you come along on January 1st, bring in all of your receipts, we'll assess all the medications that you paid for and how much you paid out of pocket. For those ones that are all eligible prescriptions, i.e. listed on our drug formulary, we'll consider that. If you've already paid beyond the amount of your cap that you've been assessed, we will actually reimburse you that amount and then set you up and it just rolls through.

Mr. Murphy: Okay.

Denise Lewis Fleming: That is the only program where it will go retroactive to the beginning of the plan year because there is an application and an annual assessment; other programs; that does not exist.

Mr. Murphy: Okay, I just have one more.

Chair: Pat Murphy.

Mr. Murphy: Under the –

Mr. R. Brown: Catastrophic.

Mr. Murphy: − catastrophic program –

Mr. R. Brown: Universal.

Mr. Murphy: Easier to say, for sure.

If there's a drug there that somebody needs but it's not in the provincial formulary, how

is that (Indistinct) – if I need this drug or I'm going to die, how do we deal with that? If it's not on the formulary, which I'm sure there has been incidents in the past where (Indistinct) –

Denise Lewis Fleming: Yeah, we do have cases of individuals coming forward and saying: I need a medication that's not on the formulary. We do work with the provincial drugs and therapeutics. If it hasn't been recommended by them and not added to the formulary, Grant's group, as well as a number of individuals throughout the health care system, will do their best to actually work also directly with the drug companies because there are a number of drug companies that have what they refer to as compassionate programs that will provide funding directly from that drug company to help offset the cost, in some cases to the full extent of that amount.

They also try and do the best they can to work with insurance companies and give them advice on what they may (Indistinct)

Mr. Murphy: Thanks.

Thank you.

Chair: Next we have Sidney MacEwen.

Mr. MacEwen: Thank you, Chair.

Thank you for your presentation and for coming in. The first slides that I missed there, can you go back to the drug programs overview; that chart? I've got a couple of questions.

Denise Lewis Fleming: (Indistinct) there you go.

Mr. MacEwen: Thank you.

The budget 2017-2018, is that actual spent or forecasted?

Denise Lewis Fleming: That is our budget for fiscal year 2017-2018.

Mr. MacEwen: Okay.

Have we been spending all of these budgets?

Mr. R. Brown: (Indistinct)

Denise Lewis Fleming: Yes, we have.

Mr. Murphy: (Indistinct)

Mr. MacEwen: Could be.

The total cost that clients are paying, is that as simple as your second column and your third column? If I wanted to find the Seniors' Drug Program total cost that Islanders are paying, is that the $25,000 by the $15.94?

Denise Lewis Fleming: No, it wouldn't be.

The example – and I'm just going to flip down a couple of slides to the Seniors' Drug Program. So we said $15.94 was the maximum client co-pay. That's all of that overview – they may actually only end up paying $12 out of pocket if their drug cost, for example, was only $6 and the dispensing fee was $6, then they would pay $12. You can't just take the math and put it across.

Mr. MacEwen: Do we track that total cost?

Denise Lewis Fleming: Yes, we do.

Mr. MacEwen: You don't have it, do you?

Grant Wyand: I don't know if I have it.

Mr. MacEwen: For all programs combined?

You don't have to tell me; we can just get it back.

Mr. Mitchell: Out of pocket pay for all (Indistinct) all programs.

Mr. MacEwen: 26 programs, yeah.

Grant Wyand: (Indistinct) all the programs or –

Mr. Mitchell: Of all programs.

Denise Lewis Fleming: Probably need a magnifying glass, but just give me one second here.

Mr. MacEwen: I've got more, you can come back with this and my next question is about private insurance and Grant, you had said 30% or basically on private, but we

don't know how much. Do we know that total, what we're paying?

Denise Lewis Fleming: Yes, we do.

Grant Wyand: Yes.

Mr. MacEwen: What I'm trying to get at is what we're all paying for drug coverage in PEI.

Denise Lewis Fleming: So, grand total of what insurance covered in relation to public drug prescriptions, or prescriptions that flowed through the public drug program, was nearly – or just over $8.8 million.

Mr. MacEwen: That's private?

Denise Lewis Fleming: Yeah, that contributed towards the cost of prescriptions that also flowed through the public drug program.

Mr. MacEwen: Okay, that's public?

Denise Lewis Fleming: Yes.

Mr. MacEwen: And then the private, the 30% of PEI that are on private plans, do we know what –

Denise Lewis Fleming: That's the $8.8 million that I just gave you.

Mr. MacEwen: Oh sorry, and what was the one going through the public?

Denise Lewis Fleming: So, I'm going to back up and walk us through a transaction.

Mr. MacEwen: Excellent.

Denise Lewis Fleming: An individual comes in, for example, I'm going to make math easy. Their prescription is $100. Then, the private insurance may pay, we'll say, 60% of that; so, they pay $60. We require, if you're a senior, you're paying the maximum of $15.94, so you're now at $75.94 total collected and then the province pays the balance, which is just under 25 in that particular piece.

When I give you the $8.8 million, it's how much the private insurance companies have contributed towards prescriptions that were also paid through the public drug program. The seniors – or sorry, not the seniors – everyone in our programs, their co-payments are approximately, I'm doing the math really quick in my head, $9 million grand total added all together. Then, the balance of the $34 million is what is paid by government.

What you saw up on that screen, that $34 million that was budgeted, that's Health PEI/government's portion of the cost. There's another $8.8 million in costs paid by the private insurers −

Mr. Mitchell: (Indistinct) plus 17.

Denise Lewis Fleming: − and then the balance of the $9 million is paid by the individual.

Mr. MacEwen: So we're looking at just under $17 million, is what Islanders are paying for drug coverage?

Mr. Mitchell: Eight public and nine private.

Mr. MacEwen: Yeah.

Denise Lewis Fleming: Yeah so –

Mr. MacEwen: I'm –

Denise Lewis Fleming: Fifty –

Mr. MacEwen: − building on your point.

Mr. R. Brown: (Indistinct)

Denise Lewis Fleming: $51 million in grand total of gross prescription costs.

Mr. MacEwen: Yeah, what I'm trying to get at is can you guys use that $17 million? Are we – I guess it's basically built on what you're (Indistinct) – are we getting to the point where we could be leveraging that $17 million against what − I'm just trying to get the numbers straight in my head.

I'll ask it this way: That $9 million that we're paying privately, are we getting our bang for our buck versus what the province could do?

Denise Lewis Fleming: I believe we are because the province – for all the prescriptions that flow through the public drug program, the province is the one that

has control over what the costs of the drug that we will reimburse for.

For example, generic drugs, we set what that generic drug price, it's based on, I think, it's the interchangeability drug pricing act. I don't think I have that quite right. So, we control that particular piece. Same for brand drugs, we are the ones that set what is the maximum reimbursable rate. It's not something that the insurance companies get to drive, or even the drug manufacturers.

Mr. Mitchell: Yeah, or the private.

Denise Lewis Fleming: Yeah.

Mr. MacEwen: With the new Pharmacare program that's coming down are we going to see this $34 million drop significantly? Are the new generic drugs that are being covered, is that going to affect your bottom line positively?

Denise Lewis Fleming: The new generic drugs? I'm not –

Mr. MacEwen: The new pan-Canadian agreement that we're –

Mr. Mitchell: I mean, that's –

Mr. R. Brown: (Indistinct)

Ms. Compton: Yet to be determined

Mr. Mitchell: That national Pharmacare program you're speaking of –

Mr. MacEwen: That's right, sorry.

Mr. Mitchell: – it's still – it's fairly early days on there. It's really – it would be hard to determine at this point in time how that could – it would be a mix of generics. It would be a mix of brands.

It's hard to say at this point in time what that would look like. As far as generic drugs that get added to the system that take away from a brand drug. Yes, those numbers continue to come down. I guess it would be fair to say that part. Any generic that replaces a brand, that, you know, we can add to the generic list, it's huge it's immense.

Mr. MacEwen: Okay. The administration for these 26 programs, what – who are they? What are we looking at there?

Mr. Mitchell: The administration?

Mr. MacEwen: Yes. Like, is it just Grant? Is it a whole team of people?

Mr. Mitchell: Two of them yeah, two of them are right here.

Grant Wyand: No, sorry. There is myself managing. We have a pharmacist consultant working with us. Then, we have four administrative officers looking out the program. Reception, as well, of course, actually, I should say, and another clerk actually handling our Home Oxygen Program as well.

Mr. MacEwen: One, two, four, you know, we're looking at seven people, maybe eight people running these 26 programs. I know there are others included, too. If they gave you a month to stop doing this, Grant, could you come up with a better way to do these 26 programs all the – you know, there are a lot one-offs here –

An Hon. Member: Yeah, I agree.

Mr. MacEwen: – it's screaming duplication. It's screaming all this stuff, but, can you convince me differently?

Mr. Mitchell: Go ahead, Grant.

Grant Wyand: I mean we have looked at different ways of handling these. The 26, the issue with that number is that you might look at another province and say, well, look they've only got 14. The problem is, is that we have ours all identified as individual programs. The other provinces will take portions of that and put them into other areas not identified through Pharmacare, but they're paying for the drugs through the government. They could have a separate transplant area that's run through, say, the QEII hospital, or a renal program that's handling some of those medications through that. They still pay for things the same way that we do, it's just that they identify them differently, so it doesn't look like they have 26 different programs.

Mr. Mitchell: Which, I think it's important to think of it as one program with 26 pieces to it that have been developed in particular time to suit needs that presented themselves at various times. It meets the needs of those that need those drugs today.

To adjust it in any way, I'm not saying it's not a worthy exercise to look at, but there will be outcomes. Negative impacts, positive impacts, maybe, and I'm not sure which ones outweighs the other.

If you look at it as one with 26 lines to it, each one was designed to meet a particular need at a particular time, which is working well. It is, when you say 26, it sounds large. It sounds like, how do I know which one?

I think, as the presentation shows today, when you start to break it down in its most simple terms, it's pretty easy to kind of figure out, except for the catastrophic term, which I do agree is very confusing.

The catastrophic term in itself, we should, I agree, look at something to call that a little better for – to make it more definite when people scan through a thing. You know, catastrophic, you roll over that one quick because that's not applying to me, but it does. If your expenses for drugs in your household is significant, it does apply to you specifically.

Other than that though, I think, they all serve the purpose. They serve them well. They provide that needed drug to who needs to get it. I like to think of it as one with 26 pieces, not 26 programs, myself.

Mr. MacEwen: Yeah, and I don't mean –

Mr. Mitchell: – (Indistinct)

Mr. MacEwen: – simplify. I know it's very complicated and all of the different intricacies of it. I think you hit the nail on the head. We're adding on one at a time every time there's a new need. We're adding it on, adding it on. Once you get under that for a long time you, you know, it seems like it's working well and that's probably the answer that you and I would give.

I know, I bet you, Denise, if you had a month, you could make things better for that program, I'm just guessing –

Mr. Mitchell: But –

Denise Lewis Fleming: If I had the time, yeah.

Mr. MacEwen: – if you had the time, you could –

Mr. Mitchell: – I think –

Mr. MacEwen: – streamline things, you could make it –

Mr. Mitchell: – if you went out and knocking on doors in your constituency, or I did, or any member did, you know, you would get the feedback that, hey, I'm pretty happy with it right now. If you adjust it, that happiness might go away in some cases. I mean, it's all relative to who we're trying to help out here with medical cares.

It's not something that we shouldn't, you know, could take a look at. But then, we'd have to make a decision. Is that really the right thing to do? Is incomes being tested every household on Prince Edward Island? Is that the right thing to do? Is paying more than zero co-pay for opioid drugs replacement? Is that the right thing to do?

Those are the questions that you would have to ask yourself as a legislative member of Prince Edward Island. Is that really what Islanders need, or, do we just keep presenting it as it is? Those are the questions, right?

Mr. MacEwen: Yeah.

Chair: Sidney, do you have any more questions on this?

Denise Lewis Fleming: There's –

Mr. MacEwen: I do.

Denise Lewis Fleming: I'm just going to –

Mr. MacEwen: Do you want me to wait?

Chair: Yeah, if you don't mind. I'll put you back on the list.

Okay, Denise, you wanted to add something?

Denise Lewis Fleming: I'm going to add one comment, is that – there's a range of, well, I'll call it harmonization that can be done. Whether it be, as the minister mentioned, you harmonize all the co-pays, so that everybody pays the same co-pays. I think, starting at the very – the first step would be harmonizing what – for those programs that we do income-test, that we do the income testing in the same manner across all of the programs.

It does vary right now. We use different lines from your income tax return depending upon, to the minister's point; at the time that there was a good reason for choosing (Indistinct) –

Mr. MacEwen: Absolutely, yeah.

Denise Lewis Fleming: – so –

Mr. MacEwen: But that's the –

Denise Lewis Fleming: – that's the –

Mr. MacEwen: – the nail on the head –

Denise Lewis Fleming: – range.

Mr. MacEwen: – that's the stuff that I want to get to right there, is just those little things that we could start looking at. We keep piling on one program after another program. All that are good. You're right; I'm not going to go to a house and say: No, we've got to change that around on somebody. I shouldn't say that. I should – that they're going to tell me that –

Mr. Mitchell: Yeah, it's good.

Denise Lewis Fleming: It is something that Grant's group has identified, and we've chatted about and continue to have discussions with the department on, the department staff, on what are the opportunities and ability to do that.

Chair: Kathleen Casey.

Ms. Casey: Thank you. Thank you, Mr. Chair and thank you for your presentation.

Mr. R. Brown: It's great.

Ms. Casey: I was really pleased to see – my question, my first question is going to be around the Diabetes Drug Program, and really pleased to see that 8,700 Islanders benefitted from this program in this past year fiscal year.

Some of the questions that I get from my constituents is – and I'm sure you hear it all the time, is – and I'm sure everybody around the table here hear it as well about the test strips and why insulin – was it a government policy? Was it your department policy on why insulin-dependent only get test strips?

We all know the importance of testing when you're a diabetic, even if you're not insulin-dependent. I'm just wondering where are we going on that? I know we've – there's been chatter about: are we going to cover all test strips? Can you comment on that?

Denise Lewis Fleming: Sure. I know there was a, I believe it was a motion that was tabled in the House a couple of sittings ago about the test strip issues. We did, at Health PEI, send it forward to our diabetes strategy steering committee for consideration and they also broke it down into components.

Because while the Canadian Diabetes Association does have a piece out saying they would like to see supports for test strips for non-insulin dependent, after review by the diabetes steering committee, which does – it's multi-disciplinary, as well, it includes physicians, diabetic nurses, or nurses that work in the diabetes program, they actually prioritized the pieces and the non-insulin dependence were not actually at the top of the priority list. It was actually women with gestational diabetes that needed that additional support because of the volatility of their (Indistinct) and they also prioritized the addition of a nurse practitioner working, both with the non-insulin dependent, as well as the insulin-dependent diabetics. That nurse practitioner can provide better self – support so that diabetics can self-manage.

It is a disease that can be managed well. I know my father would have no problem with me saying that he is also a non-insulin dependent diabetic. It can be done quite well through diet, exercise. He only tests, and his doctor has informed him he really only needs to test maximum three times a week. It's a piece of work that's still ongoing. How do we promote better chronic care management?

Ms. Casey: I know diabetic pumps are funded for those under the age of 18.

Denise Lewis Fleming: Correct.

Ms. Casey: Any talk or any update on, or is it government policy on what will – what would happen on supplying funding for pumps for those over the age of 18?

Denise Lewis Fleming: I can only speak to the part, and I really would encourage the committee if they wanted to get a review of the diabetes pump program, or the diabetes program as a whole to bring in that particular group.

Ms. Casey: Okay.

Denise Lewis Fleming: It's outside of the Pharmacare piece. Currently, I have no instructions to expand it beyond that particular piece.

Ms. Casey: Okay, thank you.

Pat Murphy asked an earlier question with regards to drugs on the formulary and I understand since 2007, the drugs on the formulary have grown exponentially.

In order to get a drug on the formulary, is it, and I'm just trying to – if somebody was requesting a drug to go on the formulary from Prince Edward Island. Is the research that it's easier to get the drug on the formulary if it's, if this drug has already been approved in say, New Brunswick, Nova Scotia, in sort of Newfoundland, in kind of the Atlantic, Maritime Provinces, is it easier to get it on the drug formulary if it's already been there?

Denise Lewis Fleming: I don't know if I would say it's easier. It's one of the factors that is considered because, as the committee is likely aware, the province does wish to move towards greater parity with our Atlantic Provinces. It's one of the factors that's considered. There, as I mentioned also, a number of physicians that participate on a Provincial Drugs and Therapeutics Committee, as well as their two sub-committee. They also apply their clinical knowledge from understanding their patient populations about what they see as the greatest gap. So, it may not necessarily be something that is approved in Nova Scotia, New Brunswick, but they bring it forward to those committees.

The two committees, the subcommittees of the provincial drugs and therapeutics, just for the group to note is the oncology subcommittee. It deals with the cancer drugs. It does actually have a representative on it from the Canadian Cancer Society. We do have some public participation on that side. We have another subcommittee that deals with, I'll call, all other drugs for other disease states.

Ms. Casey: Thank you.

That's it for now, Mr. Chair.

Chair: Thank you.

Sonny Gallant.

Mr. Gallant: Thank you, Mr. Chair.

I guess I'll go back to the Catastrophic Drug Program and there seems to be a desire to change the name.

It's seems like a wonderful program. From looking at this, so from 20,000 to 50,000 you could pay as low as $600 to $2,500?

Denise Lewis Fleming: Yes.

Mr. Gallant: What kind of feedback are you getting on that? Like, is that – this must be a very positive thing for the residents of PEI, is it not?

Denise Lewis Fleming: I think the feedback overall is generally positive. The challenge that some of the clients are expressing is having to pay that full amount upfront. You have – say, you have income of $20,000, you have to pay that entire $600. If you walk in and your prescription is $60, that first prescription in the year you have to pay the entire amount (Indistinct) 60. It's not until after you hit the 600 level that it kicks over and then we take over. People are finding, some people are finding that a challenge at the lower income levels.

Mr. Gallant: Okay, so you have to pay that right up front?

Denise Lewis Fleming: Yes.

Mr. Gallant: Okay, thank you.

My other question was, and it's around the formulary, could you give us an idea, how many drugs were added to the formulary in the last year?

Denise Lewis Fleming: Sure.

Grant Wyand: Last year, I believe, we had 37 that –

Mr. Gallant: Thirty-seven.

Grant Wyand: – were added. It's just, there's new drugs can be added. Some drugs will refer to as a budget-neutral drug if there's already a drug that treats a certain disease state, and another one that comes along and treats the same disease state, but it's the same price, then we'll add that in to give more option to the physicians, nurse practitioners out there that are prescribing.

Mr. Gallant: Okay.

Grant Wyand: Or there can be some extensions to the drugs, in terms of what they have as an indication. If there's a new indication for that drug comes along and it's not going to impact budget a whole lot, then, that will be added in as an additional indication for it.

Mr. Gallant: Okay.

Denise Lewis Fleming: Just for clarification because I know sometimes we can use terms. Coverage for an indication means a certain disease state. For example, Humira, I'm sure many people see the commercials. We get so much American TV. Humira, one indication it covers and that we cover it for it is Crohn's. Another indication is arthritis. So it's a different disease state, when we refer to indications it's what's specific diseases we cover it for or types of cancer is another example.

Mr. Gallant: Okay, thank you very much.

Chair: You're welcome.

Peter Bevan-Baker.

Dr. Bevan-Baker: Thank you, Chair.

I'd also like to thank you for your presentation, and also for your patience last time you were here when you sat for two, two-and-a-half hours and we didn't get there. Thank you for being here, today.

My first question is on accessibility of the Catastrophic Drug Program or whatever we want to call it; financial hardship drug program, I would proffer as a possibility.

It's regarding the accessibility of the program. The Seniors Drug Program, for example, enrollment is automatic when you hit 65, but for this program, and I've looked at the forms, and they're fairly complex.

Grant Wyand: Yeah.

Dr. Bevan-Baker: Each year, you have to reapply to be part of that program. I'm looking at what has happened over the last three or four years where the demand has tripled for the program, and I'm wondering whether you think that's because the demand has tripled, or do you think people are just becoming aware of the program now, and that's why we've suddenly seen, well, not suddenly, why we've seen this large increase?

Denise Lewis Fleming: Can you start?

Grant Wyand: Yeah. I would say it's related to a word-of-mouth; people enrolling in the program and seeing benefits. They would talk to their neighbour and so on is one of the bigger reasons that we would see the increase in the enrollment.

Each year, when it does come around to enrollment time where staff have – run the list of patients that were enrolled the previous year. They mail out the reminders to them to let them know that please reenroll in the program, so we're hoping that we're getting the same people back, again. That, I think, is a huge help to keep the numbers level and of course capture anybody new that hears about it and apply to it.

Denise Lewis Fleming: The other piece, as well, Grant mentioned it earlier, is that when individuals call in, for example, maybe they're – just been diagnosed with MS and they're applying for the High-Cost Drug Program, that the staff will also advise them they really consider applying for the

Catastrophic Drug Program. Because both are income-tested, you know, that particular piece. Sometimes, we have more challenges with individuals, say, for examples, in the seniors' program, it's not an income-tested program. So, then individuals are really having to consider their choice about, do they want to disclose their income. Sometimes, that is a hurdle some people need to mentally get by and accept that piece.

We do also try and promote it a bit more. It's been a couple of years since we've done the last promotion on the Catastrophic Drug Program. I will say, part of the reason why we haven't gone forward with the next round of promotion is the internal conversations we're having about what is something other Catastrophic Drug Program to call it so that people will realize that it is a program for them. It's not just if you have been diagnosed with a high-cost rare disease or suddenly facing cancer with a high-cost cancer drug.

Mr. Mitchell: If I might weigh in; I know it's on reference here, but to your original question it's a combination, I think. I think that's what everybody is trying to allude to. A fairly new program that's – people are still finding out about it. No matter whether you have a private plan or you're on the seniors' plan or whatever, there is possibility for potential use. It's until people get that figured out and then, oh yeah, that's me and then jump on board.

I think to the point, and we've hammered it pretty good, if we can call it a different name that might bring that clarity quicker, I think you'll see even increased uptake.

Chair: Peter Bevan-Baker.

Dr. Bevan-Baker: Thank you, Chair.

Probably other members in the room have heard stories of people remortgaging their houses, selling off assets or just, perhaps, choosing not to receive treatment because they're not aware of this program. I'm glad to hear Grant, that you are sending out reminders annually when the June 30th end-of-the-program comes around.

But relying on word-of-mouth to ensure that Islanders who may be eligible for this program are receiving it just isn't good enough. I think we need to do better than that. I don't know what that something else is, but –

Mr. Mitchell: As was mentioned earlier, pharmacists are pretty – they're on top of this. They know their clients and they know what's available. They're really good to steer somebody in a direction, and that's where ultimately, when you get whatever prescriptions, you're going to see your pharmacist. Relationships have been built there in a lot of cases for years, so that's one of the first points where they say: Oh, do you know about this? – irregardless of whether they're getting things in the mail.

It's a pretty good system. Can we look at making things better? Always can; whether we put flashing boards up in pharmacies, offices or whatever, to kind of draw attention to it. It's not like if you were coming with a very expensive drug to a pharmacist, the very first thing they would be doing would be to kind of direct you into some path or funnel that will help you out there.

Denise Lewis Fleming: I would also note that, in particular when we're talking about high cost drugs, kind of to the reference of do you have to mortgage your house to do it; you're usually dealing with a specialist physician at that particular point. The family practice physicians would rarely issue a prescription for a very, very high-cost, single-type drug. We have really good awareness among our specialty physicians about programs to help support these high-cost drugs, what is there.

We also do have patient navigators, in particular in the cancer treatment centre. We also have a provincial patient navigator that we also work quite closely with them to make sure they're fully aware and can help any individuals that reach out to them. The staff at the cancer treatment centre also do a lot of work to even reach out, as I mentioned earlier, to the pharmaceutical companies, and to be aware of what compassionate programs are there.

Mr. Mitchell: They deal with a lot of clinical trials.

Denise Lewis Fleming: Yeah.

Mr. Mitchell: Through oncology and oncology specialists and even all the frontline people at oncology, they're pretty aware of what's available and to help families. So that selling them a house or something is – you know, it would be a last resort, I suppose, and I don't even know if it would get there to be honest, Peter. Things have been working relatively well as far as what we have in place over there as well.

Denise Lewis Fleming: I think the ones we see more often that struggle and don't realize that there could be support is if you have 10 individual medications. It's that cumulative effect, and those are the individuals that we're trying to figure out how do we reach them better and have them identifying with the program.

Dr. Bevan-Baker: You sort of pre-empted my thought –

Denise Lewis Fleming: Sorry.

Dr. Bevan-Baker: – which is that one of the problems with the name of the program, the soon to be renamed program, is of course that it's not about –

Mr. Mitchell: (Indistinct) Richard Brown (Indistinct)

Dr. Bevan-Baker: – necessarily one massively expensive medication, but the accumulation of a number of medications that particularly many seniors these days are on.

I'd like to talk, though, about the drug and therapeutics committee and the decisions that are made regarding adding drugs to the formulary. I know there was just – I saw an announcement today that Remicade is now being covered for IBS and for Crohn's, and that's great; but if I remember right from the story I read, the cost of that is about $27,000. It didn't make it clear, but I read that as per patient.

There are other medications as well, far beyond the means of most ordinary Islanders to ever afford: new cures, for example, for hepatitis C, where I think BC is the first province who's going to come forward and cover Sovaldi, the very expensive – it can be up to $100,000 per treatment for a patient – but hepatitis C is a potentially deadly disease.

This comes with very few side effects, but you're faced with the ethical dilemma – I'm getting to my question, Chair – the ethical dilemma of here is a drug that can cure a deadly disease and there are over a thousand Islanders who suffer from hepatitis C, but if we were to pay $100,000 for a course of treatment for all those Islanders, we're going to bankrupt the medical system.

So my question is, regarding the Provincial Drugs and Therapeutics Committee, is there a medical ethicist who either sits on that committee or is available to be consulted with who would give advice to that committee as to, well, how do you deal with that? How do you make those incredibly awkward, difficult ethical decisions?

Denise Lewis Fleming: There are a couple of levels to that particular piece. Health PEI has an organizational and clinical ethics committee that is a group of individuals that are available to consult with any group within Health PEI to help them work through difficult decisions such as that. They are available to the Provincial Drugs and Therapeutics Committee.

The Provincial Drugs and Therapeutics Committee does also receive indications or guidance from all the work that is done on the side of CADTH, the Canadian Agency for Drugs and Technologies in Health, because they take into consideration the information provided to the provinces on what is the medical efficacy, what is the improvement in the person life years, best way I can express it right now.

So it's basically what improvement in the quality of life or the length of life that may come from this particular treatment, and how much does it provide additional benefit compared to the treatments that are available. Is it safe?

The other great piece about us also relying on some national bodies that exist is that by the time it gets to our Provincial Drugs and Therapeutics Committee, quite often, in most cases, there has already been negotiations by the pan-Canadian Pharmaceutical Alliance, which is an alliance of all provincial governments that

come together to negotiate pricing on new drugs that are coming to the market.

For example, the hepatitis C example that you noted earlier, the $100,000 is what I'll call the manufacturer's list price, which is not necessarily the price that even private insurers pay, nor the public plan, because they then do negotiations to bring in a lower price.

The clarification I'd like to add on the hepatitis C program is that PEI does have on its hepatitis C formulary, a pangenotypic drug that will treat any of the hepatitis C patients here on PEI. We do currently have structures to identify the cases and flow them through. Over the past two and a half years we've treated approximately 170 people. That's compared to – I believe it was four people in the five years preceding that.

PEI actually started in 2015 in bringing on those new drugs that have very little side effect, and we're continuing to work though that and support those pieces. That was also a case where it wasn't done through the national pharmaceutical alliance to negotiate the piece; it was done directly by PEI. So you can see a combination of the two in order to get to those best prices.

The Provincial Drugs and Therapeutics Committee, they do take in some consideration what the cost of the drug is, because they need to identify approximately how many people will be taking the drug and what would the additional cost be to the program, but they don't make it their focus. It's from a clinical perspective, and then they provide a prioritized list to help PEI and to the department for us to then reach a decision on which ones to add within the fiscal capacity that we do have.

Dr. Bevan-Baker: Thank you for that clarification, Denise. I appreciate that.

Could you give us a sense of how many requests for drugs to be added to the provincial formulary come in on an annual basis, and how many of them as a percentage generally get approved?

Denise Lewis Fleming: I don't have that number with me right now. I'd have to get back to you with that number. I don't sit on the Provincial Drugs Therapeutics Committee, so I'd have to go to them, get that brought in.

Like I said, last year we added 37 drugs to that particular piece. It varies year by year, and also is dictated by how many new drugs come onto the market, so I wouldn't say it's an even – it's more of a roller coaster.

Dr. Bevan-Baker: Sure, okay. Thank you.

I'd like to ask a question on the Opioid Replacement Therapy Program. I know that the costs of that are a combination of the dispensing fees for the methadone and the cost of the medication or Suboxone and the cost of the medication itself. Do you have a breakdown of what percentage of those costs – and you may not have that available for me today, but I'd be interested to get it – a percentage breakdown of the costs that are related to the medication itself and the dispensing fees? Do you know approximately what that might be?

Grant Wyand: I don't know if I can give you a direct percentage but I can certainly tell you that the majority of the spend is on fees.

Dr. Bevan-Baker: On –

Grant Wyand: On the dispensing fees –

Dr. Bevan-Baker: Yeah.

Grant Wyand: – related to methadone. The drug cost is actually quite little.

Dr. Bevan-Baker: I'm aware of a senior couple whose combined income is about $25,000 and they are on – Denise, you mentioned earlier about the cumulative costs of their co-pay, for example, for each medication and they're on multiple medications. Their combined household income is $25,000, but they spent far more than the $1,250 that would be the cap for them, given that it's 5%. Is that right?

Denise Lewis Fleming: Yeah.

Mr. Mitchell: Five, yeah.

Dr. Bevan-Baker: So, I'm wondering is this a situation where they're just – I don't know if they're aware of this program or not, by

the way. That's a distinct possibility, but are there fees? Are there drug fees beyond being an ineligible drug that would not count towards the cap? Are there any fees there that wouldn't be calculated in?

Denise Lewis Fleming: No, because under the contract that we have with community pharmacies, there is a maximum allowable amount which they can charge us for the drugs, as I mentioned and a maximum allowable amount that they can charge us for dispensing fees.

My understanding is it's extremely rare for a community pharmacy to then turn around and if they want to, say for example, charge $10 for the drug instead of the $8 we allow to pass on that additional $2, I don't think –

Mr. Mitchell: I don't think it occurs.

Denise Lewis Fleming: I'll defer to Grant on that,

Mr. Mitchell: Hon. member, did you say they're two at $25,000?

Dr. Bevan-Baker: Yeah.

Mr. Mitchell: No drug plan?

Dr. Bevan-Baker: I don't believe so.

Mr. Mitchell: No drug plan, and an annual cost of what for drugs?

Dr. Bevan-Baker: $1,850, which is $600 over the cap for this. Now, again, I'm going to have to speak to them and get some more information, but I just wondered if is it possible there are drug related expenses that they're incurring that would not be calculated into the cap? I'm hearing probably not.

Denise Lewis Fleming: Probably −

Grant Wyand: If they were on a medication that wasn't on the formulary −

Dr. Bevan-Baker: Ineligible, sure.

Grant Wyand: − then it wouldn't be capped, so we run into those situations where people will call and say: I think I've spent more. We look at their profile to explain to them that it was a particular drug that just isn't on the formulary. It's not covered.

Dr. Bevan-Baker: Sure, okay.

Grant Wyand: In terms of extra fees or whatnot that they could be charged, as Denise said, it would be pretty rate that a pharmacy would be trying to pass on extra expense. In some cases we have come across it in the past, but a quick phone call to the pharmacy just to check on what's going on and it's just an error on their end that usually winds up getting reversed and they make sure the money gets back in the patient's hands.

Dr. Bevan-Baker: Thank you, Chair.

Chair: Is that it (Indistinct)

Dr. Bevan-Baker: Yes. No, I'm done.

Thank you, Chair.

Chair: Okay, great.

Darlene Compton.

Ms. Compton: Thanks, Chair.

Thanks very much for coming in and for your patience the last session.

Just on the awareness, I'm trying to get a handle around the Generic Drug Program versus Family Health Benefit. If you have a single mother and she's got two sick children and she goes to the doctor and they both need prescriptions for whatever, she hasn't already registered with the province. She's going to go ahead and pay whatever it is because she needs to make her children well.

I'm just wondering about the forethought or letting that single mother know that she would be eligible, what the threshold is, the income threshold for the Family Health Benefit, and how that all transpires. It's easy to sit in this room and say everyone has the possibility of being covered, but if that young mother doesn't know she has the possibility of being covered, how does she find out? Is it going to be her doctor? Is it going to be the pharmacist? Is it going to be when she sees the sign on the wall; the actual mechanics of how that works?

Denise Lewis Fleming: There are some pieces, as Grant mentioned, we have a large amount that does happen by word of mouth. I'm not saying everybody in the provincial health system knows all of the drug programs, but we have nearly 6,000 Islanders that work in the health care system. Usually, if they run into an individual that's struggling they'll know to point them towards the Pharmacare programs. That touches a lot of households in that particular piece to try and spread the word.

I do recognize – I believe we can do a better job of creating that awareness. There are some populations that it's going to be easier for us to reach out and target. For example, and I'm going to go back to Peter Bevan-Baker's comment about the seniors and the catastrophic drug, I think it's something we can look at about we know everybody that's registered in that program of whether periodically, every year or a couple of years, we do an mail out to that group to say: Are you aware you're eligible, and the Catastrophic Drug Program could help you if you have multiple medications?

It's a little bit more challenging when we talk about families that are currently not identifying to that particular piece and so then that's where we try and – who are the community groups that we need to get the group out to share that piece? Posters do work to a certain extent, but by then you're already at the pharmacy in that particular state, so it's a little bit more proactive and I will be honest. I believe that being here at the committee, I know the information is streamlined and shared. What's been shared with the committee here, the conversations that you have as you go door to door, and there's spread in that. It's getting people to identify with that particular piece. We find it can be very hard for people to look at an ad or a poster and say: That's me. As opposed to more getting the word out and –

Mr. Mitchell: I think, too, for your young families that you – like public health nurses, they have a role to play about this is available, and they do that well. There are so many avenues, but as everyone working to its ultimate premium level that you want, it's hard to measure.

To Denise's point, can we do better? We'll try to do as much as we can in post outs and everything else, to blast out the information.

Ms. Compton: Yeah, so just on that note, a lot of times to me it's a single mom or it's a young family and they're both minimum wage and they're just trying to get by. They don't expect handouts, but they don't know about the programming. That seems to the people – those are the people that are always slipping through the cracks.

It's not the financial assistance, it's not the seniors, but to come to me as the MLA; you don't know what their income level is exactly. You don't really want to pry, but you're trying to direct them to the right place.

Mr. Mitchell: At the very least, if you direct them to that phone number, the person who answers that phone will be up to speed perfectly on all of the programs, and it would be very helpful for them to collect that information on the end of the phone to say: This program, this program is what you should do, but you wouldn't be eligible for this one and this one.

At the very least, if you could direct them to that phone number, that would be their very best resource to figure out their best path.

Ms. Compton: Just on the list of − the varied list of client co-pay, how that has transpired. Has it been a piecemeal thing? I've had a conversation – a number of seniors – every one of us have them in the district. They're living on old age security and maybe a little CPP or maybe just OAS. They're struggling. They're paying that $15.94 per prescription, and one gentleman said to me: If I was a drug addict I wouldn't have to pay anything. That's the perception.

We understand it's important to have methadone and Suboxone available. The dispensing fee; they go twice a day. It's huge, a huge cost, and in the interest of fairness for all have you looked at the co-pays across the board? Whether it's seniors or generic or diabetes, or how do we make it more fair for everyone?

Mr. Mitchell: I think those discussions have been going on. It's like our earlier discussion. What is the good balance? What

are the impacts that are acceptable here? We're still working through that. When you say, for instance, the comment about: If I was a drug addict – obviously those that are using those opioid replacements is a client that wouldn't have the dollars to pay a co-pay, realistically.

It is an extremely important method of getting them clean and back into productive society, and they work very well to do that and we have a lot of success cases there. To say that they should be paying, they paid a lot prior to so they're just trying to get their lives back on track. I think that's part of the overall discussions.

To say that we will continue to look at it and work on it, what ways could you collectively bring things together? There are probably some that we could do without a whole lot of significant negative impact, but some will cause impacts and we've got to really bear down and that to say is that what's important or is the spread between $15.94 for the seniors drug and the $19.95 for a young family does not have any other – is that reasonable? It was obviously determined that it was.

Those are the challenges that we work with every day when it comes to drug formularies and finding dollars to put more on formularies so that they're able to help more families.

As I said earlier, generic drugs that come on to replace brands are immense when it comes to positive outcomes for health care whether you're senior, whether you're family, whether you're diabetic. Those are the big gains, if we can get more of those added to the list.

Ms. Compton: I'm not saying that one is more deserving than the other but it's just, that's a comment that has been made to me, and I've –

Mr. Mitchell: Sure, no, I –

Ms. Compton: – had a number of seniors –

Mr. Mitchell: – understand that, yeah.

Ms. Compton: – who are struggling and really struggling just to, you know, do I buy my medication or do I put oil in the tank or do I get groceries? It's a huge issue.

Denise Lewis Fleming: We have had conversations because is it all age-based? Part of what I hear in the story that you're sharing is what is our philosophy about, do we help the most vulnerable the most as opposed to others, who have more means that may receive less assistance because they do have some means to achieve it?

Right now, we have a divide between that means testing between our seniors and the others. That was done at a time because the seniors' program has been in place for quite a number of years, when the seniors on PEI did not have very large household incomes. We do recognize, we still have quite a number of seniors that have low income levels. But, we also have a growing number going into the seniors group that their income levels are substantially better than what previous generations would be. It's something that, getting back to the conversation of what do we do? Is there a graduation between who is the most vulnerable and who has the means to pay? And, it really, through that conversation potentially resets what the program organization might be.

Ms. Compton: Thanks, Chair.

Chair: Sidney MacEwen.

Mr. MacEwen: Thank you, Chair.

There's no doubt that the drug and therapeutic committee have a very tough job to try to pick and choose and when they pass it on to you guys it's also a tough job. We all have the people coming to us saying, just like Darlene said: you know they supply methadone, but don't supply my drug that I need. There's always tough back stories.

There's, I had a constituent who has arthritis and cirrhosis. She gets a needle every two weeks. Her physician wants her to go to up – increase the dosage to every – once a week, but the – she's on the high-cost program and private insurance and it's about $900 a month. So she can't afford to move up to that.

I guess my question is, this committee, or you guys: How often are we reviewing the

current medications because sometimes the guidelines in when someone starts this medication in 2006 don't match with the guidelines of 2017 or 2018.

Are we focusing on that review, as well? Does that come up a lot?

Grant Wyand: Yeah. There's actually a – our pharmacist consultant that works with us. She's a part of the Atlantic Common Drug Review. That's Nova Scotia, New Brunswick, Newfoundland, of course, all get together and they look at what you might term and older drug and determine are there new indications for this? Has the dosage in the past that was recommended, has that changed now? They will discuss that.

She comes back with recommendations from the Atlantic group as to how the – in those cases, it's usually a special authorization medication meaning the doctor has to actually request that drug. If it comes back that there's a change and all the provinces have agreed upon it, of course take a look at fiscal kind of constraints there if there are any. If not then we would change the criteria on that drug to match what is now the recommendation so the patients can access the medications.

Mr. MacEwen: That special authorization, is that something that is done midstream? Is that something that needs to be added to the formulary, or is that something that the patient and their physician can work out before an announcement, kind of thing?

Grant Wyand: Generally, we would wait for agreement from all the provinces. Then, as I say, the kind of fiscal look at it, as well, and make sure it's not going to run things up higher than we would be expecting.

Mr. MacEwen: What kind of jobs are our physicians doing at letting people know about registering for these programs?

I'm guessing at a walk-in clinic there's probably not a lot of discussion about that. Family doctors, hopefully. Do you – do we converse with the medical society? Are we pushing our doctors to let people know? Obviously, you talked about the pharmacists are good. Are we getting good feedback from our physicians on this?

Mr. Mitchell: I guess that's something we could, you know, make an attempt to contact doctors to ensure that that's going on.

I think, in most cases, a walk-in clinic type of thing, the reason the person is there, for the most part, some simple type of a diagnosis –

Mr. MacEwen: Yes.

Mr. Mitchell: – in-the-door, out-the-door, kind of thing.

I think back to the point of, more importantly, it's the oncology folks that build those relationships because we're talking fairly significant dollars for drugs.

Mr. MacEwen: Yeah.

Mr. Mitchell: Fairly significant, you know, life-changing outcomes, as well. That's a real part of their normal day-to-day activities. Pharmacists, obviously, it's really part of their normal day-to-day activities.

The walk-in clinic – your family doctor would probably – is doing a really good job of it. You know, it's hard to address the walk-in clinic type of thing. Are they getting the full questions; what are you on? What have you been on? Little hard to determine this point in time. Maybe we could do a better part of measure that trying to calculate that.

Mr. MacEwen: I guess, yeah, I don't mean going there for something they're going to need that prescription for. It's probably, if you don't have a family physician who was probably telling you that these programs are available and you're continually going to walk-in clinics that might be the segment that we're trying to catch, or whatever –

Mr. Mitchell: You know, it's a good point –

Mr. MacEwen: – whether you –

Mr. Mitchell: – I don't have a good answer for, I guess, at this point. Maybe something you could do a little more question asking about.

Mr. MacEwen: I appreciate that.

What's coming? What's next? What drugs are coming? What's the top of our list? What are we announcing in a couple of weeks?

Mr. Mitchell: Oh god, I'm unaware for the couple-of-weeks' announcement. Obviously, as part of our internal group we're looking at drugs continuously as part of the national – figure out who – what's being – come through there. What the other provinces are doing. It's always an item that there's a continuous lens on. Where do we fit in? Where can we do better? What do we need? Discussions with those oncology folks, who are always, kind of, identifying new things that are out and on the market.

The short answer to your question is we're looking at everything. What's happening two weeks' time, that's news to me. You're into a different track than I am there. We're looking for opportunities to provide continuously drugs on the formulary and update.

Thirty-seven last year, you know, for PEI that's a pretty significant amount of drugs. Hopefully, in the next year we can have 37 and maybe a few more than that. That'll be a success for our point of view.

Mr. MacEwen: Thank you. Thank you, Chair.

Chair: That's it for questions that I have on my list.

I want to thank the presenters for coming in here today, for presenting. Again, I do apologize for having you sit in the gallery last time. We had a very engaging and interesting presentation prior to your scheduled meeting last time. Again, show that we have more time for another very interesting and engaging conversation regarding a very good program for Islanders. I'm going to thank you for coming in today.

We're going to take a two-minute break. We'll come back and work on the next item on our agenda.

Grant Wyand: Thank you very much.

[recess]

Chair: Ladies and gentlemen, thank you.

We're back again on item number four on our agenda, which is new business. Before we get onto that I'm just going to ask our clerk: just go over our workplan from what we have tentatively on the table.

Clerk Assistant: Sure. Thanks, Chair.

According to the workplan from last fall the outstanding items on this, first of all is having Dr. Morrison come in to discuss her 2016 report. I've been in touch with her office, but her availability is pretty limited to middle of April right now, which, of course, is when the House is sitting.

The next outstanding item is the funding bed allocation group. I've been in touch with Dr. Michael Corman and he's not prepared to present yet. He will update me when he's ready.

Then, the last meeting, we had, approval of the letter from Sidney MacEwen for the Rotary Club of Montague to come in and present. I was in touch with them and they are interested in presenting. It would just be – I told them I would have a better idea today on the, I guess, the appetite of the committee to meet again.

Chair: Thank you very much.

Is there any – we're going to get back this, for the scheduling of meetings, is there any other new business?

Peter.

Dr. Bevan-Baker: Well, it seems that from that report that Joey just gave us that there's not a lot waiting on the sidelines to come in. I do have a couple of new things for us, exciting new things, Chair.

Chair: Sure.

Dr. Bevan-Baker: One is that I'd like an update on the child protection review that was done a couple – no, it was last year; I think it was January last year it was presented. I've heard nothing about it since. There's no update. The, sort of, the fundamental thing that the board or the group who did the review made clear was that there were three policy recommendations that had to be put in place before the other sixty-something

recommendations. I don't know where that stands, so it would be nice to have an update on that.

Chair: Okay

Dr. Bevan-Baker: That's the first one.

Chair: Sure.

Dr. Bevan-Baker: The second one is on supported decision-making, which is a process whereby people with intellectual challenges are aided in making decisions independently rather than having to do it through the state.

It's something that exists in other provinces. I know it's been, sort of, slowly working its way through the system here, but I've been, ever since I was elected, I've been speaking to a group about it and they've said: Hold off. And they said: No, ask. So, I'm asking.

Chair: That's everything?

Dr. Bevan-Baker: Yeah, that's all.

Chair: I'm going to just open the floor for discussion on the child protection review. Does anyone else have any comments on that?

Ms. Casey: No, I think it's a great idea.

Chair: Okay, everyone in favour, so is – Peter, could I just get you to put a motion on the floor –

Dr. Bevan-Baker: Sure.

Chair: – for the child protection.

Dr. Bevan-Baker: I move that we, that this committee hear from whoever is responsible for implementing the child protection review for an update on its status.

Chair: Great, thank you.

All those in favour signify by saying 'aye.'

Some Hon. Members: Aye!

Chair: Contrary, 'nay.'

Okay, we'll ask our clerk to get in touch with those people.

Clerk Assistant: Sure.

Chair: Second request from Peter was supported decision-making, do we have, or not do we have, is there discussion on that?

Mr. R. Brown: What is that?

Mr. Murphy: Yeah, just a little bit of an update on it.

Dr. Bevan-Baker: People who suffer from intellectual disabilities, but yet are functional enough that they can make their own decisions about their finances, for example, or a number of other sort of fundamental things that we all take for granted that we can choose for ourselves. Many of those people do not have that opportunity. Supported decision-making is a process whereby those individuals can nominate, and it's usually two or three people, to help them make those decisions or at least support them in those decisions so that they – that the decision is a sound one. It takes it out of the hands of the state and it gives them the freedom, the dignity that any human being should have.

Chair: Who do you suggest we have in as presenters?

Dr. Bevan-Baker: I'd have to look back through my notes and discussions on that, Chair. I have spoken to a number of people about it over the years. I know it's in family and human services, but this is a health and wellness issue. I think this is the appropriate committee to hear about this.

I can get back to you with that, Chair.

Chair: If you would get back to the clerk that would be great.

Dr. Bevan-Baker: I will do that.

Chair: Thank you very much.

Any other discussion on that?

Peter, would you like to make a motion on that?

Dr. Bevan-Baker: Yeah. I move that this committee hear from somebody related to supported decision-making in order that we

can have an update on where that stands with the province?

Chair: Thank you, Peter.

All those in favour signify by saying 'aye.'

Some Hon. Members: Aye!

Chair: Contrary 'nay.'

We'll move forward with that.

Thank you.

Dr. Bevan-Baker: Thank you, Chair.

Chair: Any other new business?

Sidney MacEwen.

Mr. MacEwen: Thank you, Chair.

I guess it's not new business, but just a clarification on the funding bed allocation group. When we had been, correct me if I'm wrong, when we asked them to come in, it was for an update mid-process, I believe.

I know, I think it might have been the minister here at the time they said: Well, it would be better to have them at the end when everything is all settled and done. But, I think we discussed that day, too, about, no, we want an update on what's going on through the process because, as we've seen, there's been announcements on beds and that kind of thing.

Maybe, Joey, can you provide any more clarification on the exact reason why they're waiting until the very end of their study? Because, I think our point of bringing them in was, no, we want to know how it's going in the meantime because, as the minister said that day: We've got, at any given time 75 people waiting in beds at the hospital that are discharged.

Ms. Compton: Is it because of that, sorry –

Chair: Go ahead, Darlene.

Ms. Compton: Dr. Michael Corman, he's the new hire, right? He's the new hire through the seniors' strategy, I believe. Maybe he doesn't really know – it would be good for him to come in anyway, regardless of where he's at, just to maybe give us his plan and how we're moving forward with that seniors' strategy.

Chair: Joey, can you have any elaboration on that?

Clerk Assistant: Yeah. What I got from him was that he wasn't ready, he didn't give a specific reason, but that he wasn't ready to present. It wasn't because – maybe it is because he was new. I didn't push it any further than that, but I can follow-up.

Chair: Yeah, perhaps, that's what we'll ask.

Mr. MacEwen: Would it be agreeable to, you know, I think our point was – when the report is all done, the minister is going to talk about it and say. We had a lot of questions about the process; how we're going to get to it, how they're figuring out the number, and to try to make that a bit more public.

Would it be okay to go back and say: You know, we're looking for an update mid-process, especially before the House is what I'm looking, really looking for.

Chair: Sure, we'll have Joey, the clerk do that for us.

Mr. MacEwen: Sure.

Chair: Darlene Compton.

Ms. Compton: I believe that he was hired specifically for that seniors' strategy, so it would be part and parcel. He's been around now for a little while.

Chair: Okay, so we'll –

Ms. Compton: So, he should –

Chair: – ask. Yeah. We'll ask –

Ms. Compton: Yeah, he should have an idea.

Chair: – the clerk and he said he'll contact him again. And give him a little bit more of a, if we can get where he's at in the process, an update on that part, thank you.

Any other new business?

We're going to go back to our workplan again just for one moment and discuss the next meeting. Now, we have, as the clerk has stated, nothing tentatively booked. However, the only one that could be next on the list, at this time, would be the Rotary Club of Montague, who seem to be open to almost any date.

The only date, the next date available would be the 27th of March. Is everyone in favour of having the clerk ask the Rotary Club of Montague to come that day to present?

Mr. R. Brown: (Indistinct) the House.

Chair: Any discussion on that?

Ms. Casey: Mr. Chair.

Chair: Kathleen.

Ms. Casey: Can you explain to me, again, what we're bringing the Rotary Club of Montague in to discuss again?

Clerk Assistant: Oh, sorry.

Chair: Yeah, Sidney MacEwen, since it was your request.

Mr. MacEwen: Yeah. Last time I had brought the request forward and it was approved. Basically, the Rotary Club provides a lot of donations, a lot of in-kind services in Eastern PEI. They want to talk about the social fabric, about the health care services. They want to talk about what they've seen because they donate to so many service clubs, and so many things in need, they feel, I think is what I got from them is that they want to give the sense of – to talk about the money that they're giving to spots, but then also the feedback they're getting from them spots and probably some of the trends that they're looking at, especially with social assistance from the health care provided, all that kind of stuff down east is –

Chair: Okay, yeah. And was there, there was a motion and it was –

Ms. Casey: (Indistinct)

Chair: Okay, perfect, yeah.

Okay, so what we will do is, Joey, I'll have you contact them to see if they're available for that date. We'll pass the date around to the members for availability, and we'll see at that time if we're all able to have that meeting at that time.

With that said, no other new business?

Sidney MacEwen.

Mr. MacEwen: Just wondering about that. Can we also allow, just in case that funding bed allocation, if there was a misunderstanding with the Doctor Corman –

Chair: Yeah.

Mr. MacEwen: – maybe he can come in as well kind of thing, but I don't want to –

Chair: I'm not –

Mr. MacEwen: – wait two meetings ahead, kind of thing for that one.

Chair: We've been trying to hold – in the past, we've held two briefings or presenters in one day, and it seems to be we're running two hours with one presenter. So we've decided as opposed to having them sitting in here, because I mean, their time is valuable, and then ask them to come back another time, we're just doing one at a time, just out of consideration.

Mr. MacEwen: Yeah.

Chair: So maybe what you might be asking, Sidney, is, if we can have – correct me if I'm wrong – the funding bed allocations, if they're available on the 27th, have them come in before the rotary of Montague, or –

Mr. MacEwen: I just – just don't let it go off the list. Like if the rotary can't come that day and the funding bit and he says he can come, sure, no problem, like (Indistinct) –

Chair: Okay, so what I'm asking, though, is you're saying the rotary would be a priority?

Mr. MacEwen: Well, that was my request so I'm kind of biased to it, but I think the funding bed allocation group came first, so they probably should present first, you know because that –

Chair: Okay.

Mr. MacEwen: – I forget if that was me or not that put that one forward. It probably was.

Chair: So how about we do this? We find out who's available for that date –

Mr. MacEwen: Yeah.

Chair: – and then we'll circulate it, and we'll take it from there.

Mr. MacEwen: Thank you.

Chair: Okay?

Mr. MacEwen: Perfect.

Chair: Any other new business?

No new business?

Ms. Casey: Motion for adjournment.

Chair: Thank you, Kathleen, and meeting adjourned.

Thank you.

The Committee adjourned