PRESENTATION TO THE
HOUSE OF COMMONS STANDING COMMITTEE ON HEALTH

DELIVERED BY MR. JOHN WRIGHT
DEPUTY MINISTER, SASKATCHEWAN HEALTH AND
CO-CHAIR, CONFERENCE OF F/P/T DEPUTY MINISTERS OF HEALTH
WEDNESDAY, APRIL 25, 2007, 3:30 P.M.

Thank you Mister Chair.

On behalf of the Conference of Deputy Ministers of Health, I am very happy to be here to speak with you about the Canadian Agency for Drugs and Technologies in Health, CADTH, as it is known, and its Common Drug Review program.

I am John Wright, Deputy Minister, Saskatchewan Health and Co-Chair of the Conference of Deputy Ministers of Health, the CDM. I am joined today by Dr. Ed Hunt, Assistant Deputy Minister, Department of Health and Community Services, Government of Newfoundland and Labrador and Chair of the CADTH Board of Directors. Dr. Hunt is here as the designate for Mr. John Abbott, Deputy Minister of Health and Community Services, Government of Newfoundland and Labrador and Liaison Deputy Minister for CADTH.

We are very pleased to be here today to outline for you the governance and accountability structure of CADTH and the Common Drug Review, as we are aware that this is an issue that has been raised with you in earlier hearings. We want to assure you that CADTH, which is owned and governed by the Conference of Deputy Ministers of Health is fully accountable to the CDM. In fact, in our opinion, CADTH is one of the most accountable national agencies existing in Canada today.

By being here today, I also want to ensure that you have an understanding of the important role played by CADTH in Canada’s health care system and to provide you with the opportunity to ask questions of either myself or Dr. Hunt relating to CADTH’s governance and accountability.

I want to begin with a few words about the mandate of CADTH.

CADTH is a national body that provides Canada’s federal, provincial and territorial health care decision makers with credible, impartial advice and evidence-based information about the effectiveness and efficiency of drugs and other health technologies.

Unlike regulators (like Health Canada) who determine which technologies can be marketed in Canada, CADTH supports decision-makers in their determination of which technologies should be used to achieve the best outcomes for patients’ health and which contribute to the sustainability of our health care systems.
CADTH’s mandate is to facilitate the appropriate and effective utilization of health technologies, from introduction into the health system, through their optimal utilization, and to their replacement or obsolescence, within health care systems across Canada.

CADTH delivers this mandate through three core programs:

- The Health Technology Assessment program which conducts impartial, evidence-based reviews of the clinical effectiveness, cost-effectiveness and broader impact of drugs, health technologies, devices and health systems.
- The Common Drug Review, which as you are aware, undertakes rigorous clinical and economic reviews of new drugs and provides evidence-based formulary listing recommendations to publicly funded drug plans.
- CADTH’s newest program, the Canadian Optimal Medication and Prescribing Utilization Service (COMPUS) which provides evidence-based advice regarding optimal drug utilisation.

Through the products and services delivered by these three programs, and the direct support the agency provides within jurisdictions for the uptake and utilization of its work, CADTH is making a crucial contribution to the effectiveness and efficiency of Canada’s health care system.

I’ll now turn to governance and accountability. We have handed out to you today a slide which depicts the CADTH governance structure. I will now give some context to this and explain what this slide means.

CADTH was conceived (then as CCOHTA) by Canada’s federal, provincial and territorial ministers of health in 1989. It is legally incorporated as an independent, not for profit corporation. The owners of a not for profit corporation are called Members - CADTH’s Members are the Deputy Ministers of Health of each participating province and territory in Canada and the federal Deputy Minister of Health (all governments participate except Quebec).

By definition then, CADTH is owned by the Conference of Deputy Ministers of Health and each member has an equal vote in overseeing the affairs of the corporation.

The Corporation is governed by a Board of Directors which consists of Directors who are each appointed by a Member Deputy Minister of Health. The Directors are accountable to the CDM for the effective management of CADTH.

The Conference of Deputy Ministers’ oversight of CADTH is carried out at its regular meetings, as well as at CADTH’s annual general meeting where it conducts its requisite business including: receiving the report of the Board of Directors, receiving the financial statements and report of the Auditor, appointing the Auditor for the next year and conducting other business as required.
The Conference of Deputy Ministers must approve all changes to the agency, for example, mandate, amendments to the organization’s by-laws and approving changes to the CADTH’s budget.

On the topic of jurisdictional funding; I understand representatives from the pharmaceutical industry in their presentation to you last week accused CADTH (and I am paraphrasing) of “usurping” the powers of this committee by unilaterally announcing the expansion of the CDR. Let me set the record straight since we are perplexed by this interpretation.

A staged expansion of the CDR was one of the highlights in the National Pharmaceutical Strategy Progress Report released on September 21, 2006. In that report, a staged expansion of the Common Drug Review was a key recommendation made by the Federal/Provincial/Territorial Ministerial Task Force comprising Canada’s First Ministers of Health, and co-chaired by the Honourable Tony Clement.

In February 2007, at the request of the CDM and based upon this recommendation from the National Pharmaceutical Strategy, the expansion of the CDR to include new indications for old drugs was approved. Funding agreements to expand the program commencing April, 2007 were recently finalized, hence the announcement from CADTH to its stakeholders. We felt it was important for you to be aware of this information.

CADTH has a Liaison Deputy Minister who is appointed by virtue of which jurisdiction the Chair of the CADTH Board comes from. The Board of Directors meets a minimum of three times a year and the Board Chair reports to the CADTH Liaison Deputy Minister after each of these meetings.

The role of the CADTH Board of Directors is to:

- Govern the affairs of CADTH
- Provide strategic direction and counsel
- Ensure the necessary resources are in place to meet CADTH’s mandate, and
- Provide oversight to financial management, risk identification and evaluation.

Through the governance structure I have just described, it is clear that CADTH is accountable to the Canadian governments that established it. And their continued support demonstrates their confidence in CADTH’s ability to deliver on its mandate and meet the needs of Canada’s health care decision-makers.

The final area I wish to speak about is expenditures and funding, specifically related to the CDR program which you are studying.

CDR was established in 2003 with a budget of $2.0M per year. The volume of work CDR performs is determined by the number of drugs that are submitted to it by industry and by the participating drug plans. Its expenditures grew on the basis of the volume of work related to these submissions to $3.4M for the last two years.
As I referred to earlier, the CDM requested an expansion of the CDR to include new indications for old drugs, and to implement further transparency initiatives. Accordingly, CADTH’s annual budget for CDR is now $5.1M.

The funding formula for the CDR program is 70% provincial/territorial and 30% federal contributions.

The Conference of Deputy Ministers of Health is very pleased with the progress made by the CDR over the last three years. The consolidation of the 18 separate drug plan processes into one process has reduced duplication of clinical and economic reviews; improved the quality and consistency of reviews and recommendations; and contributed to improved standardization of drug coverage across the country. In doing so, the CDR has met the objectives set out by the CDM.

The CDR program is not only working, it is working well. Yes, there are challenges and no doubt you will hear about those challenges in just a few moments from Dr. Sanders. However, CADTH has shown us that they have evolved and will continue to evolve to meet these challenges.

Thank you, Mr. Chair for permitting me to speak to your Committee today. I welcome your questions at the appropriate time.