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CANADA. PARLIAMENT. HOUSE OF COMMONS. SPECIAL COMMITTEE ON DRUG COSTS AND PRICES. 1966/67.

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HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 14

TUESDAY, NOVEMBER 1, 1966

WITNESSES:

Representing Charles E. Frosst & Co.: Mr. James E. Frosst, President; Dr. R. S. Stuart, Director of Research; Mr. A. F. Coffin, Vice-President—Sales; Dr. J. R. Ibberson, Executive Medical Director; Mr. J. M. Blanch, Vice-President—Finance, all of Montreal.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1966

25073—1

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. Noble,
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—(24).

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

MINUTES OF PROCEEDINGS

TUESDAY, November 1, 1966.
(22)

The Special Committee on Drug Costs and Prices met this day at 9.45 a.m. The Chairman, Mr. Harry C. Harley, presided.

Members present: Messrs. Brand, Goyer, Harley, Howe (*Hamilton South*), Isabelle, Johnston, Mackasey, MacLean (*Queens*), O'Keefe, Tardif (10).

In attendance: Representing Charles E. Frosst & Co.: Mr. James E. Frosst, President; Dr. R. S. Stuart, Director of Research; Mr. A. F. Coffin, Vice President—Sales; Dr. J. R. Ibberson, Executive Medical Director; Mr. J. M. Blanch, Vice President—Finance, all of Montreal.

Also in attendance: Mr. A. M. Laidlaw, Q.C. of Ottawa, Legal Counsel for the Committee.

The Chairman read into the record a letter from Mr. Lawrence Wilson of Montreal, who appeared before the Committee on October 13, to correct an impression that might be gathered from the evidence given on page 571, with reference to the drug MER-29.

The Committee proceeded to the consideration of the submission made by Charles E. Frosst & Co.

The Chairman introduced Mr. James E. Frosst who introduced the members of his company and read a prepared statement.

Mr. Frosst was examined on the brief. He was assisted by Dr. Stuart, Mr. Coffin, Dr. Ibberson and Mr. Blanch.

With reference to a question asked by Mr. Howe (*Hamilton South*), about different selling prices of drugs being exported to other countries, this information being unavailable, Mr. Frosst agreed to supply it in writing in the near future.

Agreed,—That the submission by Charles E. Frosst & Co. be printed as an appendix to this day's proceedings. (*See Appendix "A"*)

Mr. Frosst was further examined.

Mr. Laidlaw also asked questions, more specifically, on patents.

The Chairman thanked Charles E. Frosst & Co. for their submission and the officials of the Company for the information supplied to the Members.

At 11.55 a.m. the Committee adjourned to 9.30 a.m. Thursday, November 3.

Gabrielle Savard,
Clerk of the Committee.

25073—1½

EVIDENCE

(Recorded by Electronic Apparatus)

TUESDAY, November 1, 1966.

The CHAIRMAN: Gentlemen, we will proceed with this morning's meeting.

First of all, I have a letter from Mr. Wilson, who appeared before the committee, to correct an impression that might be gathered from his evidence. On reading the evidence over I agree with him that an incorrect assumption could be made. I think, in all fairness, we should read his letter into the record.

"Dear Dr. Harley:

May I be permitted, in an issue of the proceedings, to correct an impression that can be gathered from my words as they appear on page 571 of the proceedings of the Special Committee on Drug Costs and Prices.

From my reference to Canadian Government communications, including communications of the Department of Health and Welfare, it can very well appear that these communications referred to the product MER-29.

This is a mistake. The product was not mentioned in any Government communication. It was withdrawn by the Company on its own initiative.

Yours very truly,
(sgd.) "Lawrence Wilson"

This morning we have with us the representatives of the Charles E. Frosst and Company from Montreal. I will call on Mr. James Frosst to introduce the delegation and make an opening statement.

Mr. JAMES E. FROSST (*President, Charles E. Frosst & Co.*): I would like to introduce members of our company who are here with me today and who will be only too pleased to answer questions in more specialized areas which may be raised.

Dr. R. S. Stuart is our Director of Research. Dr. Stuart, who attended the University of New Brunswick and received his advanced degrees from the University of Toronto, is a specialist in organic chemistry. He has had wide experience in research and development both with the National Research Council and in the pharmaceutical and allied industries.

Mr. A. F. Coffin, our Vice President—Sales, is a graduate pharmacist from the University of Alberta who, for a number of years, owned and operated a pharmacy in Medicine Hat. A member of our Board of Directors, he has been with the company for 20 years.

Dr. J. R. Ibberson is our Executive Medical Director. Dr. Ibberson took his pre-medical training at the University of Saskatchewan and graduated in medicine from Queens University, Kingston. Until recently he was a busy general practitioner and has been President of the Council of the College of Physicians & Surgeons of Alberta.

Mr. J. M. Blanch, Vice President—Finance, also a member of our Board of Directors, is a Chartered Accountant who graduated from the University of Toronto. He has been with the company 22 years.

I appreciate that, after many days of deliberation and questioning, members of the Committee are well aware of the structure of the pharmaceutical manufacturing industry and the way in which it does business. As an introduction to our discussions today, I would, however, like to make one or two comments to pin-point certain aspects of the brief.

We, at Frosst, believe that competition in the pharmaceutical industry results in drug prices that are both fair and reasonable. In terms of the real cost of drugs—the work hours needed to buy a certain product—Canadian prices are the second lowest in the world. However, we do appreciate the position of indigent Canadians who may have to face long periods of medication, the total cost of which is high in relation to their incomes. We believe those people are entitled to receive life-giving medication at prices they can afford—just as they should receive food and the other necessities of life. We recognize there will be difficulties in evolving a system to help indigent people but, as we have said in our brief, we are willing to co-operate with your Committee and the Government in helping to solve those problems.

Members of the Committee have raised questions about the relationship of internationally-based pharmaceutical manufacturers and their Canadian operations. As a company which became part of an international group last year, I can say from experience that our relationship with Merck and Co., Inc. has, in fact, helped to strengthen our Canadian operation and has given us the added advantage of the availability of a tremendous research organization.

Charles E. Frosst & Co. was lost to Canadian ownership for two reasons. My grandfather founded the company just before the beginning of the century. Control passed to the second generation of the Frosst family, who for many years were responsible for administration of the company and held the majority of the shares. They realized, two or three years ago, that they faced two major problems.

Frosst, as a company, has always been research-oriented. But it became apparent that we would need much more effort, and hence either more money or resources, than we could generate as a company in order to assure continued growth. Secondly, the major shareholders faced the possibility, due to estate taxes, of having to sell the company at a time that might be inopportune both to the family and other shareholders.

A number of offers were made for the company, although no firm offers came from Canadian sources. We finally chose Merck & Co. Inc. because it was a major research-oriented international company that offered Frosst the right climate for future development. Since then we have expanded, making available

more jobs of a technical nature to Canadians. We are also planning to move into new export fields.

I think your Committee will be interested to know that I have recently recommended to our parent company, Merck, that in the next five years we spend in excess of ten million dollars in new production, office and research facilities in Canada. This is considerably more money than Frosst, by itself, could have invested.

As I have said, Frosst has always placed emphasis on research—not just clinical and product research but on fundamental research. During this coming year we are planning to increase our research operating budget by 20 per cent to a total of over a million dollars. Of this total some 71 per cent will be spent on fundamental research in the areas of the cardiovaseular and nervous systems and basic chemistry and biology. This, I believe, will be an investment on fundamental research which is among the highest, if not the highest, in Canada.

This brings me to the all-important question of patents. Suggestions have been made by some Committee members that in return for improved patent protection in Canada, there should be more research by Canadian-based companies. Certainly, Frosst would like to see the patent laws strengthened and, if they were, I know that given a continuingly favourable economic climate we would expand our research budget even further.

I also appreciate that the main object of this Committee is to look at the prices of drugs from the point of view of the consumer. One way of reducing prices is by removal of the Federal Sales Tax. If this happens, the full extent of the tax which we collect will immediately be removed from all our products that are affected.

We will be very pleased to go through the brief and answer any questions that you may have. If we do not have detailed answers immediately available, we will certainly supply them to the Committee as soon as possible.

Thank you, gentlemen.

The CHAIRMAN: Thank you, Mr. Frosst. The meeting is open for questioning.

Mr. ISABELLE: Mr. Frosst you mentioned in your brief on page 4 what you paid in wages in 1965 compared to what you paid in wages in 1946. You said that the purchases of goods and services increased from $2 million in 1946 to $4 million but there is no mention of the profit in 1965 compared to the profit in 1946.

Mr. FROSST: I do not know if Mr. Blanch has figures showing the profit we made in 1946; that may have been a lean year. I know we had a few back in those times. But percentagewise rather than dollars, I do not believe we have ever had a year where we were over 8 per cent. Is that correct?

Mr. J. M. BLANCH (*Vice President—Finance, Charles E. Frosst & Co*): Unfortunately I do not have the figures back to 1946.

Mr. FROSST: We will supply them.

Mr. BLANCH: The earliest figures that I have here go back to 1956.

Mr. ISABELLE: If you had lean years it may be interesting to know that. You said that your purchases outside of Canada were principally for chemicals which

were unavailable in this country. If I understand correctly, you have been purchased by an American firm.

Mr. FROSST: Merck and Company, yes. Merck and Co. Inc. is the parent company.

Mr. ISABELLE: Do you think that the same policy will continue, or do you intend to change it?

Mr. FROSST: Merck is a chemical manufacturer but right at the moment we are buying just as we have in the past with the exception of one chemical, protriptylline, which we buy from them—but they are the only ones that make it, so we have no choice.

Mr. ISABELLE: You said that you have nine Ph.D's working in the company. I do not know what a Ph.D. could do in a company. Is it to write the script or write the formula or to write memoirs?

Mr. FROSST: No. I will ask Dr. Stuart, our Director of Research, to answer that one.

Mr. R. S. STUART (*Director of Research*): These are the people who do our day to day fundamental research in chemistry, biology and pharmacology.

Mr. ISABELLE: Does that Ph.D. mean a Doctor of Philosophy?

Mr. STUART: Doctor of Philosophy, yes.

Mr. O'KEEFE: Mr. Frosst, do you think the cost of drugs in Canada is too high now?

Mr. FROSST: I think, as I stated before, that drug prices are reasonable in Canada for the majority of Canadians. I used the word "indigent" here, and that may be the wrong term. There may be a segment of the population with an income of, say, "x" thousand dollars a year who fall into that category and for them, just as anything else, they are too expensive.

Mr. O'KEEFE: But only for those?

Mr. FROSST: Yes. Certainly, in comparison—of course, I am using comparisons again—we do come out, in terms of hours that people have to work to buy their drugs in Canada, the second lowest in the world.

Mr. O'KEEFE: On page 12, Mr. Frosst, I note that Frosst sells some of its products to hospitals at a lower price than that charged to pharmacists. How much lower?

Mr. FROSST: I will just answer briefly and then I will let my specialist, Mr. Coffin, get into the act. They vary. There is not a set differential between the price we charge the pharmacist and what we sell to a hospital because these are promotional prices. I will ask Mr. Coffin if he would like to elaborate on that.

Mr. A. F. COFFIN (*Vice President—Sales, Charles E. Frosst & Co*): As Mr. Frosst said, the reason we sell to hospitals at a lower price than we do to pharmacists is purely for promotional reasons. We have found over the years that this is one of the most valuable methods of promoting our products and the most reasonable. It is the one that gives us the most mileage for our dollar of any of the limited number of promotional methods that are available to us. If we have our products used in a hospital, the interns and the residents and the staff doctors get to know what they are and they tend to prescribe them outside.

We have certain products that we feel lend themselves to this type of promotion and the price is entirely dependent on what we have to sell them for to get them into the hospitals, and may bear no relationship to cost at all.

Mr. O'KEEFE: I do not quite understand that. You said it bears no relationship to costs.

Mr. COFFIN: It is determined by the competition. If one of our competitors lowers the price and we feel that it is important to have it in there, we would sell it below cost, and in some cases, we do.

Mr. O'KEEFE: Are those drugs not based on tenders? Are there those that are not based on tenders?

Mr. COFFIN: Sometimes they are and sometimes they are not.

Mr. O'KEEFE: Then how do you know that a competitor is selling at a lower price?

Mr. COFFIN: Because we have probably lost one order. We see the competitor's product in the hospital and the next time we know we have to go down a little lower if we want to get back in there.

Mr. MACKASEY: What do you charge the loss to?

Mr. FROSST: It is in the cost of goods.

Mr. MACKASEY: It is in the cost of goods. What do you mean in the cost of goods? I am sorry, Mr. O'Keefe.

Mr. COFFIN: Well, we have certain built-in costs of manufacturing the product and we get so much return. It just lowers our return for the goods.

As an accounting procedure we have often thought that it would be preferable possibly to charge it to advertising but, as a matter of practice, we have not charged it to advertising and promotion.

Mr. MACKASEY: On your balance sheet it must show up somewhere. You could not do it indefinitely.

Mr. COFFIN: It shows as lowered return.

Mr. FROSST: Mr. Blanch, our Vice President of Finance will explain that.

Mr. BLANCH: It is part of our cost for sales. In other words, the product sold to the hospitals is included in our sales, and the cost applicable to those sales appears in the cost of sales, so that it reduces the margin that is available to us.

Mr. MACKASEY: Advertising and marketing are part of the cost of sales.

Mr. BLANCH: That is right.

Mr. MACKASEY: You must be more specific when you make your balance sheet.

Mr. BLANCH: I beg your pardon; it is charged to manufacturing costs, just the same way as any other sale which is made to any other outlet. The sale and the cost of sales.

Mr. MACKASEY: Not that I am a stickler for detail, but you cannot very well charge it to manufacturing costs or you would get a distorted value of what the drug cost you when you are basing your price. You mark-up, I presume, on

manufacturing costs. I understand that what you are saying is that because you sell into the hospitals at a loss, if necessary, and because you are then charging this loss to manufacturing costs, you are spreading the hospital subsidy to the general public. The man who goes to the drug store on the corner is paying, indirectly, for the subsidy of the product you are selling to the hospitals at a loss.

Mr. FROSST: Oh, definitely, sure, naturally.

Mr. MACKASEY: I would like to get that clear. In other words, the man who goes into the drug store to buy your Frosst products, one single prescription, is absorbing indirectly a promotion of the loss-leader—if you want to call it that —to the hospitals?

Mr. FROSST: As of today, if we went out and decided to sell at even lower prices to hospitals to meet competition, we are not going to raise our prices to the drug store. So it is difficult to say. He is paying for it. But if we decide we will make less profit this year and sell to hospitals at lower prices because eventually this is going to bring in more sales, we are not necessarily going to raise the prices to the druggists.

Mr. O'KEEFE: Nor are you necessarily going to lower them, Mr. Frosst.

Mr. FROSST: We have not raised prices over the years while we have had an economy which has been going ahead by leaps and bounds, and to be able to keep prices where they are may be just as good as a price reduction.

Mr. O'KEEFE: There are people who would disagree very strongly with you, sir.

Mr. FROSST: Yes, I am sure.

Mr. O'KEEFE: I will not pursue it any further. On page 16 of your brief is a statement that Federal sales tax for the year 1965 was $791,000. How do you think it would affect the cost of drugs to the consumer if the federal sales tax were removed? What would the savings be? Do you have any figures on that?

Mr. FROSST: We would take it off our prices immediately. Let us not get down to decimal points, but on a dollar item—

Mr. O'KEEFE: How much would the savings be on a ten dollar item?

Mr. FROSST: On a ten dollar item?

Mr. O'KEEFE: Yes, because there are very few items that sell at less than ten dollars.

Mr. FROSST: Our biggest business is with a 55 cent item. On a ten dollar item it is five per cent, or 50 cents.

Mr. O'KEEFE: Thank you.

Mr. HOWE (*Hamilton South*): Mr. Frosst, what percentage of your drugs do you sell to hospitals at this reduced rate?

Mr. FROSST: It is less than 10 per cent.

Mr. HOWE (*Hamilton South*): Even if it is less than 10 per cent, if the whole thing were averaged out at one price would this not lower the price of drugs to the consumer?

Mr. FROSST: Mr. Coffin has some figures on that. It certainly will not do very much, but I will let him answer.

Mr. A. F. COFFIN (*Vice President—Sales, Charles E. Frosst & Co.*): Dr. Howe, I think that, on the contrary, it would increase the cost of drugs because, as I mentioned before, we feel that this is one of the most economical and highest leverage methods of promoting our drugs that we have available to us, and from which we recover basically the cost of our promotion.

If we did not do this—if we raised our price to the level of the drug store—we would be right out of the hospital business. This would not necessarily cripple the company, but we would not get any hospital business. Therefore we would have to spend probably two or three times this amount of money to get the same leverage on advertising in other media, so I would suggest that it would probably raise the cost of drugs and not lower the cost. This is one of the most economical, most effective, highest-leverage promotional methods and techniques that we have available to us.

Mr. HOWE (*Hamilton South*): Then to reverse the question, if you were to lower the prices of all your drugs to the prices at which you sell them to the hospitals, where would you stand then?

Mr. COFFIN: We would be out of business.

Mr. BRAND: To pursue that just a little further, Mr. Coffin, are you aware that one drug company, (Canadian), has done exactly this? Where they used to sell at below cost to hospitals, they have quite recently raised prices to the level at which they sell to pharmacies?

Mr. FROSST: Yes, I think I know of one company, and I will not use the name. I do not believe that all products lend themselves to the type of promotion that we get out of a certain line of products, such as our analgesics, we will say, where we always want to be competitive. But I am aware of them.

We have a second consideration here—it is not our first reason for low hospital prices but it does add up. These products get into the outdoor clinics at much lower prices and this enables treatment of low income people at a much lower price.

We are working with a mix right now which appears to be ideal. If we increase the amount we sell to the hospital, if it became 20 or 30 per cent, or as was suggested we balance prices with drug store prices, then we would have to raise hospital prices. We could lower others, but marginally. The way we stand now, I would say hospital sales are about 10 per cent.

Mr. BRAND: There is something interesting at the bottom of page 15. You say, regarding the breakdown of the domestic pharmaceutical sales dollar:

> In reviewing these figures you should be aware that Frosst sells directly to pharmacists across Canada and less than six per cent of its business is done through independent drug wholesalers. Our own expenses of wholesaling are therefore included in our operating costs.

If you sold all—let us speculate for a moment—your drugs through a wholesaler, do you think this would increase the cost to the pharmacists and hence to the consumer?

Mr. FROSST: I think I am going to ask Mr. Coffin and Mr. Blanch to elaborate on this after, because I am sure over the years we have looked at direct selling versus selling through a wholesaler. I think we do a more economical job. I am not saying that they do not do an economical job, but we are out looking after ourselves when we wholesale, as against a number of others.

Mr. BRAND: What you are saying is that you can sell more cheaply to the pharmacist if you by-pass the wholesaler?

Mr. FROSST: I would like to think so.

Mr. COFFIN: Dr. Brand, this is probably true. I think you are probably reasonably aware of the type of business we are in, which is quite competitive. We are not in the same type of business as some of the other companies who have solely prescription items—which are more or less unique products—and it is possibly more economical for them to distribute through a jobber than to set up a chain of distribution centres themselves.

In our case, over the years we have found with our ethical over the counter lines, and so on, that it is necessary for us to place our own stocks in drug stores, and we have found it much better. Statistically we have analyzed this, as Mr. Frosst said, on a number of occasions, and we have found that we can do our distribution cheaper and we think, better than we could hire the wholesaler to do it for us.

Mr. BRAND: What six per cent of your business is done through the independent drug wholesalers?

Mr. COFFIN: All of the independent drug wholesalers handle our product. In every city were we do not have a distribution outlet they often get emergency calls for emergency prescription products which they do not have and it is a little quicker to get them from the wholesale, even though they pay a little higher price for them than they do from us. So there is always a certain amount that goes through the wholesale house.

Mr. HOWE (*Hamilton South*): Do they sell it at the same price?

Mr. COFFIN: No, they do not.

Mr. BRAND: I think that answers the question alright, but I get the impression you are trying to get some of the others off the hook there when you say, on account of your across the counter items, you felt it was better to sell direct. In actual fact, you sell your prescription items direct as well.

Mr. COFFIN: Oh, yes, we sell our prescription items as well but, Dr. Brand, we have outlets in Vancouver, Calgary, Winnipeg, Toronto and Montreal, and you have to be a company with a pretty sizeable volume for it to be economical for this type of set up. If you are a smaller company it just would not be economical.

Mr. BRAND: How many companies do you think have the same sort of volume that you have in Canada today?

Mr. COFFIN: There is one slightly larger, who also distributes the same as we do, and there are a couple slightly smaller. One of them distributes the same way as we do. From then on they scale down. According to surveys we are the second largest in Canada.

Mr. HOWE (*Hamilton South*): How much higher does the druggist sell an item that he has bought from the wholesaler than one he has bought from you?

Mr. COFFIN: I doubt if he sells it any higher.

Mr. HOWE (*Hamilton South*): That was my question a moment ago, does he sell it higher, and you said, yes.

Mr. COFFIN: I am sorry, I misunderstood you. I thought you meant, does the wholesaler sell it higher. I doubt if the druggist does because, in general, the products he is buying are prescription products. They may be for a repeat on which he has set the price the first time round and he is not able to sell them any higher. Most druggists use our pricing set up as the basis for their pricing.

Mr. HOWE (*Hamilton South*): Well then, logically, you must sell your items to the wholesaler at a lesser price than you sell to the druggist.

Mr. COFFIN: Slightly less on prescription items. Not so on over the counter sales. To be specific, 5 per cent less to the wholesaler.

Mr. BRAND: I hear you have been involved in prepackaging or at least in some sections of it. I understand your company does some prepackaging; in other words, what you make up at the factory is the same package that is used in selling to the consumer—such as the 60 c.c. package of Trulfacillin, or something like that.

Mr. FROSST: Yes, that would sometimes be so in tablet packaging. You produce what you think would be the most popular prescription size.

Mr. BRAND: I am thinking of the liquids particularly.

Mr. FROSST: Definitely.

Mr. BRAND: You sell in bulk as well.

Mr. COFFIN: Yes.

Mr. BRAND: Now which is cheaper from your viewpoint. There was quite a discussion on this the other day and since you do both perhaps you could give us the benefit of your experience in selling both ways.

Mr. COFFIN: Well, we were able to sell per c.c. somewhat cheaper in the bulk packaging. Our bulk packages are pounds, for instance, of Trulfacillin, which you mentioned as a product, and this sells at somewhat less per c.c. than do the 60 c.c. or the 100 c.c. bottles. However, by the time the druggist packages it and puts it in his bottle, it may not turn out to be very much different; possibly it is slightly cheaper. We did a lot of soul searching regarding that particular product as to whether or not we would put it in a bulk bottle because of stability. We had to be satisfied and do a lot of stability testing to be sure that it would stay stable sufficiently long on the druggist's shelf to warrant putting it in a bulk bottle.

Mr. BRAND: So those who are not in on the know as to how these are packaged, as you say, by the druggist, would you agree that by this you mean pouring from a large bottle into a smaller one and putting a label on it.

Mr. COFFIN: Yes.

Mr. BRAND: Yes, thank you. Do you think the reasonable way to do business then is to use, say, your 60 c.c. or 100 c.c. bottles—certainly that is the way most of them are sold nowadays.

Mr. COFFIN: Yes, I think it is because we do not honestly feel, except in a dispensary that has a pretty fair turn-over, they ought to have bulk bottles of some of those products because of the short stability. We try to encourage the sale of the smaller bottle for safety reasons rather than economy.

Mr. BRAND: Do you suggest to the pharmacists the price they should charge?

Mr. COFFIN: We have a suggested list on all of our products, or most all of them—any that might be used in a unit we do—we do not always have a suggested price for the bulk packages. This is a suggested list; we have no way of controlling whether or not he uses it—and in most cases I do not think he does. However, we have done many surveys with pharmacists to see what their reaction would be if we dropped this and the vast majority of pharmacists have asked us to leave it on as a guide.

Mr. FROSST: Until such time as they all use a cost plus method there will be a need for us to carry a suggested list, but after that it will not be necessary.

Mr. BRAND: What do you suppose a cost plus method of pricing would do to the cost of your 55 cent item?

Mr. COFFIN: Well I am thinking of 222's and I question whether or not that one would be prescribed.

Mr. BRAND: 292's then. If you go on a cost plus, where you take the wholesale cost plus a percentage—

Mr. FROSST: Our cost to them plus, yes.

Mr. BRAND: —do you think this would increase the cost of a dozen 292's?

Mr. FROSST: I do not know what dispensing fee they are going to settle on as adequate to cover their professional charges, so I cannot answer that.

Mr. BRAND: Well let us say then, for example, that the dispensary fee is $2. What would be the approximate wholesale cost of twelve 292's?

Mr. FROSST: I do not think that anybody at present is getting, say, $2.25 for a dozen 292's.

Mr. BRAND: That was one of the suggested ones in the brief from the druggists, and that is the only reason I mention it.

Mr. COFFIN: This cost plus for products that are of a low range will tend to increase the prescription price of cheaper products and reduce the price of higher priced ones. Now whether this is desirable or not is really not in our field.

Mr. BRAND: I think it is in your field to say whether you sell mostly drugs which are in the low cost field or in the high cost field.

Mr. FROSST: In the low cost field. Our average return per package is less than a dollar.

Mr. BRAND: Thank you very much.

Mr. HOWE (*Hamilton South*): There are some drug stores that have taken the obvious dividing line of $5 on items over $5 sold on a cost plus $2 per prescription basis and left the drugs below that at their present price and have managed to succeed in doing this, which has simply lowered the price of the higher priced drugs and left the others where they are.

Mr. COFFIN: I do not know how the pharmacist makes out on that but it certainly would appear to be more equitable, if they can.

Mr. HOWE (*Hamilton South*): There are two or three drug stores in Hamilton that have successfully done this for at least four years now that I know of and they are still in business. One of the stores of which I speak is strictly a prescription store. They do nothing but dispense prescriptions; they have no across the counter items at all and none of the various home commodities—they simply dispense prescriptions.

Mr. FROSST: I would expect that they do a fairly large volume.

Mr. HOWE (*Hamilton South*): The volume obviously has built up and they are managing to survive at this rate.

Mr. BRAND: I wonder if we could give the committee some idea of the suggested retail price for, say, two of your most commonly used products—and I will mention Trulfacillin again because it is most certainly one of your high volume items, and certainly 292's.

Mr. COFFIN: The 60 c.c. size of the 3-200 strength of Trulfacillin is $1.90 and that is the biggest one we have. I am afraid I neglected to bring a price list along with me and I cannot go through the list for you, but that is one that I recall.

Mr. BRAND: Would a prescription of a dozen 292's retail at the suggested retail price of about $1.25?

Mr. COFFIN: We do not have a suggested retail that would be applicable because we do not now manufacture anything smaller than a bottle of 100 in 292's.

Mr. BRAND: Well let us say that it is about $1.25.

Mr. COFFIN: I think that is probably around the average price range.

Mr. BRAND: Now the question arises, do you think those prices are too high for those two particular products?

Mr. FROSST: No I do not think they are. We are selling what we consider quality pharmaceuticals. There are a number of things that are involved in the manufacture; the formula is an A, P, C and C but that does not mean that an A, P, C and C is necessarily a 292. I do not have the formula card here but we want to make sure that these disintegrate at a certain time; that they have a certain amount of stability; that there is no odour or at least a minimum of odour of A.S.A.; that they do not mottle—there are a number of things involved. We would like to think we sell quality pharmaceuticals at reasonable prices.

Mr. O'KEEFE: What percentage of the cost is in your suggested mark-up to the drugs.

Mr. COFFIN: If I understand you correctly, we sell to the druggist at our suggested list less 40 per cent. In certain cases, where large quantities are involved, there may be an additional small discount, but the basic rate is our suggested list, less 40 per cent. Does that answer your question. I am not sure I understood it.

Mr. O'KEEFE: That is just exactly what I wanted to know.

Mr. HOWE (*Hamilton South*): Mr. Chairman, may I ask a question. Mr. Frosst, do you export any drugs from Canada?

Mr. FROSST: Yes we do.

Mr. HOWE (*Hamilton South*): Which of your export drugs would you say was your largest one, just so we might pick one.

Mr. FROSST: Now I want to define export; that is where we actually export from Canada as against manufacturing in other countries then.

Mr. HOWE (*Hamilton South*): Yes.

Mr. FROSST: At the moment it is pretty well the West Indies for pharmaceuticals and it is the United States and Europe for some chemicals that we manufacture.

Mr. HOWE (*Hamilton South*): Could you name one just for the sake of giving me one.

Mr. FROSST: I would say Falapen is the biggest one, in the West Indies, at the moment.

The CHAIRMAN: And this is a brand of penicillin?

Mr. FROSST: Yes, long acting penicillin.

Mr. HOWE (*Hamilton South*): Is it correct that Falapen is exported by you to different companies in the form of a fully manufactured bottled item ready for sale?

Mr. FROSST: Yes. I believe we are still finishing that in Canada; certain products are being manufactured in the West Indies now but I do not think Falapen is yet.

Mr. BLANCH: Falapen is shipped in finished form and to the West Indies and other markets it is shipped in bulk.

Mr. HOWE (*Hamilton South*): What I am trying to establish here is the base line price as Falapen leaves your company to be consumed in Canada and to be sold in other countries. Can you give me the price as it leaves your factory to various countries as compared to the price when it leaves your factory and is sold in Canada?

Mr. FROSST: I have not that price but I can get it for you. We were looking at Falapen and I believe that it is sold at a higher price in the Middle East than it is in Canada.

Mr. HOWE (*Hamilton South*): You missed my question. I want to know the price at which it leaves your factory. I will ask a more general question. When Falapen leaves your factory does it leave at exactly the same price to every country, as it does to Canada?

Mr. FROSST: I cannot answer that one. I can get it for you though.

Mr. HOWE (*Hamilton South*): When would you be able to get it for me. This is your only day here. Is this going to be available to us.

Mr. FROSST: Oh yes, we will make this available to you.

Mr. HOWE (*Hamilton South*): I do not mind if it is Falapen or something else. I will let you pick the drug because you export them in a fully manufactured form and it has to leave your factory at a certain price. The price I am interested in is what it leaves your factory at to be sold in Canada, to be sold in the United States, to be sold in Italy, to be sold in other Eurepean countries, the West Indies, England or wherever it is sold—specifically the price that goes to each country.

Mr. COFFIN: Dr. Howe, you must bear in mind, on these prices, that the price we sell at in Canada includes all of our promotional expenses, distribution expenses and so on, whereas when we send it in bulk to these other countries somebody else is paying all of those costs. So, we would have to do a little—

Mr. FROSST: There will be a reason if there are variations in prices.

Mr. HOWE (*Hamilton South*): You mean you are charging all the promotional costs to the Canadian drug market and not charging any of it to other markets?

Mr. FROSST: No, I do not think this is what Mr. Coffin means. In the Philippines, for instance, we sell in bulk to another company, and we have no relationship to this other company except they pay us a royalty to sell Falapen. The royalty is built into the price. We have whatever our manufacturing cost is plus the royalty and that is what we sell them at. They in turn are promoting in the Philippines, and spending their money. It is just as if we were a custom manufacturer in this particular case and being paid a royalty for making the product. The markets are different and this is another thing that is not even comparable. We get our manufacturing cost back plus a royalty, which we think is fair.

Mr. HOWE (*Hamilton South*): But, leaving Canada out of it there are variations even between countries that they are sold to.

Mr. FROSST: Yes, I would say they sell Falapen competitively with other products in the Caribbean and competitively with other products in the Middle East and the market situation might be entirely different.

Mr. HOWE (*Hamilton South*): So your marketing costs or manufacturing costs should not vary whether you send it to the Philippines or sent it to Italy.

Mr. FROSST: No; that is correct.

Mr. HOWE (*Hamilton South*): But there is a difference in those prices as the products leave your factory?

Mr. FROSST: Well, if we are selling it to another company, which is the particular case in the Philippines, we are getting paid a royalty. When we sell it in the bottles of 100 or whatever it is out of Montreal to such and such a drug store in the West Indies they have a list price less discount, the same as we have in Canada.

Mr. HOWE (*Hamilton South*): But you will be able to provide us with these figures for the different selling prices from your factory to the various countries that you export to?

Mr. FROSST: Yes.

Mr. HOWE (*Hamilton South*): I have one other question that is not related to that in any way. I was late coming in and I do not know if it was brought up that the Hall Commission report recommended that promotional costs should remain within 15 per cent. If other drug companies were to agree to do this could you go along with them and lower your promotional costs to 15 per cent?

Mr. FROSST: If this was a directive.

Mr. HOWE (*Hamilton South*): No, not if it was a directive; if it were voluntary?

Mr. FROSST: If it was voluntary and the whole industry was doing it, yes.

Mr. HOWE (*Hamilton South*): You could do it?

Mr. FROSST: If it was voluntary—you used the word "voluntary"—and they all agreed to it, we would certainly agree.

Mr. HOWE (*Hamilton South*): The other companies told us they could not do it.

Mr. FROSST: I am making the supposition that the other 99.9 per cent do it.

Mr. HOWE (*Hamilton South*): So am I, and that is my point. This is the question I have asked other companies and they said no, they could not operate at 15 per cent, that they had to have a rate which was up as high as 30 per cent.

Mr. FROSST: Well I am saying if we had to we would. Let me put it that way.

Mr. HOWE (*Hamilton South*): Well I did not ask that question. I said would you if the others agreed to on a voluntary basis?

Mr. FROSST: Well, I am like the others. I said if they all did it, and I was sitting there, we would probably try it, but I am not saying it would be the most economical way to sell our drugs.

Mr. HOWE (*Hamilton South*): Why would this destroy the economy of the sale price by lowering your over-all promotional cost, if everybody did it—not if you did it by yourself. I could see a rise in cost if you alone were to do it, but if everybody did it why would this increase the price of drugs?

Mr. COFFIN: Dr. Howe, I would like to say a word or two on this subject. Over the years we have done what we felt was a necessary job to promote our products in the conditions as they exist and the cost of this seems to run a little over 20 per cent for us. However, as Mr. Frosst indicated, if we were compulsorily limited—this is a little more practical situation, and I think you are just whistling by the graveyard if you think you are going to get everybody to agree to this—by law to do that, with our volume we could possibly do a fair job, of disseminating the necessary information to doctors with 15 per cent of our volume; but you have just sounded the death knell of small companies who might want to start and have not built up the type of volume we have. If you had a company doing $100,000 in volume, on 15 per cent it could hardly publish a price list.

Mr. HOWE (*Hamilton South*): In your particular instance, if your company could on a voluntary basis, if it were law, you would have to—and I was not suggesting that.

Mr. FROSST: Well, I think you would become hard pressed in the introduction of new products.

Mr. COFFIN: How do we know what the sales of new products are going to be in order to say 15 per cent?

Mr. HOWE (*Hamilton South*): Well this is an over-all 15 per cent. If you introduced a new drug you could put 20 per cent on it and cut the others down to 14 per cent and you would still accomplish the over-all of 15 per cent. We are talking about the over-all. Your figures are an over-all price of promotional expense, not limited. I am sure you have some drugs that go higher than 20-odd per cent and some of them would go lower. Well, you still end up with 15 per cent. And if you introduce a new drug—you concentrate on drugs whether they are new or seasonal—and raise this 20 per cent at the seasonal time or when you introduce a new drug but, by the same token the others go down because they are not seasonally applicable. So this still does not prevent you going over 15 per cent on one in the same way you are doing now.

Mr. BLANCH: May I ask a simple question? You are assuming this would have no effect on the sales volume?

Mr. HOWE (*Hamilton South*): I am not assuming anything; I was asking a question. There was no assumption.

Mr. BRAND: May I ask a supplementary question. If in fact you were limited to the 15 per cent, what effect would this have on your cost to hospitals?

Mr. FROSST: I think we would find the best promotion available within the budget. We would have to look at the marketing mix and many things.

Mr. COFFIN: If we were limited to a percentage of cost for promotion and advertising we certainly would be interested in retaining this hospital leverage, which we do not charge to promotion.

Mr. BRAND: One other supplementary question which has absolutely no relationship to anything we are talking about. I am curious to know what you call 292's in Lebanon, that it all?

Mr. FROSST: They are 292's in Lebanon. There is a 222 restaurant over there, as a matter of interest. Apparently it is a place where Caesar stayed.

Mr. HOWE (*Hamilton South*): Was it named 222 at that time? I did not know you had been manufacturing that long.

Mr. FROSST: That was to let people know that he was there, was it not?

Mr. MACKASEY: Have you recovered all the research costs of a drug that existed in Caesar's time?

The CHAIRMAN: Could I ask a question for clarification? You say you export drugs to the Middle East, but do you not also have a factory in the Middle East?

Mr. FROSST: No, we do not export now, we manufacture in the Middle East.

Mr. MACLEAN (*Queens*): At the bottom of page 14 it states:

> Out to total 1965 company sales of $10,006,000, domestic human pharmaceutical sales were $8,680,220.

What is the meaning of the word "domestic" in this useage? Does this mean non-export items?

Mr. FROSST: Yes, that is correct. We export to the West Indies, and there are other chemical sales we make in the export market.

Mr. MACLEAN (*Queens*): So the difference between these two figures, roughly $1,300,000, is made up of export sales of pharmaceuticals, is it, or is there something else included?

Mr. FROSST: Pharmaceuticals and chemicals.

Mr. MACLEAN (*Queens*): And chemicals, I see. So the $8 million includes all your sales in Canada of both prescription drugs and non-prescription preparations.

Mr. FROSST: That is correct.

Mr. MACLEAN (*Queens*): What, roughly in general terms, is the relationship of the percentage of your total sales which are made up of prescription drugs and what part is non-prescription drugs?

Mr. FROSST: Perhaps Mr. Coffin could do some fast mental calculating, but I would say somewhere around 35 per cent or 30 per cent O.T.C. and the balance prescription.

The CHAIRMAN: O.T.C. means over the counter.

Mr. COFFIN: We have a litle difficulty, Mr. MacLean, in distinguishing between the two because some of our products are both prescribed and they may be sold over the counter and, indeed, are sold over the counter; 222's, for example. There are prescriptions for 222's and they also may be sold over the counter. It is a little difficult to really get down to a figure on this but I think that Mr. Frosst's figure of about one-third over the counter and two-thirds prescription is not too far off.

Mr. MACLEAN (*Queens*): I was thinking chiefly of drugs that have to be prescribed.

Mr. FROSST: That is the way I was splitting it, not whether the non-prescription drugs were prescribed or not.

Mr. COFFIN: Well, the ones that actually demand a doctor's prescription would be down to about one-third, I would say, and two-thirds could be sold over the counter.

Mr. FROSST: Two-thirds?

Mr. COFFIN: Yes. P.R. drugs and controlled and narcotics. I am not including 222's.

Mr. FROSST: I am including 222's as an O.T.C.

Mr. COFFIN: Well, we would not be more than—

Mr. FROSST: Well, we can give you the figure.

Mr. MACLEAN (*Queens*): I just wanted a rough idea. I do not have to have the actual figures. I was leading up to another question. Have you any means in your bookkeeping of determining the relative merchandising costs of the two classifications? Which comes higher?

Mr. FROSST: Let me say, first of all, the 222's are a large proportion of the O.T.C. segment and they cannot be advertised by law, so a large proportion of promotion for them has to fall on the prescription items, our only method of promotion—and this is always difficult for us to relate—is to detail our analgesic line, the 292's and the 282's, and so on, to physicians along with 222's in the hope that he will recommend 222's for somebody to take before he gets over to the house to visit them if they have a cold, and then by word of mouth. There is no other way to promote. We are not allowed to promote 222's.

Mr. MACLEAN (*Queens*): Have you any public relations studies which would give you any clue to when you reach consumer resistance on price, and is there a tendency to reach a consumer resistance sooner in the categories of drugs which are prescribed? I think, as with most commodities, the consumer has some peculiar idea that he wants to get his necessities cheaply enough so that he can splurge on the things in which he has a choice. It would seem to me that if you raised the cost of over the counter drugs by, say, 10 per cent you would probably get less consumer resistance than you would if prescription drugs went up by that amount. Is there any basis for such an assumption?

Mr. FROSST: We have not done a survey per se. We set our prices at what we think are competitive in the O.T.C. items. I would be careful about raising O.T.C. prices in certain areas without a survey.

Mr. COFFIN: About the only concrete thing I might tell you, Mr. MacLean, is that we reduced the price a couple of years ago of one of our vitamin preparations, which is a sort of combination prescription-O.T.C. product, and the sales immediately dropped off. We were trying it out to see if it would have a beneficial effect on our sales, but it did not.

Mr. MACLEAN (*Queens*): This was a non-prescription drug?

Mr. COFFIN: That is right. However, it is very widely recommended by doctors.

Mr. FROSST: I think it is very difficult to speak of this as a strictly O.T.C. item. We hoped in this particular case the physician would recommend it oftener, but vitamins are not as price sensitive as other drugs. What Mr. Coffin says is true, we took as much as 30 per cent off the price and that is what we lost in sales. We have been going down ever since. We reduced our sampling.

Mr. MACLEAN (*Queens*): Well, as a consumer of drugs, I think the average person going into a drugstore to buy something over the counter will assume that the price is what they want to pay and they will buy it. But if they go to the drugstore to have a prescription filled, and they find usually that the price is higher than they expected, whether it is or not, there is a tendency, I think, to resist the price because it is something they have been told to get. They have no choice in the matter, or little choice in the matter.

Mr. FROSST: I agree.

The CHAIRMAN: Gentlemen, before I pass to Mr. Mackasey, do you agree that we should print today's brief as part of today's proceedings?

Some hon. MEMBERS: Agreed.

Mr. MACKASEY: I think Dr. Isabelle wants to ask a short supplementary first.

Mr. ISABELLE: I have a question and perhaps a suggestion at the same time. On page 16, at the conclusion of your brief, you state:

> Also we stand willing to participate in discussions with Federal and Provincial Governments in the development of a plan for providing needy persons with the drugs they require.

Are you aware that some companies are doing it right now? Because you belong to private industry I think it would be a nice gesture on your part if you would try to contact the Pharmaceutical Manufacturers Association of Canada and make a plan and after that you could present your plan to the federal or provincial government. In a democracy this should come from you, not from us.

Mr. FROSST: I agree on this.

Mr. MACKASEY: Mr. Chairman, I think Mr. Frosst mentioned that his goods were sold to the druggist less 40 per cent. Have you ever done any spot check to see whether this is the price at which the druggist sells it or whether they ignore the recommended 40 per cent off and sell it higher than your recommended selling price?

Mr. FROSST: Are you talking about prescription items?

Mr. MACKASEY: Yes, and over the counter.

Mr. FROSST: Well, on the over the counter items our suggested list is either adhered to or it is cut.

Mr. MACKASEY: But never over?

Mr. FROSST: Never over.

Mr. MACKASEY: And on prescriptions?

Mr. FROSST: As there are various methods for pricing prescriptions and every province is not the same, I could not say.

Mr. MACKASEY: Why I asked, Mr. Frosst, is last week I took the trouble to take a prescription to three drug stores in Ottawa and I got a price of $12 at one, $8 at another and $5 at a third. I am going to suggest to the Committee that these three druggists be called before the Committee to explain how their problems differ according to neighbourhoods, and the rest of it. I am wondering if we are going after the right source of price cutting in going after the manufacturers rather than the wholesaler or retailer.

I would like to compare your financial sheet on page 15 with the general brief of the PMAC I presume you have that with you?

Mr. FROSST: Mr. Blanch, do you have it?

Mr. BLANCH: Yes.

Mr. MACKASEY: I note that your figures are fairly similar to that of the industry, although you are lower on what we have been calling here marketing.

Mr. BLANCH: That is right.

Mr. MACKASEY: We spent a lot of time questioning the drug companies on marketing, but according to the PMAC brief, which we have not managed to refute or destroy or put a new interpretation on, at page 2 of section 2 the cost of

marketing represents only 11 cents out of the prescription dollar and therefore, Mr. Blanch, it would be lower in your own case?

Mr. BLANCH: That is correct.

Mr. MACKASEY: Have you figured out what it would be? Of course, if you go from 24 to 30 per cent it would be about 8 cents.

Mr. BLANCH: It is a question of the relationship of the selling prices of our products to the final price to the public.

Mr. MACKASEY: Well, let me ask you as an accountant and then let us take the brief and ignore yours for the moment. Since this marketing is supposedly only 11 cents of the prescription dollar and if we cut it in half, as suggested by the Hall Commission Report, we would only be saving 5½ or 6 cents on the prescription dollar.

Mr. BLANCH: That is probably correct.

Mr. MACKASEY: Now, getting back to your own brief, if I may. On page 3—

The CHAIRMAN: For clarification, Mr. Mackasey was speaking about the 15 per cent levelled by the government.

Mr. MACKASEY: The point I am making is that the Hall Commission Report made about 28 recommendations to reduce prices. As I see it, and based entirely on the presentation of the PMAC, perhaps the most insignificant and ineffective way of reducing the price on drugs is to try and reduce the cost of marketing, because it represents a relatively small part of the prescription dollar. I think it is 11 cents on the whole prescription.

You say you manufacture in Columbia, Lima Peru and Beirut, Lebanon, for which I commend you. Do you manufacture there under Frosst or under Merck? Was this before or after—

Mr. FROSST: This was before.

Mr. MACKASEY: Are you familiar with the patent laws in these particular countries?

Mr. FROSST: Not in detail. In most of these cases we have always had partners in the country itself. We own the majority of the companies, but we have partners there. There are patents in Colombia, certainly in Peru, and to an extent in Beirut, Lebanon.

Mr. MACKASEY: When you say patents, do you mean—

Mr. FROSST: They are recognized.

Mr. MACKASEY: The Canadian patent is recognized?

Mr. FROSST: Yes.

Mr. MACKASEY: Would you say the climate in these countries is more favourable for manufacturing than Canada?

Mr. FROSST: Most of these countries, particularly in Peru and Colombia, we had to manufacture.

Mr. MACKASEY: Why did you have to manufacture?

Mr. FROSST: Because if anyone else was manufacturing the product locally and you did not manufacture it, I believe you could not import it. Is that right, Mr. Blanch?

Mr. BLANCH: You either have to get in and manufacture or get out of the business.

Mr. MACKASEY: That is exactly the point I have been trying to make on this Committee since it started. In general Canada is very fair to the pharmaceutical industry, but we do not have enough teeth in our law concerning manufacturing. While your industry is asking for more patent protection, you are not guaranteeing this country any increase in manufacturing. Now, obviously you are manufacturing in certain countries because certain countries have said you either manufacture here or someone else will, some all-Peruvian company or some all-Colombian company. Do you know specifically which country has this law in force?

Mr. FROSST: In the two areas we are in in Colombia and Peru that is in effect. It is not in effect in the Middle East but we foresaw the possibility of an Arab state union over there and therefore we built on that premise.

Mr. MACKASEY: Dr. Howe asked you earlier about goods that you export and in your answer you brought in the word "bulk". Is anything shipped to these countries in finished package form?

Mr. FROSST: In the West Indies I would say we sell in finished package form wherever we can, but if someone else manufactures a product locally you have to do it too, and we have set up to do that.

Mr. MACKASEY: The point I am getting at is I would like to see a comparison of the prices at which you sell your finished package goods to these countries as against your prices in Canada. When you say you ship in bulk we then get into an ambiguous situation.

Mr. FROSST: The one in bulk I was talking about happened to be Falapen that we ship in bulk to another pharmaceutical company. We are not in that market. That is the way they purchase from us and they pay a royalty in the price.

Mr. MACKASEY: This royalty in the price intrigues me. In other words, you do sell them—theoretically at least or on the surface—at a lesser price than you sell in Canada, and you are telling us that the difference between the price you sell them and the price you sell to your Canadian outlets can be classified as royalty payment?

Mr. FROSST: No, because, as we all know, the cost of the ingredients bears small relationship to the end price, and if this other company is doing business in the Philippines, such as we are doing in Canada, they have all these other costs which must be included in their selling price. I cannot give you their selling price, but I would say it probably is not lower.

Mr. MACKASEY: To make it easier, Mr. Frosst, are the goods you ship in completed package form sold higher or lower? Is the invoice higher or lower to Canadians?

Mr. FROSST: I have not got that price.

Mr. MACKASEY: I do not need the specific price, but surely you as president of the company know whether that invoice is higher or lower than the invoice to Canadian outlets.

Mr. FROSST: I am talking about the West Indies now, and some of the Falapen still comes from Montreal. If we sell directly from here to some drug store in the West Indies, I think their price would be higher.

Mr. MACKASEY: Do you ship directly to a drug store in these countries or do you ship it to a selling agent?

Mr. FROSST: To a distributor.

Mr. MACKASEY: Until very recently these were the products of an all-Canadian company doing its research in Canada, but as part of the pharmaceutical family you had the same problem of recovering research, which is normal. Many American firms have told us how they recover research costs. They are recovered in grants, royalties, and so forth, to the parent company, but in your case you are the parent company, or were until recently. How did you regain the cost in your company?

Mr. FROSST: We got royalties out of Beirut, Lebanon. We expect we will get royalties in the other countries we are going into.

Mr. BLANCH: First of all we recover the costs through the selling prices to these countries. Where we have special manufacturing arrangements there are royalty arrangements between these countries for payments.

Mr. MACKASEY: In other words, your selling price to these far away companies must be considerably higher than in Canada because you have to add to their buying cost the royalty fees you expect to recover?

Mr. FROSST: We sell very little Falapen to Colombia, Peru or Lebanon. They manufacture most of their products in those areas. Falapen may have been sold directly—and this is one that keeps coming back—because of the patent process we had. It is difficult to set up manufacturing in these countries. I believe they are producing Falapen now in Colombia.

Mr. BLANCH: No.

Mr. FROSST: Where are they doing it?

Mr. BLANCH: We are shipping it to Lima and to my knowledge there is no other—

Mr. FROSST: This particular product is difficult to manufacture. Other than that, these people are manufacturing in their own country. This one bulk export I told you about is entirely different. It is a very small thing we are doing with another company. It has nothing to do with our total export picture at all.

Mr. MACKASEY: I see an opportunity here of getting the whole picture in reverse. Up until now we have been dealing with international companies who have been charging sizable and probably legitimate amounts to their Canadian subsidiaries to recover what is vaguely known—or specifically known, for that matter—as research. In this Committee we obviously started out on the premise, and the logical one, that one of the big intangibles, and one of the main costs to the pharmaceutical firms, is the money devoted to research and the fact that it

must be amortized over all products and must be amortized over many years. I think this is true. Now, surely in the case of Frosst the same thing must have worked in reverse for the goods you are exporting, the goods that were manufactured here. The research was done here until very recently.

Mr. FROSST: Yes, and it still is being done, and our research in Canada is growing.

Mr. MACKASEY: Can royalties be recovered from Lebanon?

Mr. FROSST: And from Colombia and Peru, either in the form of dividends or royalties.

Mr. MACKASEY: How do you recover them? Do you recover them as an additional mark-up on the product you are selling to your distributor?

Mr. FROSST: No, it is out of the net profit of the company, or royalties on sales.

Mr. BLANCH: It is included in the price of the products which you ship to them. In addition, you have a royalty arrangement on the total sales of Frosst products in these countries.

Mr. MACKASEY: That is what I wanted to know. In other words, when you do produce your prices, under no circumstances will the price to the Caribbean countries or other countries be lower than the price you are selling to Canadian firms. In other words, you are not dumping or you are not taking advantage of Canada or Canadians. That is the point I am getting at. All these arguments you have been giving us have convinced me that your price to your distributor outside the country must be higher than to your distributor or to your druggist in Canada.

Mr. BLANCH: I would like to take a look at the actual price.

Mr. FROSST: I want to get the actual prices, but we do recover money in the form of royalties and dividends, which has helped to pay for our research in Canada.

Mr. MACLEAN (*Queens*): I have a supplementary question. You say that you manufacture in Peru, not for economic reasons, necessarily, but because the Peruvian law requires it. Is that correct?

Mr. FROSST: It requires that if someone else is manufacturing the same products there we also have to.

Mr. MACLEAN (*Queens*): In this case can you put the product manufactured in Peru on the market as cheaply or more cheaply than if you manufactured it in Canada and just exported it to Peru? In other words, looking at the other side of the coin, is the cost of drugs to the Peruvian higher or lower because of this requirement?

Mr. FROSST: Because of the requirement?

Mr. MACLEAN (*Queens*): Yes.

Mr. FROSST: It can be higher. I have not got the price of goods down there with me but I would say it could be higher.

Mr. MACKASEY: The fact that is has to be manufactured in Peru increases the cost to the consumer. In other words, if you could export directly into Peru from your Canadian base, would it result in cheaper drugs in Peru?

Mr. BLANCH: It would depend upon the duty going into the country.

Mr. MACKASEY: If you keep saying "it would depend", it does not answer Mr. MacLean's question. The fact that the Peruvian government has a law which says that any product that is manufactured in Peru cannot be imported into Peru, you must open another manufacturing firm in Peru—is that the law?

Mr. BLANCH: Yes.

Mr. MACKASEY: —do you think this results in a higher cost or a lower cost?

Mr. FROSST: I would have to get the figures but I believe probably it could be higher.

Mr. MACKASEY: In other words, manufacturing costs. Does that not lead to another recommendation of the Hall Commission Report, which I presume you are against? I notice you gentlemen smiling. That report recommends that the Patent Act be amended to extend compulsory licence to include the licensing of imports, the quality of such imported drugs to be assured by the food and drug committee. In other words, is recommendation 67 of the Hall Commission a legitimate and logical one, that is, that we increase importations into this country. If Peru permitted the indiscriminate importation of drugs manufactured outside Peru it would drive the cost of drugs down. Is the same thing true in Canada?

Mr. FROSST: If it is consistent with quality and the fact that the food and Drug Committee has approved where the product comes from and where it is manufactured, and it passes all the tests that we feel Canadian physicians want to have when they prescribe it so that it will give them the security they need, and provided the product is not patented in Canada. This has been the right of everyone up until now.

Mr. MACKASEY: Let us presume that source is a well known European one like Merck Sharp & Dohme, Smith Kline & French, Hoffman-LaRoche, or any one of the other companies, would you not say their drug would meet our standards?

Mr. FROSST: Yes, I would expect they would meet our standards.

Mr. MACKASEY: I am not trying to put words into your mouth, but would you not also go on to say that it would also destroy the industry as it exists?

Mr. FROSST: That is correct.

Mr. MACKASEY: Would you like to elaborate on that?

Mr. HOWE (*Hamilton South*): Please excuse the interruption, but would that lower the price of drugs?

Mr. FROSST: I am not prepared to say, but it certainly would be—

Mr. HOWE (*Hamilton South*): If patent restrictions were lifted and the Food and Drug Committee were assured of quality control of imported drugs from countries where there are no patents, such as Italy and Yugoslavia, what effect would this have on the price of drugs to Canadians?

Mr. FROSST: If this is the type of society or climate, or the way Canada wants to go not only in our industry but in recognition of all patents—they are

not going to recognize them and therefore ours will not be recognized in other countries— and this is the climate they want to live in I would say possibly you might get them in cheaper to begin with, but I do not think that is going to be the final result.

Mr. MACKASEY: I would like to go on the record, Mr. Frosst, that I do not approve of these recommendations of the Food and Drug committee because I think you do have a manufacturing industry in Canada, but I think the industry has got to police itself to some extent to kep prices within reason or these types of suggestions will ultimately come into existence to the detriment of destroying an industry that does hire thousands of people and spends millions of dollars in the country.

The CHAIRMAN: I assume when you said Food and Drug committee you really meant the Hall Commission Report.

Mr. MACKASEY: The Hall Commission Report, I am sorry.

Mr. Chairman, I have just one further question. You are now part of the Merck & Company family. Does that mean, practically, that you are in competition in Canada with Merck Sharp & Dohme?

Mr. FROSST: Yes, we most definitely are.

Mr. MACKASEY: Are there any areas where you are in direct competition? Do they produce an equivalent to 222 or Ostoco?

Mr. FROSST: No, they do not. Many companies looked at us and we chose, as I said, one that was heavily research oriented. The other criterion was that the product mix did not conflict.

Mr. MACKASEY: Now, Mr. Frosst, you spoke about research. I understand your firm has done a lot of research in Canada and I think you are to be commended for it. Will your research facilities in Canada remain independent from those of Merck Sharp & Dohme in Canada?

Mr. FROSST: I will let Ron Stuart answer that. We definitely have a research unit at Frosst; we had one before and we have one now under Merck and of necessity we will be growing in Canada, so there is no duplication of effort. We are tied in with $40 million worth of research that Merck is doing in the United States.

Mr. MACKASEY: Yes, but I am speaking of Canada now. Would you at any time pool your research facilities with Merck Sharp & Dohme in Canada?

Mr. FROSST: Yes. We did not conflict with their research before. Dr. Stuart, would you explain how it operated prior to that time? Dr. Stuart was with Merck. We had a vacancy at the time that the merger came along and he took over as our director of research.

Mr. STUART: Since the merger took place, our research at Merck Sharp & Dohme in Canada has actually been incorporated into the Frosst research group. Now, I might, for clarification explain how our research operates opposite the research in the United States. Our research is a part of that $40 million. We have chosen to operate in co-operation rather than in competition with them. In other words, we have chosen projects that are not being worked on by our research groups in the United States and these projects are, in essence, as important as

any other single project in the whole Merck research organization. We have also chosen to emphasize more particularly in Canada the fundamental aspects of research than in any other research group. The reason is that the Frosst research team that we acquired, and the additions we have made to it, have made it possible for us to build a fine team of chemists and biologists who are capable of doing fundamental research in the two principal fields which we mentioned.

Approximately 16 per cent of our effort is on fundamental chemistry and biology, which is not specifically orientated towards any product or any disease, which I think is a pretty good record.

Mr. MACKASEY: Sixteen per cent in Canada?

Mr. STUART: Sixteen per cent of our effort in Canada is on fundamental chemistry and biology.

Mr. MACKASEY: May I interrupt you there. When you say "our effort", would you be more specific. Who do you mean by that? Is it Frosst's effort or Merck Sharp & Dohme's effort?

Mr. STUART: I should say "Frosst" instead of "our", because as part of the over-all Merck research management I have to stop and think and clarify it myself. The Frosst effort in Canada, as Mr. Frosst pointed out in his introduction, is 71 per cent fundamental research, and of that 71 per cent 16 per cent of the whole is in fundamental chemistry and biology. The other two pieces are directed toward the cardiovascular field and the nervous system.

Mr. MACKASEY: The point is, sir, that sooner or later, and properly so, the cost of research gets back to the consumer. It goes into the cost of every product. This is the whole story. I am trying to find out if this research facility that now exists in Montreal—you are just speaking about Frosst—is in conjunction with Merck Sharp & Dohme and another one of the Merck family, or is it independent?

Mr. STUART: You mean Merck Sharp & Dohme of Canada?

Mr. MACKASEY: Yes.

Mr. STUART: Merck Sharp & Dohme research is part of the whole Merck research, so is Frosst research part of the whole Merck research.

Mr. MACKASEY: How is the cost of the research apportioned to your product and to Merck Sharp & Dohme's product, because Mr. Frosst tells us you are both competitors?

Mr. STUART: Well, I would prefer that the financial people answer that part of the question, but I will say that as the projects we are working on are for products that will be useful anywhere in the world wherever they are sold, whether it be in the United States, Canada, or elsewhere, then the selling price will have to cover the research that is put into them. Perhaps Mr. Blanch or someone could tell you exactly where the immediate money comes from.

Mr. MACKASEY: Have you followed what I am trying to find out?

Mr. BLANCH: I would like you to rephrase your question, Mr. Mackasey.

Mr. MACKASEY: Well, obviously before the merger Frosst had a very vigorous research division in Canada which, of course, recovered the cost of research through the sale of its products and, according to the figures which you have

provided, it obviously recovered even from exports through the medium of royalties. Now, because of the absorption of Frosst in Merck & Company, which is an international firm, we have the ambiguous situation of having two members of the Merck & Company family in Canada; that is, Merck Sharp & Dohme and Frosst.

Mr. BLANCH: That is correct.

Mr. MACKASEY: They are in competition with each other. First of all, did that competition go right down to research facilities or are there pooled research facilities?

Mr. BLANCH: It is pooled research facilities.

Mr. MACKASEY: That is right. Now, if it is pooled research facilities, how do you apportion the cost of research against Frosst Products and against Merck Sharp & Dohme products?

Mr. BLANCH: The research which was done by Merck Sharp & Dohme in Canada was on a particular field of products.

Mr. MACKASEY: I mean at the moment, never mind the past.

Mr. BLANCH: It so happens that we have not as yet had occasion to allocate the research between the two individual companies.

Mr. MACKASEY: Is it because the business year is not completed?

Mr. BLANCH: It so happens we are just in the process of making the fiscal years coincide, but that really is not a factor in the allocation of the research projects. As far as Merck Sharp & Dohme are concerned, of course, their products have come from research in the United States. The research which is done in Canada at the present time is practically all related to the Frosst line of products, but it is envisaged that we will have an arrangement between the companies where we will be charging each company a share of the research work which is applicable to their respective activities.

Mr. MACKASEY: How is it going to reflect in the product to the consumer? How are you arbitrarily going to apportion this research over two products which could be in competition with each other? There are bound to be some Frosst products in competition with—

Mr. FROSST: May I say something on this? If a product is developed out of the research unit in Canada, for instance, and it happens to fit into MSD of Canada's line better than ours, and if their men are more knowledgeable in the particular field in which this product is developed, then they will get it.

Mr. MACKASEY: When you say in their line, Mr. Frosst do you mean in their selling line, their retail line, or what?

Mr. FROSST: Well, if it was a new diuretic, which they have been famous for, it is more logical for their men to detail, it fits into the total line they are detailing to the physician, then this product would probably go to MSD in Canada and there will be a reflection in their price of so much for research. If it went to Frosst it would be the other way.

Mr. MACKASEY: Well, what you are saying is that the parent company, Merck & Co. Inc., have two selling agents, two outlets, in Canada; Frosst and

Merck Sharp & Dohme. They are going to allocate it to the company that suits their financial picture best.

Mr. FROSST: Not the financial picture best; just how it would fit into their total program best.

Mr. MACKASEY: Which I imagine, in a private enterprise system, is the same thing.

Mr. FROSST: Yes. We would pick the company which was going to make more sales and the product would be given to that company?

Mr. MACKASEY: The royalties that you have been collecting from outside the country have, no doubt, lowered the cost of the Frosst operation, making your product that much cheaper to the consumer. What will happen to these royalties under the new set up?

Mr. FROSST: We expect to get royalties from Frosst products sold abroad.

Mr. MACKASEY: You expect to get them, but who is going to benefit from them? Will it be Frosst organization, the Merck, Sharpe and Dohme organization, or the Merck company?

Mr. FROSST: They will be paid into Charles E. Frosst.

Mr. BLANCH: It will be the total Canadian operation.

Mr. MACKASEY: The total Frosst Canadian operation?

Mr. BLANCH: That is right.

Mr. MACKASEY: That is all for the moment, Mr. Chairman.

(Translation)

Mr. GOYER: Mr. Chairman, before Frosst Company became part of Merck Company, did you sell in the United States?

(English)

Mr. FROSST: Before we became part of Merck, did we sell products in the United States? We exported some chemicals. I think this year it would be as much as half a million dollars.

The history on it is that back in the thirties my grandfather, having come from Richmond, Virginia, opened up a branch down there but with not very many items. I suppose it was partly sentimental because he came from Richmond, Virginia. When the war came along in 1939, and we could not travel there and could not get the money to run it on the spot, it folded up at that time.

We had an experiment in Buffalo in 1952, which I think we can best term as an artistic success but a financial failure. We then concentrated our efforts in Canada and in our other export fields. We have always had an eye to the United States, and we are certainly not ruling it out for the future, but with the personnel we had we thought we had better concentrate our efforts in Canada.

(Translation)

Mr. GOYER: Did you get any royalties from the United States?

(English)

Mr. FROSST: Did we get any royalties from the United States? No.

(*Translation*)

Mr. GOYER: None whatsoever?

(*English*)

Mr. BLANCH: No; because the products we were selling to the United States were shipped on a straight export basis. It was all included in the selling price of the product.

(*Translation*)

Mr. GOYER: When you were operating alone, did you sell royalties to other countries, or, in other words, patent rights. I had better say patent right for operations.

(*English*)

Mr. BLANCH: We received royalties from other companies on the sale of Frosst products in these foreign countries where we had manufacturing facilities. Of course, in those manufacturing countries we had partners, and it was on a straight manufacturing licence basis that we were operating there.

(*Translation*)

Mr. GOYER: Yes, precisely. Did you simply sell patent rights without manufacturing in any given country. Did you, for instance, sell patent rights to Great Britain, Switzerland, France or elsewhere in those countries, rather than in countries in which you had to manufacture?

(*English*)

Mr. BLANCH: Yes; we sold patented drugs to Great Britain. The price at which we sold those drugs included what we considered would be a fair price for the product and, in one instance, there was an additional royalty on the sales of those products in the country in which they were sold.

(*Translation*)

Mr. GOYER: Now that you are operating together with Merck Company, will your sales in the other countries or the royalties you receive from them be favouring subsidiaries of the Merck Company?

(*English*)

Mr. FROSST: I think I heard a couple of questions there, but we are operating, as we have in the past, in our export countries. We are manufacturing Frosst products and selling Frosst products.

(*Translation*)

Mr. GOYER: Do you, at the present time, sell to subsidiaries outside the United States, do you sell your products to subsidiaries?

(*English*)

Mr. FROSST: Most of the countries where we sell, the manufacturing is done there. I think I mentioned earlier that Falapen had been an exception because it was a special process.

(*Translation*)

Mr. GOYER: Do you have business relations with the Merck subsidiaries?

(*English*)

Mr. FROSST: Yes, we have a manufacturing unit in Beirut, Lebanon, and they do not have one. We will probably manufacture their products for them there.

(*Translation*)

Mr. GOYER: Yes, but what I mean is this. Do you yourselves, have business relations with those Merck subsidiaries which are already set up? Has the fact that you have become part of the Merck Company opened new markets for Frosst?

(*English*)

Mr. FROSST: Definitely; we are going to expand in the export field much faster than we expanded before.

(*Translation*)

Mr. GOYER: Have you concluded any agreements with the subsidiaries concerning the royalties which you receive or does that go into a melting pot?

(*English*)

Mr. FROSST: No; but certainly our intentions are that if Merck is helping us get into a market where our products are sold there will be some royalty arrangement.

(*Translation*)

Mr. GOYER: Are the arrangements clearly defined at the present time?

(*English*)

Mr. FROSST: No, they are not.

(*Translation*)

Mr. GOYER: Have you made any arrangements with the parent company, Merck, to the effect of having to pay any given amount for inter-company services rendered, or in order to cover overhead costs which the parent company has to assume?

(*English*)

Mr. FROSST: We are not paying any fee at the moment.

(*Translation*)

Mr. GOYER: Do you foresee that you may have to pay such costs?

(*English*)

Mr. BLANCH: We foresee that there is the possibility of having certain inter-company costs charged to the Canadian company, which is only a natural inter-company operation. In other words, we will pay for those services which are performed in Canada.

(*Translation*)

Mr. GOYER: What is the type of services that you expect to receive from the parent company?

(*English*)

Mr. FROSST: Certain auditing services, too.

Mr. BLANCH: There are financial services, there can be marketing services, there are what you might term general management services for the Canadian company; but these have not been defined. As you well know, there is the usual argument between the various government sources to make sure that the charges are properly allocated to the various countries, and then we get into difficulties between the government bodies and the various taxing authorities in these countries.

(*Translation*)

Mr. GOYER: Would you have any objection to submitting to a disclosure law concerning the relations that you as a subsidiary have with the parent company, Merck?

(*English*)

Mr. FROSST: No, not at all.

(*Translation*)

Mr. GOYER: You have given percentages in regard to the expenses paid through your sales. It appears that you devote 32 per cent to professional representation services and that, further, it might be necessary for you to pay an additional amount in this respect to the parent company. Do you believe that this figure of 32 per cent—it might even be larger than that—is a normal one as compared, for example, to the amount you devote to research: 8 per cent? Or to general manufacturing costs: 29 per cent? Do you think that this proportion of expenses is normal in any given industry?

(*English*)

The CHAIRMAN: May I ask a question? You mentioned the figure of 32 per cent. Did you get that figure by adding the 24 and the 7.7?

Mr. GOYER: Yes; by adding the 24 and the 7.7.

The CHAIRMAN: The 7.7 is part of the 24? It is just broken down?

Mr. FROSST: It is the last figure, advertising and promotion, 7.7, and it is broken down.

(*Translation*)

Mr. GOYER: In any case could I ask a question? Do you think that this figure of 24.7 per cent, to which you might have to add, as you say, certain extra marketing costs payable to your parent company, is a normal figure as compared to manufacturing or research costs. These seem to be proportionately very much smaller.

(*English*)

Mr. FROSST: I would say, first of all, that we are not going to have any additional charges to our marketing cost in the domestic division. I think that when Mr. Blanch said that there may be marketing costs, it would be on an international basis where they are in a country which has nothing to do with our domestic sales in Canada.

(*Translation*)

Mr. GOYER: Does that mean that you will have to pay for marketing costs that would not apply to the Canadian market?

(*English*)

Mr. BLANCH: Any cost which we would pay to the parent company for services rendered would be applicable to the Canadian market.

Mr. FROSST: But not specifically marketing.

Mr. BLANCH: Not specifically marketing.

Mr. FROSST: Not at all. We have our own marketing set up, and the charges are allocated accordingly. We direct our own marketing activities. Merck does not direct the marketing activities of our products. Management fee, possibly; we do not pay anything at the moment, though.

(*Translation*)

Mr. GOYER: In relation to the amount that you direct to research, which is 8.3 per cent, do you calculate in that 8.3 per cent whatever you receive through tax reductions from the Federal Government under the research item?

(*English*)

Mr. BLANCH: Unfortunately, we have not been good recipients of the research incentives here in Canada because we were unfortunate enough to increase our research laboratories in the year 1961, which was the base year. We have been trying ever since to increase the research expenditures to offset the capital expenditures which were incurred in that year.

In 1965 we did receive a small amount of tax benefit from the incentives. We are hoping that in subsequent years, when the new incentive program is finally announced by the government, we will be more fortunate in receiving some benefit.

Mr. MACKASEY: May I ask a supplementary question? Would you not be better off then with outright grants for research? Your firm would be better off with a grant than with the tax incentive?

Mr. BLANCH: Well, it depends: so long as the base year is not a fixed year; but it did so happen that in 1961 we did have major capital expenditures which a number of other companies also had, and it has affected very seriously the amount of benefit which we have received under the research incentive.

(*Translation*)

Mr. GOYER: If patent regulations were made stricter in Canada, would that enable you to lower the professional service representation costs, because you would meet less severe competition, at least in the first years?

(*English*)

Mr. COFFIN: I would doubt very much if it would affect our company. Our professional sales representatives perform two services. They detail doctors and take information to doctors and bring back information to the company from doctors, but, in addition, they service drugstores and they service hospitals. It is about a fifty-fifty split. About half of the cost you see here—this 13.4 per cent—is devoted to the detail function, and about half of it is devoted to servicing drugstores. Under our system of operation we still have to have that. I would question very much whether a change in patent laws would really cause us to need less detailmen, because the large majority of our products, contrary

to those of some other companies, are fairly open; they are competitive. I doubt if it would affect ours very much.

We think we need this many detailmen to do an adequate job. It might have some other effect, but I do not think that it would affect the size of our detail force.

Mr. FROSST: I think we do an adequate job of calling on physicians, with the size of force we have now and, therefore, if, over the years, we could double our sales we are certainly not going to double our cost of representation and, in effect, your total marketing costs should be a much lesser percentage of your dollar than they are now.

We have built an organization which is capable of increasing its volume without increasing its cost. Therefore, your percentages could come down.

(*Translation*)

Mr. GOYER: But do you see or foresee or can you conceive in any way that if the Government helped your industry towards decreasing the cost of drugs, you could, in turn, through good management decrease your production or marketing costs? Is there not a possibility of an inter-relationship between what we on the outside can do and your side can do?

(*English*)

Mr. COFFIN: I think I understand your question. I am sorry, but I have not got a ready answer. One of the greatest things which would tend to make it possible to reduce the cost of drugs would be to increase the volume. If we could, as Mr. Frosst said, double our volume, then, since a great many of our costs are fixed costs of doing business in the Canadian climate, our costs would not automatically double.

However, I do not—

(*Translation*)

Mr. GOYER: May I just interrupt at this point? It is nevertheless rather surprising to see that when a Canadian company goes into American hands, for instance,—it is of necessity to broaden its market, expand its operations and expand its research possibilities—there is never felt any decrease in the cost of drugs. If you say that if you were able to double the volume then you could decrease costs, then does not the fact that you have merged with Merck, which is as you said, is a very strong international company, mean that you could automatically decrease the cost of drugs?

(*English*)

Mr. COFFIN: It is quite possible that it may, on certain products. However, I take a little issue with the statement that as the volume increases there has been no evidence of a decrease in the price of drugs. We have quite a number of products, which I could list for you, for which, as the volume has gone up, our prices have gone down. I might mention the one which was referred to some time ago, Trulfacillin. As the volume has gone up we have had three or four decreases in the price of this drug, to the point that it now sells for somewhat less than half what it did when we first introduced it with a very small volume.

The prime reason for expanding research is to keep abreast of new developments and to develop new drugs for the health and well-being of the public, and also on which, hopefully, we might make a profit.

(*Translation*)

Mr. GOYER: Yes, I understand very well that the more you concentrate research nowadays, the more you can spread out the cost for it, that is obvious. But it is surprising to note that the Canadian companies, when they were purely Canadian, had to operate in circumstances that were not easy, granted, but nevertheless there were some profits and profits increased and they compensated the owner of the company. Immediately, and that we note from our own figures, we note that between 1946 and 1965 you were able to double the number of your employees. Therefore it was an enormus expansion for a company which started to operate in 1898. But the fact that you merged is not only your case—with an ever larger company in order to, I hope, not only get profit out of the Canadian company but also to derive benefit from the scientific point of view and marketing. I wonder how it is possible that in the pharmaceutical industry we do not see a benefit also at the level of the consumer, whereas in other industries when mergers occur the cost decreases and it is the consumer who benefits.

In your company there is a standstill. There is almost the same percentage of profit even in the case of a merger; but then one suddenly notices that there are additional costs because of inter-company charges, dividends. The fact that you expand does not in any way give you the possibility to produce on a less costly basis. Does that mean lack of imagination or do some profits go where they should not go?

(*English*)

Mr. FROSST: Actually, it has only been a year and a bit. We have not felt this expansion internationally; we are looking forward to it internationally. As far as domestically is concerned, we are the same company as we were before. We have a line of products different from Merck.

It is not a case of the two getting together on one line and being able to do something for less. We are an entirely different sales organization. We have not been swallowed up. That was not our intention when the family disposed of the business. We wanted to continue as Frosst in this country and around the world, and this was one of the requirements of the person who was going to purchase our business, that we did not lose our identity or stop operating as Charles E. Frosst & Co.

(*Translation*)

Mr. GOYER: I certainly do not want to blame Frosst for having sold out to Merck, that is the owners' business, that is not our business, although we may deplore it. Frosst which was, shall we say, an average company, has merged with a very large international company and yet it cannot manage to decrease its cost to provide some benefit for the consumer. Is that in conflict with our economy if we say the more we can spread out the overhead costs of a company, the larger a company is, the lower its production costs and the better the consequences for marketing. That is to say, you can put new products on the market at the same time as your former products, because you have merged with a large company already in operation which will help you put new drugs on the market.

Mr. FROSST: I would say that we hoped to see some savings in costs because of the merger even if we had stood still; but as we are growing, and as we pay more wages and everything else, perhaps that is where the saving is; we do not have to increase our prices. Where it is going to be feasible to reduce prices, we certainly will, but if we can even hold the line in this economy, then, as a relationship, prices in effect are lower even if we hold them the way they are. We expect to see some savings because of the merger. We have not seen them all yet because we have not been together long enough.

(*Translation*)

Mr. GOYER: I am afraid that the savings you are going to effect will have to be paid out in lump sums, termed "inter-company costs" which in the long rum disappear from our market.

(*English*)

Mr. FROSST: At the moment we are not paying any.

(*Translation*)

Mr. GOYER: You foresee that the possibility exists. All you have to establish now is the agreement, according to the statement of one of your officials.

(*English*)

Mr. FROSST: May I say that if it is a product out of Merck research in the United States—and we have one we are marketing now, Protriptyline, which the Frosst organization, got from Merck, & Co. we are not paying a royalty at the moment. But I am not saying that maybe we will not; just as, if we develop something out of Canada which goes to Merck in some other part of the world, there will be a royalty paid to us.

The CHAIRMAN: Could you spell that Protriptyline.

Mr. FROSST: Protriptyline, p-r-o—you are selling it, Mr. Coffin.

Mr. COFFIN: I can pronounce it!

Mr. MACKASEY: May I ask Mr. Frosst a question while you are getting your spelling straightened out? Different firms which have appeared before us have handled this question of financial arrangement with the parent company in different ways. I think Hoffman-LaRoche show no royalties—or perhaps it was Smith Kline and French—but they do show—and I will read it to you—"Inter-company service charges, included as part of the costs of general administration, amount to approximately $500,000 on an annual basis. This payment represents a proportionate share of the management services provided by the international division of Smith Kline and French." Do you have, in your agreement, something built in like this?

Mr. FROSST: Nothing.

(*Translation*)

Mr. GOYER: Did Merck Company operate its research on a centralized or a decentralized basis before you became part of that company?

(*English*)

Mr. FROSST: Dr. Stuart, I think, can best answer that, having been with Merck.

Mr. STUART: Merck has operated on a decentralized basis since 1953, when it merged with Sharp and Dohme. They had two laboratories, one in Rahway, New

Jersey, which is not far from New York, and the other in West Point, Pennsylvania, which is not far from Philadelphia.

Merck has done research in Canada since 1953 as Merck, Sharp and Dohme of Canada, so that also was, if you like, a diversion.

Frosst research was added last year. Merck has opened a laboratory in England. It has a laboratory operating in Australia, and possibly will be opening in other countries. Therefore, I think the answer is that Merck does not intend to centralize research.

Mr. A. W. LAIDLAW (*Legal Cousel*): Mr. Chairman, if I may, I would like to pursue certain questions relating to patents, which were initiated by Dr. Howe and followed up by Mr. Mackasey and now by Mr. Goyer.

In your merger with Merck, Mr. Frosst, were the Frosst patents assigned to Merck?

Mr. FROSST: I do not think so. I was not going to give you a fast answer, but I am pretty sure they were not.

Mr. LAIDLAW: It was not part of the merger agreement that the patents would be included?

Mr. FROSST: No, the patents are still in the Frosst name.

Mr. LAIDLAW: Since your merger, are you licensed by Merck in so far as concerns patents which are created, or instituted, in the United States?

Mr. FROSST: I mentioned Protriptyline which is one of the drugs that came out of their research, which we are marketing.

Mr. LAIDLAW: In other words, you are operating under your own patents, as well as under licence from Merck with respect to other patents; am I correct?

Mr. FROSST: Yes. Dr. Stuart informs me that the patent on Protriptyline has not been granted yet; but let me say that a product on which they have a patent would be licensed to us if we sold it.

Mr. LAIDLAW: Would this not be the situation, then, that your parent company would license its patents throughout the world to the various subsidiary companies of Merck?

Mr. FROSST: This is a question really that Merck could answer better than I could. I do not know.

Mr. LAIDLAW: The reason I pointed it out really for the committee is that the world market, I assume, in this particular industry, and probably with Merck as well, is divided up into certain patent areas, and certain companies connected with Merck are limited to the manufacture of those particular drugs in specific and certain areas. I suggest to you—and I would like to know if this is true—that if this is so your export activity cannot really be largely increased. You are exporting now to the West Indies and to certain smaller South American countries, but presumably you are not entitled to export to perhaps France or to the United Kingdom because of the fact that in France and in the United Kingdom your sister corporation—if I can call it that—has the licence?

Mr. FROSST: You are talking about one product out of 200 at the moment. All our products, I would say, without exception are saleable in those countries. We could sell up in France, if we had the people and the time and the inclination.

Mr. LAIDLAW: In all countries in the world?

Mr. FROSST: Most of our lines are very competitive. In the case of patented items that we have, and where we have the patent in force, we can sell in other countries. We are not prevented from going into these countries because of any—

Mr. LAIDLAW: You would not be prevented by patents?

Mr. FROSST: Not at all.

Mr. LAIDLAW: You are not prevented from expanding your export activities?

Mr. FROSST: Not at all.

Mr. LAIDLAW: I have another question, Mr. Frosst: I wonder if I could have some specific information on your 217 tablets and your 222 tablets? I assume that you have had patents on both these products, or have patents?

Mr. FROSST: There are no patents on them. There are trade marks on them, but there are no patents on APC or on APC and C.

Mr. LAIDLAW: No patents whatsoever?

Mr. FROSST: No.

Mr. LAIDLAW: Has the price, since you have introduced these tablets, gone down markedly at all? You state on page 5 that these products are now being imitated. As the growth of these so-called imitations grew has your company's price gone down—the company's?

Mr. FROSST: No, it has not gone down. I cannot think of the last price increase. I know that when the sales tax went up we increased 222's. We did not increase our total line. We put a lot of it on 222's and we did not change our list on the balance of our prescription items. But we have not had price increases in 40-odd years. I do not know whether it went up five cents or not back somewhere before my time. I could say that this is still the free choice of the public, to pay that price or buy something else. They are not locked into that price, in any way at all.

Mr. LAIDLAW: But not being in a patented situation, competition in this particular area has brought down the price, perhaps has it?

Mr. FROSST: Well, it certainly held it where it is over the years. There is a lot of competition in this field, as you know. There are TV advertised products and everything else, and we cannot advertise this product.

Mr. LAIDLAW: Has the Commissioner of Patents ever granted to a third party a compulsory licence for any Merck product?

Mr. FROSST: You are asking a question which I cannot answer.

Mr. LAIDLAW: You do not know the answer to that question right now. Have you granted, Mr. Frosst, voluntarily licences for any of your products to any people?

Mr. FROSST: Falapen; but not in this country, nor have we been approached.

Mr. LAIDLAW: In other words, you are not worrying too much, as some other companies were worrying, about Section 41(3) of the Patent Act?

Mr. FROSST: Without using any sort of legal terminology, our position on patents, if I can state it in layman's language, is that we think that, in exchange

for a patent granted, a person must perform a certain function in Canada with that product.

We also think it should not be abused. If I may take two particular cases: first, if a manufacturer is granted a patent, and after a reasonable length of time—a number of years—he is not marketing it in Canada then I think that a compulsory licence should be granted to somebody who wants to fulfil that need in Canada, in exchange for a fair equitable royalty for the man's invention.

The second situation is this: he is marketing in Canada, but after a reasonable length of time he is not manufacturing it in Canada. If somebody else wants to assume that responsibility of manufacturing, which he claims the other man is not fulfilling—if he wants to fulfil that responsibility, then he should be granted a compulsory licence; again, in exchange for an equitable royalty.

I think that is basically it.

Mr. LAIDLAW: Thank you, Mr. Frosst. I have one final question and it relates to two statements made on page 8 of your brief. At the bottom of paragraph 2 you say that "the risk of obsolescence within a short period is exceptionally high." and yet in the immediately following paragraph you state that "the pharmaceutical industry in recent years could not have developed without the patent protection that made possible industry's sizable and continuous investment in comprehensive research and development." My question is this: Is the 17-year period, this term of patent protection that we have in Canada too long, considering the type of obsolescence you refer to in paragraph 2?

Mr. FROSST: I do not want to say what is too long, but from my experience I doubt if many companies have had the benefit of 17 years. Some other product has probably replaced the original one's usefulness.

Mr. LAIDLAW: That was what I was curious to know. You have a good product in the first year, but 17 years later you can have all the patent protection in the world on it but presumably the product will be outmoded.

Mr. FROSST: Yes, I agree with you.

Mr. LAIDLAW: That is all, Mr. Chairman.

Mr. BRAND: I would like to pursue that a little further. Do you have a patent on Danilone?

Mr. FROSST: Danilone is an anticoagulent. No, we do not have a patent on it. We developed it, though.

We have today Climacteron it is a patented product—one of the ingredients, Falapen, is a patented process in so far as the Polymer 37 coating is concerned.

Mr. BRAND: Does anyone else manufacture Danilone except yourselves?

Mr. FROSST: I think it was listed by a few other companies.

Mr. COFFIN: Parke-Davis had it listed, but I believe they have gone off the market. There are a couple of other companies—smaller houses—who sell it. I do not know whether they manufacture it.

Mr. FROSST: I do not know whether they manufacture it.

Mr. COFFIN: I do not know where they get it but they sell it.

Mr. MACKASEY: Where do you think they might get it?

Mr. COFFIN: It is pretty hard to tell. It is manufactured for them, I am sure, by some custom manufacturer of which there are a number. The people who sell it do not operate their own manufacturing so they must buy it from someone.

Mr. MACKASEY: Are these custom manufacturers Canadian.

Mr. COFFIN: They may or they may not be. There are a few in Canada. It is pretty hard for us to tell you where they get it, because we do not know.

Mr. BRAND: In the matter of the development of this drug, I am curious about why it is not patented. Is it because the process was not patentable? Is that what you mean?

Mr. FROSST: The work was done in France, I think. I am not sure where it was done. This is quite some time ago. What we did was to develop a process for manufacturing it economically. We did not really discover the drug.

Mr. BRAND: You did a lot of the actual research work on it. I know you did some at the University of Saskatchewan.

Mr. FROSST: Yes, we did.

Mr. BRAND: I would like to go back to the matter of research. A lot has been made of research, and we hear a lot of very confusing things today. Eight point three per cent research and development: Does that development include building new plants, or is that strictly research that 8.3 per cent?

Mr. FROSST: I think we have a breakdown of that figure. Mr. Blanch, are there any lab improvements in that? We have not built any—?

Mr. BLANCH: That would include the current operating costs of the research laboratory, but it certainly does not include the capital costs of the research.

Mr. BRAND: That is why I did not know what you meant by development.

Let us say that you quit research completely. What difference would this make to the cost to the consumer on the dollar presecription?

Mr. FROSST: Let us assume that it is double. I would be half of that. It would be 4.15.

Mr. BRAND: That is all. As you probably realize, after perusing some of the previous minutes of the committee, a very cogent point has been made against some of the generic manufacturers, that one of the reasons why their costs are so much lower is because they do not do any research. If it is a matter of only 4.15, would this argument hold water in this regard? It does not seem to be very much. Surely their costs are quite a bit lower than 4.15 per cent?

Mr. FROSST: I suppose so if I were alone and did not want to research and did not want to spend the money in making the physicians of Canada aware of a new product, its indications and counter-indications, and build in the quality standards that we have I could lower costs. Research is only part of this total mix. Under circumstances not very long ago, I might have got away with whacking some of these things out in the garage somewhere and taking the chance whether they were going to work correctly or not. But I could have sold them and I could have sold them at the prices at which some other people are selling them.

Mr. COFFIN: I think one of the things, Dr. Brand, that we should bear in mind here is that the generic houses are, by and large, only interested and only able to function, in those products for which somebody has created a substantial market.

I think that if Frosst, Merck, or anyone else, were to offer most of the houses a brand new drug, no matter how good it may be, if it was at all competitive but had no marketing they would not be interested in it at all. They are interested in them only after somebody else has spent a great deal of money creating the market, creating a sale, at which time it is feasible for them to go in with no expenditures and substantially reduce the price. However, there would be no new drugs under that circumstance.

Mr. BRAND: I believe, Mr. Frosst, you made the statement that it is really cheaper to import drugs providing the import duties were not too high. Did you make that statement?

Mr. FROSST: No, I did not make that statement. I said that they might come in cheaper.

This has been an avenue open to anybody in the past, so long as the drug was not patented and met FDA requirements.

Mr. MACKASEY: Supplementary to Dr. Brand's question, and more as a point of clarification: In all fairness to the firms, Dr. Brand, which have appeared, they have not stated that the only difference between their costs and the generic costs was research.

Mr. BRAND: I think they made that point, Mr. Mackasey.

Mr. MACKASEY: I think the generic firms themselves emphasize that they can market their product at a lot less than 30 per cent. They did point out some of the reasons and the ways in which they do cut down. I think one of them was the advertisement in the Pharmacopoeia, as I recall.

The CHAIRMAN: Are there any other questions, gentlemen? If not, I would like to thank the Frosst Company for coming before us this morning to present their brief and answer our questions.

Mr. MACKASEY: Mr. Chairman, who are the next witnesses, may I ask?

The CHAIRMAN: On Thursday, Parke, Davis and Company.

Mr. MACKASEY: When do we intend to have representatives of PMAC back? I ask this because at the time they presented this brief we skipped entirely their very detailed section on patents.

The CHAIRMAN: The twenty fourth of November. At that time we also expect to have representatives of Canadian drug manufacturers—in other words, some of the generic manufacturers—to discuss the same thing, and possibly one or two individuals who are also interested in the same thing.

Mr. MACKASEY: All at the same meeting?

The CHAIRMAN: I would certainly think that they would all be in attendance at the same meeting, but the exact format of the meeting, we have not as yet worked out.

Mr. BRAND: Is our good friend Dr. Wright coming next week?

The CHAIRMAN: Yes; Dr. Wright has accepted our invitation for the eigthth of November.

The meeting is adjourned.

APPENDIX "A"

Submission

to the

HOUSE OF COMMONS SPECIAL COMMITTEE

ON DRUG COSTS AND PRICES

by

Charles E. Frosst & Co.

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– 1 –

Gentlemen:

I am pleased to have this opportunity of appearing before your Committee on behalf of Charles E. Frosst & Co., a company that my grandfather founded in Montreal at the turn of this century. Our growth since then and our experience as manufacturers of high quality pharmaceuticals can, I hope, throw some light upon aspects of the pharmaceutical industry that are not always clearly understood.

At the outset, I shall point out that my description of our Company is based largely on facts and statistics that pertained as of May 31, 1965. In mid-1965 Frosst became part of Merck & Co., Inc., an outstanding and heavily research-oriented international pharmaceutical and chemical company based in the United States.

We entered into an agreement with Merck because it was easily demonstrable that the joining of our companies would be mutually beneficial and that Frosst's ability to serve both the Canadian medical profession and the people of Canada would clearly be broadened and the expansion of its export business could be accelerated.

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Over the past 15 months our own research facilities in Canada have been expanded and our total staff increased. We are now benefiting from joint research with Merck, a company backed by an annual research operating budget of U.S. $40 million. In the international field our export activites are also expanding.

I would emphasize, however, that the managerial philosophy and the standards of professionalism that governed the activites of Charles E. Frosst & Co. before the agreement and which we share in common with Merck, continue to guide our company today.

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BACKGROUND OF THE COMPANY

Charles E. Frosst founded the company bearing his name in Montreal in 1899 to produce prescription medicines and other pharmaceutical products. The Company's original plant was located on Lagauchetiere Street in the heart of one of the oldest business sections of the city. As the business grew, Frosst expanded its facilities by annexing space in nearby buildings. To permit further expansion, the Company moved to its present headquarters in Westmount, Montreal, at the beginning of 1926.

The Company's continued growth is reflected in the seven major additions made at the Westmount location, the most recent being completed in 1965. Today, facilities for research, production, administration and other office services cover an area of 175,000 square feet. Frosst maintains a network of sales offices, warehouses and depots in Toronto, Winnipeg, Calgary and Vancouver. Abroad, Frosst products are manufactured in Bogota, Colombia; Lima, Peru; and Beirut, Lebanon. In addition, export sales are made from Montreal to the West Indies, the United Kingdom and other countries.

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Frosst experienced its greatest growth period following World War II when employment in Canada climbed from fewer than 200 in 1946 to more than 500 in 1965. The bulk of these—420—were employed in Quebec province; but we also had 48 employees in Ontario, 18 in Alberta, 16 in British Columbia, 7 in the Atlantic provinces, 6 in Manitoba, and 5 in Saskatchewan.

More than a quarter of our employees—141—held university degrees including 4 M.D.'s, 9 Ph.D's, 7 with Master's Degrees in Science, 26 with Bachelor of Science Degrees and 80 who had their Bachelor Degrees in Pharmacy.

Wages paid by the Company in 1965 totalled $3,434,000 compared, for example, with $836,000 in 1946. Purchases of goods and services increased from $2,261,000 in 1946 to $4,512,000 in 1965. Since both wages and purchases made in Canada contribute to the nation's economy, it is worth noting that approximately $3,755,000, or over 80 per cent of the 1965 purchase figure, went for materials or services bought in Canada. Purchases outside of Canada were principally for chemicals which were unavailable in this country.

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PRODUCTS

Charles E. Frosst & Co. makes and markets more than 200 different products in Canada in more than 500 package sizes. The products fall into five general groups:

Analgesics:

Frosst is the largest producer in Canada of ethical products for the relief of pain. Company scientists developed the formula for the product known in Canada as "217" Tablets in 1910 and, a year later, that for another pain-relieving product, "222" Tablets. These products are now imitated in many countries under a variety of trade names.

Chemotherapy and Antibiotics:

These consist of sulfanamide preparations, penicillin preparations, combinations of sulfa drugs with penicillin, and tetracycline preparations.

Vitamins and Minerals:

Since 1928, when the Company became the first producer of synthetic vitamin D in Canada, Frosst has developed a comprehensive group of vitamin and vitamin and mineral preparations suitable for various age groups.

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Hormones:

Following basic research work in Europe, Charles E. Frosst & Co. began manufacture of testosterone, estradiol and progesterone at a time when these were little more than laboratory novelties. The Company's activity in this field led to production of naturally occurring conjugated estrogens of equine origin, and to their stabilization and standardization.

Other Therapeutic Preparations:

Among numerous other Frosst products are anti-coagulants for oral administration; a non-barbiturate hypnotic; products for the relief of nasal congestion,

hay fever and other allergies; and products for the treatment of hyperacidity and gastric and duodenal ulcers.

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RESEARCH

Over eight per cent of the Charles E. Frosst & Co. pharmaceutical sales dollar is spent for research, continuing a tradition in this field that dates from the earliest days of the Company. The research and development staff, as of May 31, 1965, totalled 54, including 9 Ph.D's and four medical doctors.

Today, our research and development staff has grown to 77. Among current research projects are those directed to the development of new psychotherapeutic drugs, cardiovascular drugs, anti-cancer compounds and the improvement of hormone products.

The Company operates the only laboratory producing radio-active pharmaceuticals in Canada. Under licence from the Canadian government, radioactive drugs of rapidly changing potency are standardized daily and delivered by air to major hospitals across the country. Other compounds are synthesized with more stable radio-active isotopes.

Research in the pharmaceutical field has become particularly complex, requiring a broad variety of disciplines and skills, as well as a major financial investment. Our company participated in the preparation of the chart, presented with the Pharmaceutical Manufacturers Association of Canada (PMAC) brief,

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which showed the evolution of a product from the time it is conceived until the drug reaches the patient. This chart, "New Drug Submission for F. & D.D. in Canada" is Appendix H of the PMAC brief.

The incentive for such research is the desire of scientists to understand the unknown and to see their knowledge applied in ways that are beneficial to mankind. The incentive for such investment has been and remains the opportunity to make a profit commensurate with the financial risk inherent in a field where only one candidate compound in several thousand becomes a product, and where the risk of obsolescence within a short period is exceptionally high.

In the Company's opinion, based upon its experience, the pattern of product research that has characterized the pharmaceutical industry in recent years could not have developed without the patent protection that made possible industry's sizable and continuous investment in comprehensive research and development. These investments, in both personnel and money, that are made today, are for products that will help cure diseases in the years to come.

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MANUFACTURING AND QUALITY CONTROL

The standards that govern manufacturing and the control tests that verify quality are designed by Company scientists and pharmacists during the developmental phase of a product's history. Scientific quality tests are applied scrupulously to all basic materials, to in-process materials at important points in

manufacturing, and to the finished products themselves. To mention two examples, one Frosst product, "222" Tablets, is backed up by 263 different quality control tests, 71 of which are analytical. "OSTOCO", a liquid vitamin drop preparation for infants, undergoes 303 different tests during manufacturing, 107 of which are analytical. At Frosst, the cost of quality control alone is over seven per cent of manufacturing cost. Making prescription medicines to the highest standards involves much more than careful scientific policy, however. It requires a sense of responsibility on the part of the individuals who participate in the manufacturing process and a company policy that precludes expediency and insists on excellence. The complete manufacturing history of any Frosst pharmaceutical item can be reconstructed readily through its identifying control number. We keep a record of all tests performed during manufacturing, of the personnel who conducted the tests, of the persons responsible for each phase of manufacturing and packaging, and of the equipment used. In keeping with the tradition developed over its nearly 70 years of making products to meet the professional need of medicine, Frosst makes product reliability the first of its manufacturing guidelines.

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MARKETING

Frosst's experience has demonstrated that the Company's most effective method for keeping the practicing physician abreast of the advantages and limitations of its new and established products is through its professional service representatives. The field force in Canada, including zone and district sales managers, numbers 90 men, most of whom are graduate pharmacists. They spend about half their time calling on physicians and dentists and the other half servicing hospitals and pharmacies.

Continuously trained to discuss Frosst products thoroughly, the men visit approximately 16,000 practicing Canadian physicians on an average of four times each year. This liaison with the medical profession enables us to exchange information that is helpful both to the doctors and ourselves. The majority of doctors welcome the opportunity to discuss new pharmaceutical products and also to provide our representatives with information on our products already in use.

In visits to pharmacists it is the responsibility of the representatives to give information on new Frosst products or new information regarding old ones. Our representatives also help maintain adequate up-to-date inventories of Frosst

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products in the 6,000 retail outlets used by doctors and patients. It is Frosst practice to make sure its prescription products are available, even in areas where the demand may be negligible, and the Company accepts the return for credit of any dated item that has not been sold before its shelf life expires and in addition will accept for full or partial credit any non-dated product depending on age.

In terms of the Frosst domestic pharmaceutical sales dollar, the field force in 1965 cost 13.4 per cent. This figure includes salaries to highly qualified professional men, extensive and continuing training courses for them and travel expenses in maintaining a service to physicians, hospitals and pharmacists even in the remotest areas of our country.

Other promotional expenses includes samples delivered to physicians only upon request, which account for 2.7 per cent of the sales dollar, and advertising, in which we invest 5 per cent of the sales dollar.

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Frosst believes that pharmaceutical advertising performs a necessary function in informing physicians concerning new drugs and new information about old drugs; moreover, by helping to create a broader market, it makes possible increased production that, in turn, has often contributed to the lowering of prices.

Frosst sells some of its products to hospitals at a lower price than that charged to pharmacists. Experience has shown that products used in hospitals become known to staff physicians, residents and interns. The products to which they become accustomed in hospitals are the ones they prescribe in their practice. Our costs are not always a determining factor in setting these prices. We compete for the hospital business at prices which are sometimes below cost and consider this activity as part of the promotion of our products to the professional staff. Our sales to hospitals account for less than 10 per cent of our total volume.

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We have been criticized by retail pharmacists for this practice. We feel it is justified because it

(1) advertises our product and creates sales for the pharmacist.

(2) aids in keeping hospital costs down and makes it possible for them to supply medicines to indigent out-patients at less than their normal price.

Essentially, however, the price of each Frosst product results from the interplay of many factors, including:

—The competitive situation.
—Potential market.
—Support of our continuing research and development costs.
—A reasonable profit during the product's lifetime.
—Ingredient and manufacturing costs.
—Production overheads.
—Introductory promotional costs, literature, detail effort, advertising and free trial medication.
—A share of the Company's administration costs.

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SALES, PROFIT AND PRICING

Over the last five years, the Frosst Company's sales and profit picture has improved in a gradual but encouraging fashion, as shown by the published financial results for all the activities of the Company.

	1961	1962	1963	1964	1965
	Thousands of Dollars				
Sales (including F.S.T.)	9,099	9,695	9,838	10,276	10,797
Federal Sales Taxes	699	719	708	750	791
Sales (excluding F.S.T.)	8,400	8,976	9,130	9,526	10,006
Profit Before Taxes	1,172	1,295	1,235	1,359	1,547
Profit After Taxes	644	722	694	718	803

The Company's profits after taxes are eight per cent on sales—in line with PMAC figures—and 16.3 per cent on shareholders' equity. Our rate of profit reflects the cost of doing business in a limited market such as Canada, the kind of industry we are in, which involves high risks of many kinds including product obsolescence, and our relatively heavy long-term commitment to research.

Out of total 1965 company sales of $10,006,000, domestic human pharmaceutical sales were $8,680,220. The breakdown of the domestic-pharmaceutical sales dollar for the year was as follows:

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Breakdown of Frosst Domestic Pharmaceutical Sales Dollar—1965

	%
Manufacturing	29.8
Distributing and Warehousing Costs	7.5
Professional Service Representation, Marketing and Medical Information	24.7

	%
Field Sales Expense	13.4
Administration of Marketing, Selling and Advertising Functions	3.6
Advertising and Promotion	7.7
	24.7

	%	
Medical and Pharmaceutical		
Advertising	2.7	
Direct Mail	0.7	
Samples	2.7	
Medical Exhibits, Space and Other	1.6	
	7.7	
Research and Development		8.3
Manufacturing Administration, Order Processing, Financial Services and General Administration		12.5
Income Taxes		8.8
Earnings		8.4
		100.0%

In reviewing these figures you should be aware that Frosst sells directly to pharmacists across Canada and less than 6% of its business is done through independent drug wholesalers. Our own expenses of wholesaling are therefore included in our operating costs.

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CONCLUSION

In your proceedings, the effect of Federal Sales Tax on the Cost of Drugs has been brought to your attention. For Frosst, the total amount of Federal Sales Tax for the year 1965 was $791,000. If drugs are exempted from the Federal Sales Tax, the prices of our products will be reduced to the full extent of the sales tax applicable.

The Pharmaceutical Manufacturers Association of Canada (PMAC) of which we have been a member since its formation in 1914, has made recommendations to your Committee. We support these recommendations. Also we stand willing to participate in discussions with Federal and Provincial Governments in the development of a plan for providing needy persons with the drugs they require.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 15

THURSDAY, NOVEMBER 3, 1966

WITNESSES:

Representing Parke, Davis & Company, Ltd.: Mr. Clifford A. Rogers, Vice-President and Managing Director, of Montreal; Mr. Gordon M. Stockwell, Manager-Accounting, of Brockville, Ontario; Mr. John M. Godfrey, Q.C., Legal Counsel, of Toronto.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1966

25075—1

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
[1]Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

[1] Replaced Mr. Noble on November 2.

ORDER OF REFERENCE

WEDNESDAY, November 2, 1966.

Ordered,—That the name of Mr. Forrestall be substituted for that of Mr. Noble on the Special Committee on Drug Costs and Prices.

Attest.

LÉON-J. RAYMOND,
The Clerk of the House of Commons.

25075—1½

MINUTES OF PROCEEDINGS

THURSDAY, November 3, 1966.
(22)

The Special Committee on Drug Costs and Prices met this day at 9.50 a.m. The Chairman, Mr. Harry C. Harley, presided.

Members present: Messrs. Brand, Enns, Harley, Howe (*Hamilton South*), Isabelle, MacDonald (*Prince*), MacLean (*Queens*), Tardif.

In attendance: Representing Parke, Davis & Company, Ltd. Mr. Clifford A. Rogers, Vice-President and Managing Director of Montreal; Mr. Gordon M. Stockwell, Manager—Accounting, of Brockville, Ontario; Mr. John M. Godfrey, Q.C., Legal Counsel, of Toronto.

Also in attendance: Mr. A. M. Laidlaw, Q.C., of Ottawa, Legal Counsel for the Committee.

The Chairman referred to a communication received from Smith Kline & French Inter-American Corporation of Montreal, supplying, at the Committee's request on October 27, material dealing with the relative potencies of "Stelazine" and other trifluoperazine tablets.

Agreed,—That a copy of this information be made available to the Members of the Committee.

The Committee proceeded to the consideration of the Brief presented by Parke, Davis & Company, Ltd.

The Chairman introduced Mr. Rogers who introduced his colleagues.

Mr. Laidlaw opened the questioning dealing more particularly with patents and royalties.

Mr. Rogers supplied information; he was assisted by Messrs. Stockwell and Godfrey.

Agreed,—That the brief of Parke, Davis & Company Ltd., with the exception of Appendix 6, being the Annual Report for 1965 of Parke, Davis & Company, Detroit, Michigan, be printed as part of today's proceedings. (*See Appendix "A"*)

The Committee resumed the examination of the officials of the Company.

Mr. Laidlaw asked further questions.

The questioning being concluded, the Chairman thanked Parke, Davis & Company, Ltd. and their representatives for having presented a brief and for the information provided to the Members of the Committee.

Mr. Rogers reiterated the invitation of his Company to visit its plant at Brockville.

At 11.25 a.m. the Committee adjourned to 9.30 a.m., Tuesday November 8.

Gabrielle Savard,
Clerk of the Committee.

EVIDENCE

(Recorded by Electronic Apparatus)

• (9.50 a.m.)

THURSDAY, November 3, 1966.

The CHAIRMAN: Gentlemen, we will proceed with the meeting.

During the representations made by Smith Kline & French, they were asked to provide some material dealing with the relative potencies of stelazine and other trifluoperazine tablets. They mentioned that they would provide this material to the Committee. I have the material here. It is very lengthy. I think it is obvious that it goes into great detail, and that it could not be reproduced as part of the Minutes of this meeting. What I would suggest is that I have it reproduced on the photocopy machine and see that each member gets a copy of it. If anyone wants to discuss it, or take certain portions out of it as being relevant, perhaps we could do that later. Would that be satisfactory?

Some hon. MEMBERS: Agreed.

The CHAIRMAN: We have with us today the representatives of Parke, Davis & Company, Ltd., who have come to present their brief. We will ask the vice president of the Canadian operation, Mr. Rogers, to introduce his colleagues.

Mr. CLIFFORD A. ROGERS (*Vice President and Managing Director, Parke, Davis & Company Ltd.*): Thank you kindly, Dr. Harley. Ladies and gentlemen, we prepared this brief knowing full well the importance of this Committee and the problems you are faced with. We have tried to give you as much information as possible to be helpful in your coming to a successful conclusion in your deliberations. There is no fore-statement. The brief in itself is a complete statement.

Here with me this morning are Mr. Gordon Stockwell, the manager of our accounting department, and Mr. John Godfrey of the firm of Campbell, Godfrey and Lewtas. Mr. Godfrey is representing us through his legal affiliation with the company.

The CHAIRMAN: The meeting is now open for questioning.

Mr. A. W. LAIDLAW (*Legal Counsel for the Committee*): I wonder if I could start the questioning by referring to the patent position of Parke, Davis & Company?

My first question deals with pages 5, 6 and 7 in which are listed a certain number of drugs which have been introduced by the Park, Davis firm. Who holds the actual patents of these particular drugs?

Mr. ROGERS: Parke, Davis & Company holds the patent on adrenalin, mapharsen, dilantin and benadryl; Parke, Davis & Company Ltd., holds the patent on chloromycetin; and Parke, Davis & Company holds the patent on vanquin and ponstan.

Mr. LAIDLAW: Now, Parke, Davis & Company is the Canadian subsidiary—

Mr. ROGERS: Parke, Davis & Company, Ltd. is the Canadian company. Parke, Davis & Company is the parent.

Mr. LAIDLAW: I see. Therefore, in your particular situation, Mr. Rogers, the Canadian firm holds some patents and in addition receives licences with respect to other drugs from the parent firm. Is that correct?

Mr. ROGERS: Would you please restate that question? Did you say Parke, Davis & Company, Ltd.?

Mr. LAIDLAW: Does the Canadian firm hold certain patents?

Mr. ROGERS: Only on chloramphenicol, chloromycetin.

Mr. LAIDLAW: I see.

Mr. ROGERS: All the others are owned by Parke, Davis & Company.

Mr. LAIDLAW: This means you are licenced to manufacture in Canada from your parent firm?

Mr. ROGERS: That is right.

Mr. LAIDLAW: Do you pay royalties for these licences?

Mr. ROGERS: Yes.

Mr. LAIDLAW: Could you give me an estimate of how much your royalties are per year to your parent firm?

Mr. ROGERS: They vary from year to year, but covering the year of 1965, in this brief, our total royalties paid, were $216,133 but those were not all paid to Parke, Davis. Pardon me; the $216,133 was to Parke, Davis.

Mr. LAIDLAW: And then there were other royalties paid to other firms?

Mr. ROGERS: Very minimal royalties on other products which we manufacture under licence from the inventor.

Mr. LAIDLAW: What would be the percentage, Mr. Rogers, on the manufacturer's dollar, of the royalties you pay—that is, your total royalties?

Mr. ROGERS: The total is 2.288 per cent.

Mr. LAIDLAW: Thank you. With respect to mapharsen, the second drug listed on page 5, which, you stated, is now obsolescent, could you tell me the period of time from the date the patent issued until the date it became obsolescent—this particular drug?

Mr. ROGERS: This would only be guessing—I have not the figures—but the original clinical investigation work was done in Canada in 1932, and I believe we marketed it for the first time in 1934, and about 1940 it was finished. Those are not factual figures, but that is a close summary of what happened.

Mr. LAIDLAW: That is an example of what happens in the drug industry.

Mr. ROGERS: That is right.

Mr. LAIDLAW: Therefore, you cannot get the benefit, in some instances at least, of the full term of your patents?

Mr. ROGERS: Oh, definitely not.

Mr. HOWE (*Hamilton South*): Why would it have become obsolete in 1940? Penicillin did not come in in 1940.

Mr. ROGERS: All right, doctor; it was a guess on my part. When did penicillin come in?

Mr. HOWE (*Hamilton South*): I used it first in the air force in 1943.

Mr. ROGERS: That is when mapharsen became obsolescent, then.

Mr. HOWE (*Hamilton South*): I was not quibbling over years, but I was wondering if there was some intervening drug before the use of penicillin?

Mr. ROGERS: No; my dates were wrong.

Mr. LAIDLAW: Mr. Rogers, you probably do not have the information with you, but I wonder if you could supply the Committee with the dates these various patents were issued with respect to the drugs cited on these pages? I am rather curious to know whether or not the terms of some of them have expired?

Mr. ROGERS: I do not have the date that the patent was issued, but I do have the dates when the drug was first introduced for sale, and the intervening period would be, perhaps, two years, or six months. Adrenalin was marketed in 1900; mapharsen was first marketed in 1935—I was wrong there; dilantin sodium in 1937; benadryl in 1945; chloromycetin in 1949; vanquin in 1960; and ponstan in 1966.

Mr. LAIDLAW: Therefore, all the patents are now in the public domain with the exception of the last one or two?

Mr. ROGERS: Chloromycetin will remain under full patent for, I think, two more years.

Mr. LAIDLAW: Would you be able to supply the Committee with the price at which you sold these drugs during the time they were patented and when the patent ceased?

Mr. ROGERS: In the case of lilantin, we sell it for more money now than when we originally patented it.

Mr. LAIDLAW: And your explanation for that is labour costs?

Mr. ROGERS: Well, yes; you must remember that such a product as dilantin sodium fits into a catastrophic disease, and a person who takes it practically takes it for a lifetime. When we priced it in 1937 we and everybody in this country were earning about 25 per cent of what we are earning today, and naturally all of our costs have gone up since those years. We have had to increase the price of dilantin 21 per cent which is very, very nominal compared to the costs of other commodities which have gone up around the country. You cannot blame it all on labour. Packaging and all of these things, as you know, have gone up in price, and that is why dilantin sodium has gone up in price.

Benadryl has also gone up in price for the same reason since it was introduced.

Mr. HOWE (*Hamilton South*): Could you not increase volume in these drugs to compensate for the other increased costs, or improve the manufacturing methods and distribution and so on?

Mr. ROGERS: Well, it would compensate to a degree, but not sufficiently.

Mr. LAIDLAW: Another question relating to your section on patents, generally, which starts at page 12 of your brief, Mr. Rogers: In the presentation of your views relating to compulsory licence application, which in your opinion, should be abolished—this compulsory licensing provision—you state, and I quote from your brief on page 13: "Under Section 41(3) his patent is subject to the grant of compulsory licences bearing only a modest royalty almost as a matter of right." I would like to ask you: If legislation could be introduced where an appropriate royalty was granted under the compulsory licensing system would your objection fall to the ground? Because, if this were so, presumably the licencee, having to pay you a reasonable royalty rather than a pittance, as it was referred to earlier before this Committee, would start at least at a disadvantage to the amount of the royalty paid. Would you have any objection to that?

Mr. ROGERS: First, I think I would have to know what would be an appropriate amount.

Mr. LAIDLAW: I would suggest that an appropriate royalty would perhaps be the same form of royalty as is paid under voluntary licensing, which has been done by the drug companies.

Mr. ROGERS: I do not think I can answer that question, because I do not know. I would have to give that a considerable amount of thought.

Mr. LAIDLAW: Has Parke, Davis—the Canadian firm—been subjected to any compulsory licence applications.

Mr. ROGERS: Oh, yes.

Mr. LAIDLAW: How many sir?

Mr. ROGERS: I think, off the top of my head, three—benadryl, dilantin sodium and chloromycetin. Those are the three.

Mr. LAIDLAW: When this was done, and when the licencees presumably were operating under the licence, did your business suffer at all with particular, reference to the three applications?

Mr. ROGERS: Tremendously with respect to chloromycetin.

Mr. LAIDLAW: Could we have figures on how much the drop in business was on that particular drug, and the others which are affected by licencees.

Mr. ROGERS: Well, there was not enough business in the others for the licencee to work them.

Mr. LAIDLAW: So the licencee received the licence but did not work under it.

Mr. ROGERS: There was not enough volume. It was not a good "steal" you might say.

Mr. LAIDLAW: I will not make any comment on that word.

Mr. HOWE (*Hamilton South*): Does a manufacturer of generic chloramphenicol eat into Parke, Davis' business to any great extent.

Mr. ROGERS: The manufacture of unlicensed chloramphenicol—yes, it has hurt us severely.

Mr. HOWE (*Hamilton-South*): You say unlicensed; was this compulsory licensing, or strictly unlicensed?

Mr. ROGERS: Well, unfortunately when you grant a compulsory licence apparently a lot of people get the idea that everybody can license it. I think that over 45 or 50 different organizations and firms have brought in unlicensed chloramphenicol to this country. We have to protect our patent rights and I do not know how many court cases we have had over it. The cost to us has been tremendous to protect our patent.

Mr. HOWE (*Hamilton South*): Are these being manufactured in Canada, or being manufactured outside of Canada, or both?

Mr. ROGERS: They were manufactured outside of Canada, unlicensed.

Mr. HOWE (*Hamilton-South*): In other words, they were granted a compulsory licence to manufacture outside the country.

Mr. ROGERS: No; our licence covers only Canadian manufacture.

Mr. HOWE (*Hamilton South*): So that the only protection you had against it then was the anti-dumping duty?

Mr. ROGERS: I do not know where the protection was, because we have never been able to get any on it. They just dump it into the country here, they run it around all over and sell it at ridiculous prices. They do not try to distribute it through legitimate channels. That is, they do not look after the druggist in Portage la Prairie or in North Bay. They just go to large accounts who will consume a great quantity. They are not interested in any servicing, or anything.

Mr. HOWE (*Hamilton-South*): In other words, they are just simply capitalizing on the information which you have given out. They do not have to do the promotion; all they have to do is say: "We are selling it at 'X' per cent less than Parke, Davis sell its for," and this is their sales value.

Mr. ROGERS: That is their entire sales presentation.

Mr. HOWE (*Hamilton-South*): You feel that the patent laws of this country are not sufficiently binding, or protective, to the drug companies?

Mr. ROGERS: Absolutely not.

Mr. HOWE (*Hamilton-South*): Well, where do you figure that the anti-dumping duty comes into this. There is quite a protection there to the drug manufacturers within the country, is there not?

Mr. ROGERS: Not to my knowledge; it has not worked so far as chloramphenicol is concerned.

Mr. HOWE (*Hamilton-South*): The anti-dumping duty prevents the import of anything of a class or kind that is being made and sold in Canada by Canadian manufacturers. This is the actual wording of it.

Mr. ROGERS: They are brought in at the fair market value of the country which they are in. That is Italy, and some of it comes from Hong Kong. Heaven only knows where it comes from. Some, I presume, comes from Red China and there are no patent rights there.

Mr. HOWE (*Hamilton-South*): No; you are talking about patent rights. I am talking strictly about anti-dumping duty which is supposed to protect the

Canadian manufacturer against an outside country importing into this country a manufactured product of a class or kind that is being manufactured in Canada. In other words, are you saying that there is no protection in this, or that it is not being enforced—that this can be dumped in and they can undersell a Canadian manufacturer?

Mr. ROGERS: The price is set on the fair market value in the original country in which the product is sold.

Mr. HOWE (*Hamilton-South*): In other words, it is not at your selling price; it is at the price at which it is being considered it should be sold?

Mr. ROGERS: Yes; it is not at our selling price. It is at the imported—

Mr. HOWE (*Hamilton-South*): In other words, the government then rates what it should sell for, rather than what you sell it for?

Mr. ROGERS: No, no.

Mr. HOWE (*Hamilton-South*): Perhaps I misunderstood your answer.

Mr. ROGERS: Not the Canadian government; the government of the country where it originated. I do not think they have anything to do with it. But they cannot sell if in Canada for less than what they sell it at in their country—Italy, or Hong Kong, or wherever it may be.

Mr. HOWE (*Hamilton-South*): Do you mean, then, that the anti-dumping duty applies only to the price that it would sell for in the country in which it is manufactured?

Mr. ROGERS: Where it originates; that is right.

Mr. HOWE (*Hamilton-South*): So that any drug manufactured anywhere, in spite of this anti-dumping duty, can be bought and undersell Canadian prices? This is not my interpretation of this legal point. I do not pretend to be a lawyer but my understanding of it was that this was a protection to the Canadian drug manufacturers, that a drug could not be brought in and undersold without being subjected to this anti-dumping provision of any drug of class or kind that is manufactured in Canada; and this class, of course, gives you a great, wide scope as far as protection is concerned. I have possibly misinterpreted this legal aspect of it.

Mr. ROGERS: Mr. Godfrey, would you answer that, please?

Mr. JOHN M. GODFREY, Q.C. (*Legal Counsel, Toronto*): My understanding of dumping duty is that the country which is exporting into Canada cannot dump its product into Canada—that is, sell it in Canada—at less than it is being sold for in that particular country. Therefore, if it is being bought in from Italy it is the fair market value in Italy that counts. It has no relationship to what it sells for in Canada whatsoever. They have no patent laws in Italy; therefore, if things are being sold very cheaply in Italy they can bring them into Canada at exactly the same price and not be subjected to dumping duty.

Mr. HOWE (*Hamilton South*): Then why can they be sold so much more cheaply in Italy? Is it because they are simply copying and do not have the expenses which lead up to the discovery of the drug and its promotion? In other words, it does not have any promotion costs and it does not have any patent royalties to pay, and this is why they can undersell?

Mr. GODFREY: That is right.

Mr. ENNS: May I just follow this up? Supposing a new drug is developed by Parke, Davis this year, or has been within the last few years, and in Canada and on the North American continent there is some patent protection which will cover this product for a given period of time, is it possible that during this same time and within a short time someone can manufacture this new drug in Italy without any development costs, research, promotion and so forth and sell it in Canada while the patent is valid?

Mr. ROGERS: Yes; that is, if it has been already approved by the Food and Drug Directorate.

Mr. ENNS: Let us assume everything is legal and you believe you have a patent on a drug. Along comes a manufacturer in another country, who, if you want to use the term copies the product and brings it back to your customers over here and they get it for so much less. Is this going on, or can this happen now?

Mr. ROGERS: Oh, it does happen all the time, and it is up to us to protect our patent and to take legal action against that person as an infringer against the Canadian patent. He is infringing the Canadian patent.

Mr. ENNS: Of course.

Mr. ROGERS: But the government does not protect us. We must take this man to court and prove we are right.

Mr. ENNS: So that you are involved in court costs, court procedures and so forth. And you have found this not always to be a successful pursuit?

Mr. ROGERS: Well, not always.

Mr. HOWE (*Hamilton South*): Your patent only protects your mode of manufacture, as I understand it. It does not patent the end product?

Mr. ROGERS: That is right.

Mr. HOWE (*Hamilton South*): Therefore, you are not infringing on a patent right if the process of arriving at it is different whether it be in Canada or outside of Canada. They cannot import a drug that is manufactured by the same process in another country. It is a matter of innovating a different process and arriving at the same chemical, and marketing it. They have not then infringed on your patent rights?

Mr. ROGERS: That is right. You can only patent a process in Canada, so if they can make drug X by another process—an absolutely different process—then I do not think you could approach them as infringers.

Mr. HOWE (*Hamilton South*): They are not infringing on your patent rights as they are established.

Mr. ROGERS: No.

Mr. HOWE (*Hamilton South*): Therefore, if the process is different there is no point in incurring a lot of court costs trying to stop it, because they have not contravened any law so far as the patent right is concerned. It is your contention that the patent should extend to the end product rather than just the process?

Mr. ROGERS: Oh, definitely.

Mr. TARDIF: Some pharmaceutical firms in Canada have branches in Europe, I presume?

Mr. ROGERS: Yes.

Mr. TARDIF: If some pharmaceutical firm in Canada discovers a new drug and patents it and manufactures very little of it in Canada and establishes a price which is comparatively high, then allows its European firm to manufacture the same drug at a much lower cost because there is no patent protection, or there is a lower cost of labour, do they bring the drug into Canada and sell it at the Canadian established price, or do they sell it at the established price at the European factory which made it?

Mr. ROGERS: That is quite a question, Mr. Tardif. Let me see if I can get this straight.

Mr. TARDIF: If you will give me quite an answer I will be quite happy!

Mr. ROGERS: You mean if we manufacture product "A" in Canada and sell it for $10 a unit could we manufacture the same thing in Britain to sell for $5 a unit and then bring it back here?

Mr. TARDIF: You patent it in Canada. You discover a new drug, you patent it in Canada and you manufacture very little of it so that the price, of necessity, will be high. After you manufacture a little of it in Canada, the price is $15 per hundred, we will say. You have a factory in Hong Kong and the labour in Hong Kong is very cheap and there you can manufacture it for $2. Instead of continuing to manufacture this in Canada you manufacture it in Hong Kong and you bring it into Canada for $2. What do you sell it for—$15?

Mr. ROGERS: I cannot answer that because I do not think Parke Davis would do such a thing. We respect the countries we work in. We feel that all of us should earn our living and manufacture the product in Canada wherever possible.

Mr. TARDIF: I would not want you to think that I feel you are unethical?

Mr. ROGERS: Oh, no. I could not answer.

Mr. TARDIF: I was referring to other drug firms, not yours.

Mr. ROGERS: I cannot answer for others.

Mr. ISABELLE: I am sure it could be done.

Mr. ROGERS: I presume it could be done, but we have never practiced that, Dr. Isabelle.

Mr. ISABELLE: No?

Mr. ROGERS: No.

Mr. HOWE (*Hamilton South*): If I may, I am going to ask a question, which I asked of a drug company at the last meeting we had. Do you manufacture here and export any drugs?

Mr. ROGERS: We do not export, although we have done a little this past winter strictly on an experimental basis; and it is so infinitesimal that it has no

bearing at this time. But we are experimenting, you might say, in the export field.

Mr. HOWE (*Hamilton South*): Then if I may ask a related question: does your parent company export drugs?

Mr. ROGERS: Definitely.

Mr. HOWE (*Hamilton South*): Manufactured drugs?

Mr. ROGERS: Oh, manufactured—finished?

Mr. HOWE (*Hamilton South*): Yes.

Mr. ROGERS: We purchase some from our parent company, as we show in the brief.

Mr. HOWE (*Hamilton South*): Would it be possible for you to get me figures—presuming you do not have them at hand—of the relative cost of drugs being exported by your parent company to different countries?—the export prices as they leave the United States compared one country to another?

Mr. ROGERS: The only thing I can give you is the prices exported from the United States to Canada as outlined very well in the Department of Industry brochure, "Doing Business in Canada, Canadian Custom Duties. Department of Industry, Ottawa," prepared by the Department of Industry. It covers the subject very nicely.

Mr. HOWE (*Hamilton South*): Perhaps you do not understand my question. There are certain drugs which leave your parent company, going to different countries—Canada, England, countries in Europe, possibly down to South America, and so on. Are they all at the same price as they leave the manufacturer to go to these various countries, or there is a difference in the prices to two different countries?

Mr. ROGERS: I do not know.

Mr. HOWE (*Hamilton South*): Could this be found out for me?

Mr. ROGERS: We could ask Detroit; but I imagine that the price would be the same—the manufactured cost plus whatever the agreement is between the countries as far as tariff and excise tax are concerned.

Mr. HOWE (*Hamilton South*): I am not interested in that. I am interested in the price at which it leaves your factory before any of that is added.

Mr. ROGERS: Oh, no; it would probably be exactly the same price, because it is distributed at our cost.

Mr. HOWE (*Hamilton South*): Therefore, there would be no difference in the manufacturer's price as it leaves f.o.b. your factory in Detroit, going to every country in the world? No matter where it went, this price would not vary?

Mr. ROGERS: The actual cost of the drug, no.

Mr. TARDIF: You say that that drug would be shipped at cost price? That would be to your other branches, or your other factories, of course?

Mr. ROGERS: Plus whatever tariff regulations the country has to which it is going.

Mr. TARDIF: How do you manage to make a profit at the end of the year when you ship some of your goods at cost price? Does it reduce your profit? If you ship a lot of goods out of your American factory—

Mr. ROGERS: Oh, it is refinished in the countries to which it goes. I am thinking of a raw drug that perhaps has then to be formulated or tabulated in capsules.

Mr. HOWE (*Hamilton South*): But that was not my question. My question referred to the finished product being exported, leaving your factory and going to different countries?

Mr. TARDIF: Ready for use?

Mr. HOWE (*Hamilton South*): Ready for use; f.o.b. Detroit, Parke, Davis Company.

Mr. ROGERS: Such as certain biologicals for Canada which we bring in from Detroit?

Mr. HOWE (*Hamilton South*): Is there any difference as it leaves your factory in Detroit for the different countries to which it goes, or is the price identical as it leaves your factory to go to any country in the world?

Mr. ROGERS: The price would be our cost price plus what arrangements there are for tariffs in the countries it is going to. That is how it happens in Canada. I do not know what happens when it goes to, say, Chile.

Mr. HOWE (*Hamilton South*): Yes, well, that is what I am interested in. Could you take one drug and find out from Detroit the price at which it leaves the factory to go to different countries? Could you find this out, without reference to tariffs, or anything—before tariffs are added and before duties are added? I do not care about transportation. I want the f.o.b. rate at the factory as it leaves, with nothing added on. Is there any difference?

Mr. ROGERS: We will have to inquire.

Mr. HOWE (*Hamilton South*): Could you do that for me?

Mr. ROGERS: Certainly.

Mr. HOWE (*Hamilton South*): I just wanted my question understood. Perhaps I have not worded it too well, but perhaps it is clear now what it is that I am interested in.

Mr. ROGERS: If they are getting a better price than I am I would like to know.

Mr. TARDIF: I am sorry I was late. I was wondering if your firm manufactures drugs in any other country but the United States and Canada?

Mr. ROGERS: In some 30 odd, or 40 countries.

The CHAIRMAN: Incidentally, gentlemen, before I forget, is it agreed that we should print today's brief as part of todays proceedings, with the exception of Appendix 6 which is the financial statement and which I do not think would reproduce very well. Is that agreed?

Some hon. MEMBERS: Agreed.

Mr. ISABELLE: What are you manufacturing at Brockville? You say that Brockville is a good plant, one of the finest in the country, and I agree with this; and also that you are proud of the calibre of the facilities, as is mentioned in the brief. What kind of product are you manufacturing in Brockville?

Mr. ROGERS: Well—

Mr. ISABELLE: Give me just two brand names.

Mr. ROGERS: We manufacture chloromycetin right from the ground up in Brockville. We synthesize it, package it and everything else.

Mr. ISABELLE: You do everything there?

Mr. ROGERS: Everything, yes.

Mr. ISABELLE: Do you ship this product into the United States?

Mr. ROGERS: No.

Mr. ISABELLE: Just in Canada?

Mr. ROGERS: It is just for Canadian consumption.

Mr. ISABELLE: Do you manufacture any product at Brockville that you ship to the United States?

Mr. ROGERS: No, none whatsoever.

Mr. ISABELLE: You are not manufacturing the same products as those that are manufactured in Detroit?

Mr. ROGERS: Oh, yes; we manufacture the same products in Brockville that we manufacture in Detroit and that we manufacture in Hounslow, England.

Mr. ISABELLE: Why is that? You are duplicating the manufacturing of one product. Suppose we take benydryl. If you manufacture benydryl in the United States and you manufacture benydryl in Canada you would be manufacturing the same kind of product. Do you not think this might increase the price of drugs?

Mr. ROGERS: No; we buy pure benydryl in bulk. It is synthesized in Holland, Michigan, in our synthetic plant there, near Detroit; and we buy that as bulk chemical. We bring it to Brockville where we encapsulate it, or put it in tablets and ointment and all the rest of it.

Mr. ISABELLE: In other words, you buy the raw substance at the same place?

Mr. ROGERS: That is right.

Mr. ISABELLE: Which is near Detroit in the United States; is that correct?

Mr. ROGERS: We buy it from Detroit, yes—the raw material.

The CHAIRMAN: But not chloromycetin?

Mr. ROGERS: Not chloromycetin.

Mr. ISABELLE: No, I am talking about benydryl now. Is the price of benydryl by the 50 mgm. capsule the same price in the United States as it is selling here?

Mr. ROGERS: I do not have the American catalogue here, but as a rule the prices are very close with the exception of the 11 per cent sales tax.

Mr. ISABELLE: What do you mean by "very close"?

Mr. ROGERS: Oh, within 1 or 2 per cent. I would have to have the American catalogue, Dr. Isabelle.

Mr. ISABELLE: It would be interesting to know, because I think the consumer would be very interested in our asking that question. If you add on this 1 or 2 per cent to the 11 per cent sales tax it comes up to 12 per cent. I imagine—I am not sure—that there is quite a difference of price, especially on benydryl, between the United States and Canada.

Mr. ROGERS: As I say, I do not have the comparison prices here; but I do not think there is too much difference. That is covered in the PMAC brief also although not specifically on our products; but there is not too much difference. Some of our products in Canada sell cheaper than they do in the United States, because we determine our own marketing policy in Canada, and some of our products, I can tell you, Dr. Isabelle, sell for less. We were quite surprised to find, when these things come up, that these is quite a variation in price.

Mr. ISABELLE: Could you tell us if the total manufacturing cost of one product in the United States is about the same as it is in Canada?

Mr. ROGERS: In appendix 4 we have tried to bring this forth where we can make the same product in the United States and Canada. We try to bring this out on fine chemicals. This is a fine chemical very clearly, and we can buy it 70 per cent cheaper in the United States and pay all these tariffs than we can manufacture it in Brockville.

Mr. ISABELLE: Why? Is it because you are in Brockville?

Mr. ROGERS: No: because there is 13 times as much production in the United States.

Mr. ISABELLE: Do you think if you were more protected it would help? Have you read the Hilliard Report?

Mr. ROGERS: Yes.

Mr. ISABELLE: Do you agree with the Hilliard Report?

Mr. ROGERS: I certainly do.

Mr. ISABELLE: Do you think it might have the effect of reducing the price of drugs to the consumer in the long run?

Mr. ROGERS: Again, this is hard question to answer because by the time it possibly became effective the costs of production would have gone up again. If you compared today's prices and when this law became effective—whenever it was—the advantage would be lost. At the same time, we would have to assume that it would materially help to prevent the price from going higher.

Mr. ISABELLE: Still dealing with the same matter, do you thing we should change the idea of calling a new drug a new drug? Suppose, through your research, you became an innovator and you find a certain new drug and it is classified under "new drugs" by the Food and Drug Act. "After four or five years it becomes what we call an old drug, and everybody can copy it and can manufacture it in Italy, or Hong Kong, or anywhere. Do you think that this five years—which is not in the law, but the general rule, that within four

or five years a new drug becomes an old drug—which is a crazy idea to me—if that were extended, or if we put it in writing in the law to extend it from four years to ten years on a new drug, you could cut the price after five years by half of what it is selling for now. Do you understand?

Mr. ROGERS: I absolutely do. First of all, if the patent ran for the full 17 years, with no compulsory licencing, there would be no necessity for any action on the part of Food and Drug. You would have full protection, and it would then depend on the type of drug. Supposing it were a widely used drug, for which, as in many instances, the volume goes up, we have reduced our prices, over the past years—which is shown very plainly in appendix no. 1, yes that would be right, because we would be able to reduce the cost when production went up.

Mr. ISABELLE: You would not say by half?

Mr. ROGERS: It would depend; we have reduced some of them by half.

Mr. ISABELLE: Thank you.

Mr. BRAND: Mr. Rogers, what specific product are you talking about in appendix 4.

Mr. ROGERS: Well, there is competition here.

Mr. BRAND: It says here: "...to the best of my knowledge, it is not offered for sale by anyone else in Canada...". Where is your competition?

Mr. ROGERS: I know; but the simple reason is that it is a field of discussion into which I would not want to enter at this time. I will tell you on your own, doctor.

Mr. BRAND: That is fine. I just wondered why it was not mentioned.

According to this you would agree, then, that it is much cheaper to import from the United States, and you can sell this certain product to the Canadian public more cheaply than by producing it in your plant at Brockville?

Mr. ROGERS: This is an absolute fact; but if we get production up so that we can produce it and do it as economically in Brockville as we can by bringing it in and paying the tariff, we will then do it, because this is Parke Davis policy. If we can get it in Canada we will get it in Canada, but we are going to buy the highest quality raw materials wherever in the world they are obtainable at the best price.

Mr. BRAND: Despite that, in order to keep the Brockville plant going and provide a little stimulus to your industry here, you kept producing it in Brockville. Therefore, if it was cost alone you could just bring it in and forget about Brockville, I suppose.

Mr. ROGERS: No. If it is more economical for us to bring it in, we will bring it in, if there is a variation of 70 per cent, as there is in this case; possibly on 10 or 15 per cent, no.

Mr. BRAND: Sir, I noticed you said you had two choices to make, manufacture in Brockville and increase your selling price or import from the United States without increasing your price.

Mr. ROGERS: That is right.

Mr. BRAND: We had a little excitement engendered here a few months ago over one of your products chloramphenicol. One of those who have a compulsory licence to produce this drug made a few statements about it and I wondered if you agreed with it, such as, in your literature and in the Vademecum you point out a lot of the problems associated with improper use of the drug and the statement was made to this Committee that a lot of this was not really true. You did not really believe it. What do you think about the selling of choramphenical or chloromycetin under your trade name?

Mr. ROGERS: We feel that we should give the medical profession in the form of literature, or in the Vademecum, or whatever we tell about the drug, a full disclosure and the side reactions, the dosage and its uses and everything. Tell the whole story and tell the truth. The only way we can do it is to see that the literature gets into the doctors' hands.

Mr. BRAND: Do you think it would be dangerous for someone who did not know about it to use this drug and some of these others produced by another firm, Empire, I believe, is the one concerned, where they do not provide this type of information.

Mr. ROGERS: It could be dangerous if the doctor did not have our information.

Mr. BRAND: Was this not prompted by an incident in the States a few years ago which caused the withdrawal of chloromycetin from the market and investigation to be done by your company before its re-release?

Mr. ROGERS: Chloromycetin has never been withdrawn from the market since it was introduced.

Mr. BRAND: When one of the first compulsory licences for chloramphenicol was granted and it was produced under the trade name, I believe, of mycinol at a lower price, you did reduce your prices accordingly, did you not, to meet this competition?

Mr. ROGERS: We had to, yes.

Mr. BRAND: Did it result in any loss to your company to reduce your price?

Mr. ROGERS: Several millions.

Mr. BRAND: Is this still continuing or are you back making money on chloromycetin?

Mr. ROGERS: We never lost any money but we reduced our profit considerably.

Mr. BRAND: But you still made a profit?

Mr. ROGERS: We still are making a profit on chloromycetin.

Mr. BRAND: At the time you had to do that did you feel that you had recovered enough of the costs of producing this drug to justify this drop in price?

Mr. ROGERS: No. It set us back in Canada from further expansion, and we are just now coming up to the point where we can possibly start to expand again.

Mr. ISABELLE: On the same subject, if you did not lose any money that means that you were making too much money with it.

Mr. ROGERS: No, we lost considerable money.

Mr. ISABELLE: Oh!

Mr. ROGERS: And in losing that money it cut back our expansion plans that we had programmed at that time, and it is unfortunate. We could have expanded into other allied fields which we were not able to do.

Mr. ISABELLE: I thought you were saying that you have made less profit.

Mr. BRAND: Is chloramphenicol one of the drugs that came into Canada under false pretences and was labelled as tetracycline or something?

Mr. ROGERS: That is what I understand. I believe it was the tetracyline that had chloramphenicol in it. It is in the records here some place.

Mr. BRAND: Do you think the standards required under 74GP1 are adequate?

Mr. ROGERS: We do not personally ourselves. We go a little further.

Mr. BRAND: What do you think would be more in line with what you consider quality control? Do you think there are insufficient—I do not know how to phrase this—points required under 74GP1?

Mr. ROGERS: Dr. Brand, I do not feel that there are any of us here who can give you or this Committee a clearcut answer, the answer that you want, to this. I would be very glad to have you discuss this with our quality control manager, Mr. McCalla, in Brockville. I am sure he would even be pleased to come up here and sit down and talk to you some day on this. To get into this whole field, although one should be completely familiar, I am not, but you cannot be familiar with every operation in our plant.

Mr. BRAND: No, I can appreciate that. I was thinking it would be useful for the Committee to have some idea of what additional safeguards should be built into this from the viewpoint of suggestions that this Committee may make in the future in the over-all picture of the cost of drugs and the quality. That is the only reason I mentioned it. Are you familiar with the method used in Britain of granting compulsory licences under the tribunal system?

Mr. ROGERS: No, I am not.

Mr. BRAND: Is any of your staff familiar with it? I can hardly ask any questions on it then, can I, to see whether you approve of it or not? It seems that the drug firms in Great Britain are much more satisfied with that method than the present method of fighting through the courts for the granting of licences.

Mr. ROGERS: I am not in a position to comment, Dr. Brand, although, England is our second oldest establishment after Canada, outside of the United States. We run a fairly autonomous organization. Canada looks after its affairs and lets Britain worry about their troubles. I have not got into a discussion with our people on that at all.

Mr. BRAND: Somebody else can ask a question now. I have finished.

Mr. HOWE (*Hamilton South*): I was just going to say, in line with what you said on chloromycetin that you had to reduce your profit and this prevented

expansion, in reverse would you say that when a patient buys a drug they are subsidizing the future expansion of your drug company.

Mr. ROGERS: I think when you buy anything today you are helping the industries to expand in this world whether it is milk, eggs, automobiles, or what it is. This is a free economy. You go out and sell things to increase production, so it is just as true for drugs as it is for anything else.

Mr. ENNS: Well, mine is mostly an explanation of terms I suppose. In your very readable 99th Annual Report, and I suppose one should congratulate you on being in your centennial year as far as the company is concerned which is no doubt a tribute to the record of public service your company has provided. On page 1 of the brief at the bottom line you speak of the return of 4.3 per cent on the investment, and then on Appendix 2 on page 20 again at the bottom, you speak of the net income on earnings as 4.09 per cent. In the Annual Report you speak of the net earnings as being 14.2 per cent. This might be apples and oranges that are being confused.

Mr. ROGERS: No, that report that you have, is for Parke, Davis and Company, that is the parent Company, and it was put in there as a courtesy to this Committee.

Mr. ENNS: Oh, I see.

Mr. ROGERS: As the American parent it owns the entire world operation of Parke, Davis. That is our entire disclosure to our stockholders, and it is put here strictly as a courtesy to this Committee. The profit shown here in Canada of 4.3 per cent on investment is our return for our Canadian operations: that is Parke, Davis and Company, Ltd. Because there is criticism that money goes back to the parents in various nefarious ways. This is not so with Parke, Davis and Company. All is done within the laws of the land. Any money that Detroit gets has been earned according to the tax structures of this country. These incidentally have been audited by the revenue department.

Mr. ENNS: Yes. Does it follow then that the Canadian operation is less profitable than the American one if there is an earning of 14.2 per cent, in the total parent firm operation, and yet, in the Canadian structure there is only 4. some per cent? Is this an indication or a reflection of a less profitable operation in this country?

Mr. ROGERS: Well, actually, that is right. The profit is around 11 per cent but we do pay income taxes of 6.86 per cent leaving our 4.9 per cent as net profit.

Mr. ENNS: I refer to Appendix No. 1. I thought this was a very interesting comparison you had at the bottom, which says, the above, "referring to the tables above", represents an average hourly increase of 46.6¢ or 28.8 per cent, in the hourly wage rates paid, and your average unit price in this time period had reduced by 23.8 per cent.

Mr. ROGERS: That is right.

Mr. ENNS: So your actual reduction is some 51 per cent really in the over-all picture, is it not?

Mr. ROGERS: Yes, efficiency came into the picture and we were able to—

Mr. ENNS: So in actual fact, over the years, you have been reducing your prices generally speaking, is that right?

Mr. ROGERS: Yes, we reduce them, and we sometimes have to increase them, too.

Mr. BRAND: On the over-all picture, you have reduced the prices?

Mr. ROGERS: Oh, yes.

Mr. BRAND: Despite the fact that our economy has gone skyrocketing? I think that is very commendable. It is a feature of this report with which I was very impressed. It is one of the few I have seen like this.

Mr. HOWE (*Hamilton South*): Your promotional costs on drugs in per cent in Appendix 2 on page 20, adding up what I consider to be promotional, come to 6.73 per cent. I do not see any allowance there for your detail men.

Mr. ROGERS: That is covered by marketing salaries. It actually comes to 18.9 per cent, if you consider all the promotional costs.

Mr. HOWE (*Hamilton South*): Eighteen point nine?

Mr. ROGERS: Yes, 18.9 per cent. If you add marketing salaries, marketing travelling and so on.

Mr. HOWE (*Hamilton South*): I see. I did not see that.

Mr. ROGERS: It includes samples, including stock packages, representatives' equipment—all that adds up to 18.9 per cent.

Mr. HOWE (*Hamilton South*): Therefore, yours is considerably less than the P.M.A.C. average of around 30 per cent?

Mr. ENNS: That was not average, was it? They said that in some cases it goes up to 31 per cent, but we have heard witnesses give us a figure well below that 30 per cent.

Mr. HOWE (*Hamilton South*): Yes, but I said "average". We have seen 29.9 from individual drug companies, and the Hall Commission Report, as you likely know, recommended this could be done at 15 per cent. You certainly approach that closer than anybody else has, and yet other drug companies have denied that they could sell their drugs economically without using approximately 30 per cent as their over-all promotional value. Yet you apparently have done it very successfully at 18.9 per cent.

Mr. ROGERS: You must remember, Dr. Howe, that we are 100 years old, and we have been 79 years in Canada. Have you ever had a detail man take a piece of literature in an spend his time talking to you about adrenalin?

Mr. HOWE (*Hamilton South*): No, that is true, with adrenalin. But you still come out with new drugs and you still have to promote the sale of new drugs. You still have to compete. You must be doing quite a competitive job on chloromycetin, too. Even though it is well-established, you mentioned the competition itself, so you have to do a selling job on that. Yet, apparently, with the obstacles you have been up against you are still able to keep this within a reasonable figure compared with some of the other drug companies, so you demonstrate the fact that the 15 per cent the Hall commission report suggests could be feasible, as you are so close to it.

Mr. ROGERS: It possibly could be feasible for us, but I would not want to have to live under such a law. Suppose we brought out two—this is really dreaming—outstanding drugs in one year. This would not be our figure. It would be up, I would say, considerably. We would have to spend additional promotional money on these two drugs in one year.

Mr. HOWE (*Hamilton South*): In other words, you have not brought out drugs recently which required this—

Mr. ROGERS: Yes, but they are only coming one at a time over a long period. You see, we have 375 items in our catalogue. I know I should be taking a bow that we are doing what the government thinks we should do, but this is not the case, because we would not want to work under any limitations.

Mr. HOWE (*Hamilton South*): You would not want to be bound by it.

Mr. ROGERS: No, absolutely not.

Mr. HOWE (*Hamilton South*): Even though you are able to do it under ordinary circumstances.

Mr. ROGERS: Our marketing people might give us a wrong forecast of our anticipated sales, and the cost that we set aside for promotion and advertising and so on would then be thrown away out, and we would be penalized in the tax field.

Mr. HOWE (*Hamilton South*): Let us say, if other drug companies did it, would it make it more feasible for you to be able to?

Mr. ROGERS: By law?

Mr. HOWE (*Hamilton South*): I do not see where this enters the picture, but let us put it on a voluntary basis for the sake of the question.

Mr. ROGERS: I am sorry, I could not speak for the other drug companies.

Mr. HOWE (*Hamilton South*): I said, if the other drug companies did, could you? You would have less to go down than the others, so you would be more likely to be able to.

Mr. ROGERS: I think we would try to run our business the way we have in the last 100 years. Regardless of what the other people do we try to run it our way.

Mr. HOWE (*Hamilton South*): I just said, could you or would you, if the other drug companies did, that was all.

Mr. ROGERS: I do not know.

Mr. BRAND: What you are saying, Mr. Rogers, is that the matter is an extremely individual one. Is that correct?

Mr. ROGERS: That is right.

Mr. BRAND: And as such, to have an arbitrary figure set would impose great difficulties on the industry generally?

Mr. ROGERS: That is my personal feeling.

Mr. MACLEAN (*Queens*): In Appendix 2, you start out by saying, "During 1965 we invoiced our customers a total of $9,444,757" and so on. On what

percentage of this was sales tax paid, or why is the percentage of sales tax 5.79 per cent of total sales?

Mr. ROGERS: Generalizing, Mr. MacLean, a large percentage of our business goes to hospitals where there is no sales tax. We do not collect sales tax for the government from the hospitals. Then we work on a formula, due to the fact that we do our own distribution. Another company's products may go out through a wholesale and give their price less their regular discount, less the wholesale allowance, and they pay to the government the tax on what they charge the wholesale. Since we do our own wholesaling or distributing, we work on the formula 8.374 of our invoice on taxable merchandise; that is, to accounts where we must collect the tax, but not from hospitals or anyone who is tax-exempt.

Mr. MACLEAN (*Queens*): Do you do your own distribution entirely, os is some of your distribution done through wholesale companies?

Mr. ROGERS: Approximately, 10 to 12 per cent of our merchandise goes through wholesales, across Canada.

Mr. MACLEAN (*Queens*): I notice that your main manufacturing plant—perhaps your only one—in Canada is in Brockville. Originally, I believe you manufactured in Walkerville?

Mr. ROGERS: That is right.

Mr. MACLEAN (*Queens*): Is it a fair question to ask what were the deciding factors as to the location in the first place, and the relocation in the second place?

Mr. ROGERS: The first location in Walkerville, goes back to 1879 or so, and I do not think we can answer that one. But it was right across the river from Detroit, so I suppose that they were almost mirror images, its convenience, closeness. And Brockville is mid-point, we feel, in a real fine community between two of our largest markets, and we have reduced the transportion on merchandised items considerably. We have not, really, because the transportation rates keep going up, and we have to just keep going to keep ahead of the increases.

Mr. MACLEAN (*Queens*): I have a question which is a very general thing, but quite a bit of attention has been given to the possibility of retaining in Canada the manufacture of a higher percentage of the drugs consumed in Canada, and the general desirability from an economic point of view of manufacturing our own needs in Canada generally, including drugs.

To accomplish this such things as patents, duties and so on are required. Is there any possibility that, as a result of this, the manufacturing of drugs and drug research might spread from central Canada to such places as British Columbia or Saskatchewan, or Newfoundland if you like? This is, perhaps, a political problem, but people in the other eight provinces get very tired of being under the impression that they are paying extra for drugs so that they will be manufactured in Canada—whether that is correct or not—eternally for the benefit of the economy of two provinces, in this case.

Mr. ROGER:: Mr. MacLean, I do not know of anyone in this room who has more sympathy for you on that statement than I have, being a Saskatchewan farm boy. I have often thought the same thing. But it is an economic factor, Mr. MacLean.

Mr. MacLEAN (*Queens*): It is too great to expect it to be overcome?

Mr. ROGERS: The economic factor?

Mr. MacLEAN (*Queens*): Yes.

Mr. ROGERS: I believe so, owing to the way our population is spread out, the vast areas we have in Canada. I think that research can be carried out any place, but there must be a climate for it; you must be close to universities and other research centres, so that there can be an exchange of information. These people are working with only one commodity and that is brains, and they like to have a lot of other researchers around to transfer information, and naturally that is why research centres tend to go to large university centres.

Mr. MacLEAN (*Queens*): But there is development of the chemical industry in places like Alberta—I am thinking now of industrial chemistry—and there is a growth in the scientific population, if you like, of highly trained scientists in some other areas in Canada. Now there are good universities in most provinces, and so on.

Mr. ROGERS: I would not want to make any prediction on that whatsoever, but I presume that if our population ever got up to the 100 million that we would have pharmaceutical companies spread all over Canada; however, distribution is the main problem.

Mr. MacLEAN (*Queens*): The population in the United States is nearly 200 million, or something around that figure, is the drug research and manufacture centred in one area of the United States or is it now becoming more widely spread. Do you happen to know?

Mr. ROGERS: Well it is fairly widely spread and it always has been to a degree. Naturally, the original growth was in the east, in the New York area; but I just noticed in a news clipping the other day that the second oldest biological firm is located in California. We are the oldest in the United States, and the Cutter people in California; they have been there for many years. There are firms in Chicago, which is considered naturally the midwest of the United States. We in Detroit, when we started there 100 years ago, were considered upstarts; they would not even let us into the New York market.

Mr. MacLEAN (*Queens*): In the annual report of the parent company I notice that in Australia your research laboratories are in a place I never heard of, I must admit, but I presume this is a suburb of some large city.

Mr. ROGERS: No, this is specialized research in the field of animal husbandry, concerning sheep particularly, and there is no place in the world where there are more sheep in one place than in Australia. That is the type of work we are doing there, and climate; that is why we are there. You might say climate, and not weather, but the factors are right for that kind of specialized research.

Mr. MacLEAN (*Queens*): I think I will pass for the moment.

Mr. HOWE (*Hamilton South*): Was the move to Brockville made because of the savings in transportation costs or were there other factors?

Mr. ROGERS: Actually, this is just from the top of my head, I was an ordinary salesman you might say in those days when the move was made, but the reason is that there were other factors, for instance, the climate, the people.

You see our industry is not like putting hub-caps on automobiles and things of that nature; you have to have a different temperament of person, and we felt that the farm community around Brockville and the various areas there were ideal and the fact that it is between Toronto and Montreal. There is an ideal type of person there for this type of work and there is a ready, available market for labour in that area too; it is one of the finest in Canada.

Mr. MacLean (*Queens*): I would think, as a layman, that perhaps in the drug industry transportation distribution costs would be lower per dollar of value than almost anything you could think of; is this true?

Mr. Rogers: Our transportation costs were 2.73 per cent of our total sales last year. Now I cannot compare that with groceries, sugar and so on. We do prepay all our merchandise, whereas for example, if you were to buy a ton of sugar you would pay for the freight on it from Montreal to Brockville; so I could not give you any comparison.

Mr. MacLean (*Queens*): Now, in Appendix 2 there is no separate mention of the cost of research in this—I suppose that is included in the first item, the cost of goods sold.

Mr. Rogers: That is right, that is the figure we gave here a few moments ago.

Mr. MacLean (*Queens*): Yes.

Mr. Rogers: It is in there, yes.

Mr. MacLean (*Queens*): Now, what is the amount of research done by your company as compared with this figure of $9 million and something. How does that ratio compare with the amount of research done by the parent company or by some other subsidiaries in other countries.

Mr. Rogers: We get a real gift from the parent company in Canada. Our charges are less I think than a lot of them, and they really give us a break on our research.

Mr. MacLean (*Queens*): In other words, you benefit economically and the consumers of drugs in Canada benefit economically from research that is done by the parent company in the United States or somewhere else.

Mr. Rogers: That would be my understanding in comparing these figures.

Mr. Brand: Would you agree that the generic firms sell some of these products a lot cheaper than the others, the P.M.A.C. group for example.

Mr. Rogers: Yes, they do. I am speaking for ourselves.

Mr. Brand: Now, what do you suppose would be the result if we made it feasible for such generic companies to sell as much as possible in Canada, what do you think would happen to the large P.M.A.C. group?

Mr. Rogers: In five years I would not be here.

Mr. Brand: I suppose that would mean something to the rest of the industry as well.

Mr. Rogers: That is right.

Mr. BRAND: Do you think the generic companies would be able to handle say the—how many products is it you have, 300 and some products—would they be interested in manufacturing all these, would you say?

Mr. ROGERS: To date they have only been interested in one or two.

Mr. BRAND: Is there a reason for this?

Mr. ROGERS: Volume of business; ease of marketing to hospitals, government sales, and so on.

Mr. BRAND: So you believe that the end result would be that the drug industry as such, with the research and all, would be disappearing in the next few years?

Mr. ROGERS: Bluntly, it would be catastrophic to the people of Canada.

Mr. BRAND: Have you ever done any comparative studies on the various products produced by these other firms on the compulsory licence, say chloramphenicol as an example, comparative studies as to quality or *in vitro* studies or anything of that nature?

Mr. ROGERS: Under compulsory licence?

Mr. BRAND: Yes.

Mr. ROGERS: Yes we have.

Mr. BRAND: Have you any results of any of these?

Mr. ROGERS: Not available.

Mr. BRAND: Not available at all? Why not?

Mr. ROGERS: The only one studied was chloramphenicol, and on chloramphenicol at the present time I think we have four of five cases pending on litigation and we would not want to divulge any results of these things at this time.

Mr. BRAND: Do you deal with governments; that is, sell to governments?

Mr. ROGERS: Yes, definitely.

Mr. BRAND: What has been your experience in selling to the Canadian government; do they buy just on price alone, or what?

Mr. ROGERS: Yes.

Mr. BRAND: Do they make any inquiries as to quality of the products or are any particular studies done say by the Department of National Defence, or whoever purchases for them.

Mr. ROGERS: Not to my knowledge, as long as you qualify for GP741A. There may be tests done but not to my knowledge; however I am not saying they do not, because I do not know.

Mr. BRAND: There have been some persistent rumours that some of the drugs purchased by the armed forces and used by the armed forces have been proven to be of such quality that they have been quietly flushed down the various service toilets particularly in Europe, because they were completely unusable. Have you any knowledge of this?

Mr. ROGERS: It is only hearsay.

Mr. BRAND: Then you have heard the rumours as well as I have.

Mr. ROGERS: This has been reported by our salesmen.

Mr. BRAND: By your salesmen, where?

Mr. ROGERS: In Canada.

Mr. BRAND: They do seem to buy on price without particular regard as to the absolute quality of the nature of the drug. Do you think this is a good thing?

Mr. ROGERS: I think that they should have *in vitro* studies and *in vivo* studies as well.

Mr. BRAND: Thank you, that is the point I wanted to make.

Mr. ISABELLE: Do I understand that the hospitals throughout Canada are sacrificing quality for price by buying generic drugs because I know that some of the generic drugs are nearly poison, but nevertheless—

Mr. ROGERS: I think I would have to fairly state that the majority of the hospitals are very conscious of their obligation to the medical profession and the patients and in most cases they will buy a high quality—

Mr. ISABELLE: Generic or—

Mr. ROGERS: Of our manufacture, but it does occur on occasion and I do not think we could give you the names. Most of the hospitals we find have been most fair.

Mr. HOWE (*Hamilton South*): Do you sell at a lesser price to the government than you do generally?

Mr. ROGERS: We sell on tender to the government.

Mr. HOWE (*Hamilton South*): Does the price work out to be less than the general—

Mr. ROGERS: On occasion it does. It is a highly competitive field. We come to a breaking point where we stop. I can tell you that we do not get too much government business because we stop bidding fairly high.

Mr. HOWE (*Hamilton South*): What percentage of your business is government business?

Mr. ROGERS: Federal? Less than 1 per cent.

Mr. HOWE (*Hamilton South*): Negligible.

Mr. ROGERS: That is right.

Mr. HOWE (*Hamilton South*): In other words, you will not sell just on price alone?

Mr. ROGERS: Heavens, no! Quality only.

Mr. LAIDLAW: There is a vary interesting statement, at least to me, on page 14 of the brief, Mr. Rogers, which reads as follows:

> For almost any means of treatment, patented or unpatented, there is an alternative or several alternatives.

Mr. Rogers, the Committee has been told repeatedly that each drug in itself, regardless of who is the manufacturer of the drug, has a specific purpose and

although the drug may have the same type of molecular structure, nevertheless, the dilutant which is put in it or what it is mixed with has also an effect which varies from patient to patient.

Now, if your statement is true, am I not correct in saying that perhaps the high cost of drugs in this country is because of the intense competition between the drug firms? Am I also correct in stating that perhaps the drug industry is different from any other industry because an intense competition raises the price, where under our free enterprise system which we have in Canada generally the price becomes lower?

Mr. ROGERS: On the first one, Mr. Laidlaw, we are talking about two different things. We are talking about a therapeutic class, that is to say, that there is an alternative. Suppose I have an allergy for about six months or a year the only antihistamine available to the medical profession in Canada was Benadryl and now I suppose there are two dozen on the market or maybe more. The doctor has a choice; he can use our Benadryl or he can use these other products. So, if that is not competition I would like to know what it is. Competition has reduced the cost of drugs in Canada.

Mr. LAIDLAW: It would seem to me that the intense promotion which is carried on by the various drug companies—and the figures seem to prove this out—is raising the price because of the additional money spent.

Mr. ROGERS: Not in Parke, Davis.

Mr. LAIDLAW: I would like to refer to page 22 of the brief if I may Mr. Chairman, and the question that has been well set out here of why a certain product is imported into Canada rather than manufactured in Canada. I assume that this particular product is patented in the United States and you have the licence for this product in Canada. Am I correct?

Mr. ROGERS: The parent, Parke, Davis, holds the Canadian patent for this product.

Mr. LAIDLAW: If your Canadian company holds the patent you are aware of course that under Section 67 of the Patent Act you are required to manufacture the product within three years. After a period of three years goes by that patent can be impeached.

Mr. ROGERS: I am not aware of that.

Mr. LAIDLAW: How long has this particular product been patented in Canada?

Mr. ROGERS: Not too long. We can manufacture it in Brockville any time we want to.

Mr. LAIDLAW: It is just question of cost?

Mr. ROGERS: It is a question of economics. If you want to pay more money for this we will manufacture it in Brockville.

Mr. LAIDLAW: Do you realize that there may come a time when you will be faced with this particular provision in the Patent Act, that you will be required to manufacture here or you will lose your patent?

Mr. ROGERS: I presume our patent attorneys are aware of this. I cannot discuss this because I do not know.

Mr. ISABELLE: You have manufacturers in Japan; you have two, I think, in Tokyo.

Mr. ROGERS: Yes.

Mr. ISABELLE: Now, is that for domestic use.

Mr. ROGERS: That is for domestic use in Japan.

Mr. ISABELLE: They cannot export.

Mr. ROGERS: No, not to my knowledge. It might be exported to Korea or some place but I do not know.

Mr. LAIDLAW: Mr. Rogers, it has been stated several times before the Committee that if more research was done in Canada, and which probably would be done if the Patent Act were strengthened, this would improve the export situation from Canada. Now, I am asking you if this is in fact possible, because of the international patent system. In other words, you could not export to the United Kingdom because your sister corporation in the United Kingdom has that particular market, and so on. Do you have any comments to make on that point?

Mr. ROGERS: Well, I have often looked at this. We have so many plants all over the world I just do not know where we would export to.

Mr. LAIDLAW: Well, this is my point—you have made it precisely. The international patent system prevents, to a great extent, the possibility of exporting Canadian drugs elsewhere in the world.

Mr. ROGERS: But, if we had a Canadian product—I think the Ayerst people gave a fine example here. At one time we use to export all the Cascara from Canada to all our locations in the world. We extracted and exported it from here. In the early days of natural vitamins, when Vitamin "B" was from wheat germ, we extracted our wheat germ in Canada. But you can synthesize a chemical just as well in Hounslow, England as you can in Brockville, Ontario.

Mr. LAIDLAW: Thank you very much, Mr. Rogers.

Mr. HOWE (*Hamilton South*): Mr. Chairman, may I ask one question? In every instance, as far as the ultimate retail price of the drug is concerned, does it pay to manufacture what you do manufacture in Canada?

Mr. ROGERS: Oh, definitely.

Mr. HOWE (*Hamilton South*): Everyone of them pays. There would not be any instance where importing rather than manufacturing them would be cheaper?

Mr. ROGERS: I cannot make a blunt statement "Yes" on that because we review these every six months.

Mr. HOWE (*Hamilton South*): So those which are cheaper to manufacture elsewhere are as a general rule done and imported.

Mr. ROGERS: Yes, in a very small lot. There may be a reason for this—they are hard to handle, contamination and special facilities which we do not have in Brockville which would have to be built at a tremendous cost. It is much cheaper to bring them if from our parent company. It is only a little over 8 per cent, which is pointed out in our Appendix 3.

Mr. HOWE (*Hamilton South*): But that is not the general rule. With respect to the ones which are manufactured here, there is an economic reason for doing so?

Mr. ROGERS: Oh, yes.

Mr. ISABELLE: Do you sell this product which you are manufacturing in Brockville at the same price in Vancouver and in Ottawa?

Mr. ROGERS: Absolutely, and in Brockville, too.

Mr. ISABELLE: You absorb the transportation.

Mr. ROGERS: That is correct.

Mr. MACLEAN (*Queens*): I have a couple of supplementary questions. Could you say in general terms what part of your business is devoted to prescription drugs and what part is devoted to over the counter drugs, of your total sales?

Mr. ROGERS: I cannot give you an exact figure on that because we have some real borderline ones. They just fit into two categories and it would be very hard. Actually we have never done an exact study of that. Let us take a product like hydrogen peroxide which has been made for I do not know many years, well doctors use that product in their offices, hospitals use it and lay people buy it over the counter in the drugstore. So, it is pretty hard for us to determine. We do not know where it is going once it goes to the retail pharmacy. We know when it is going to the hospital that it will be used by the medical profession and the nurses in the hospital. But, when it goes to a drugstore do they send it to the doctor's office or does a lay person purchase it?

Mr. MACLEAN (*Queens*): Well, perhaps I can put my question in different terms. What percentage of your business is devoted to pharmaceuticals that can be given only by prescription? I just want a very rough figure.

Mr. ROGERS: I would say about 75 per cent. That is a rough estimate, too; please do not hold m to that one.

Mr. MACLEAN (*Queens*): Now, with regard to the research aspect of your operation, I suppose you supply new drugs that are still in the research stage to research institutions, universities and this sort of thing.

Mr. ROGERS: We started our first research in this division in Canada in 1932, and at the present time we have 11 compounds under investigation in various clinics and with physicians who are connected with university centres and hospitals. There are 11 under study in Canada at this time.

Mr. MACLEAN (*Queens*): Have you any drugs you have developed, which are useful in the treatment of uncommon diseases, which you manufacture and distribute at a loss because their cost of manufacture is high and the market is very small?

Mr. ROGERS: From my point of view we have too many.

Mr. MACLEAN (*Queens*): But you do have them?

Mr. ROGERS: We have lots of them.

Mr. MACLEAN (*Queens*): Now, I have a question that has been asked before, I think, of nearly every witness that has appeared before the committee. You

have not been asked it yet. So, I guess I will ask you. In the light of your distribution system could you give a specific example of the effect on the retail price of one of your products if the federal sales tax was removed?

Mr. ROGERS: You would almost have to choose an over the counter, product let us say, an O.T.C. product. This is the way you would look at it. In our pricing structure, our catalogue, let us say, this item lists for $1. The druggist then receives a 40 per cent discount. It costs him 60 cents. Immediately on an order in council, or whatever it takes to remove the 11 per cent sales tax, we would then reduce our list price, I presume, in this case, by 10 per cent. 89 cents is rather an awkward price but we might even go to the 89 cents. Let us say it is 10 per cent. One of your members said he would rather talk of 10 per cent than 11 per cent because 10 per cent works out easier. Then our list price would become 90 cents and it would cost the druggist 54 cents and the consumer would pay 90 cents for it. But as in this brief, if this ever happens, the people of Canada must be informed about this by the government of Canada, that they cannot expect price reductions immediately because we cannot retrieve the sales tax that has already been paid to us because the government has it, and we cannot get it back from them, to give back to the druggist.

Mr. MACLEAN (*Queens*): You mean there will be a transition period?

Mr. ROGERS: That is right. There should be, in fairness to the retail pharmacist.

Mr. MACLEAN (*Queens*): Yes, until his present stocks are sold. But, after that, the full benefit would accrue presumably.

Mr. ROGERS: Well, that is what we would hope.

Mr. BRAND: Mr. Chairman, in view of the fact we have heard a lot over the past few meetings of this committee regarding compulsory licences and a lot of different views, perhaps biased in a sense, and naturally so, and in view of the fact that we have not so far before us anyone that is familiar with the tribunal system of setting up compulsory licences in Britain, would it be possible, since these are the ones who make the decision, to have some person from this tribunal appear before the committee? I think it is of utmost importance and I can carry this a little bit further. I do not know about the propriety of this, but in this country the people who make the final decisions on this matter are justices of the Supreme Court of Canada. What possibility is there of having before us as witnesses one or two of these judges who have made decisions along these lines to see what leads them in their interpretation of this to grant compulsory licences.

The CHAIRMAN: I am not a lawyer but I doubt—we could probably ask Mr. Laidlaw—whether you could get a justice of the court before a Committee to answer questions as to why he did such and such a thing. I think this would be highly unethical.

Mr. BRAND: I was not thinking of just why he did it but the mechanisms which in his interpretation, since they make the decisions, lead to this type of decision. That is all I am interested in. Otherwise how are we going to know except from a prejudicial viewpoint from either side.

The CHAIRMAN: Somebody wants to make a comment but first I will make two comments. First of all, I think the day that one of the drug companies was before us, Hoffman-LaRoche, they did have a gentleman here who had come all the way from England, who did make some comment on this during his presentation and during the questioning, Mr. Hunter. As of Tuesday this gentleman was still here, I know.

Mr. BRAND: I quite realize this. I was suggesting someone from the actual tribunal.

The CHAIRMAN: The other person we might wish to call would be the Commissioner of Patents in Canada.

Mr. HOWE (*Hamilton South*): Mr. Chairman, may I suggest in lieu of this or move, as the case may be, that you call a meeting of the steering committee to decide on our future witnesses.

The CHAIRMAN: I think on the 1st of December we do not have a meeting scheduled and it had been my thought this might be a good day to get the Committee together to have an in camera meeting to just decide what further witnesses we should call and what direction we should pursue it further.

Mr. BRAND: I do not see anything improper at all about calling a judge of the Supreme Court before this Committee.

The CHAIRMAN: Would someone like to comment on that?

Mr. JOHN M. GODFREY (*Legal Counsel, Toronto*): There has just been a case reported which I saw for the first time a couple of days ago. It was a Hoffman-LaRoche case. Although it was decided some months ago it has just recently been reported. The Supreme Court of Canada—I have only read it through once—in effect said "we will not try and set what the royalty is; that is the job of the Commissioner of Patents, unless he has proceeded on wrong principles the onus is on somebody else, then we accept his royalty." In that particular case, although the drugs were being sold at retail by Hoffman-LaRoche, the Commissioner of Patents established a price of 15 per cent on the bulk price and not on what they actually sold. If they ever sold in bulk they would get a royalty only on that bulk price which is much less than they would sell to the wholesaler. But the Supreme Court of Canada did not specifically go into the point. They said that is the job of the Commissioner of Patents and only if he proceeds on the wrong principle and we cannot say he did in this particular case, so they really touch on the point.

Mr. LAIDLAW: Mr. Chairman, that was strictly interpreting the statute as it is now. The interpretation now is settled and it can only be changed by amending the statute by legislation. But in the case the judgment is quite clear, it strictly interprets section 41. There is no leeway in it now as I understand it and I am sure Mr. Godfrey would agree with me, that the law is now settled on that point unless it were changed by legislation.

The CHAIRMAN: Would you care to comment on the question whether a justice should come to the Committee? I should say to the Committee that because the Hall Commission report goes deeply into the question of costs we did invite Mr. Justice Emmett Hall to appear before this Committee and he

said it was not the practice to appear before the Committees, as the report spoke for itself.

Mr. BRAND: I think, however, practices have been changed in recent times.

The CHAIRMAN: Would you care to comment on that?

Mr. LAIDLAW: I would agree with you, Mr. Chairman. It is a case of trying to ascertain what went on in the Justice's mind at the time he was writing his judgment and I do not think that would be appreciated.

The CHAIRMAN: I suggest that the Chairman will call a meeting of the steering committee to consider all these problems.

Mr. BRAND: The opinion, as I pointed out, is exactly what we are getting now, opinions on two sides of the matter. I would like to hear it from the horse's mouth.

Mr. HOWE (*Hamilton South*): Could you call this steering committee meeting fairly soon because if we are running out of witnesses at the end of this month it will take us a while to re-organize.

The CHAIRMAN: No, we are not running out of witnesses. The list I gave you only went to the end of November. We are now up to at least the 15th of December, with witnesses. I am afraid the list of witnesses is going to go on forever rather than come to an end.

Mr. ENNS: Should we not look at this to see at what point we are gaining new information. Surely there might be many that want to appear but if we are not going to be helped or informed by the new witnesses, then perhaps we should be more selective as we have heard more and more witnesses.

The CHAIRMAN: If it is the wish of the members of the steering committee, who are actually here, we could call a steering committee meeting for 10 o'clock tomorrow morning. Dr. Howe and Dr. Brand, would you care to have a steering committee meeting tomorrow morning at 10 o'clock?

Mr. BRAND: What day is tomorrow?

The CHAIRMAN: Friday.

Mr. BRAND: All day? That interferes with my French lesson, but it would be un grand plaisir M. le President.

Mr. ENNS: Dr. Isabelle just made a comment that might be of some help or some use to us, and that was to hear from pharmacists because there are different retail prices on similar products.

The CHAIRMAN: The pharmacists have already made a presentation.

Mr. ENNS: I know that, as an association they have, but is that as good as you can do?

Mr. HOWE (*Hamilton South*): Mr. Chairman, would it not be wise for people on this Committee to make suggestions to their representative on the steering committee rather than extend this meeting with suggestions?

The CHAIRMAN: Yes. Are there any other questions of the witnesses?

Mr. MACLEAN (*Queens*): I have one that I am afraid may be a bit naive but which I would like to pose to Mr. Godfrey. The Patent Act includes patents

of all descriptions and section 41 deals not only with drugs and pharmaceuticals but with foods and so on. Would it be considered advantageous by the industry if there were a separate section in the Patent Act dealing with pharmaceuticals only, so that any peculiarities of the problems involved in the patent of processes and patents of any sort having to do with drugs, could be separately dealt with so that many things which do not apply to other types of patents would not be confusing the legalistic problems involved.

Mr. GODFREY: I have never really given it that much thought but I would not think it would be an advantage to separate foods and pharmaceuticals. Thinking of them both separately some things that might apply to foods would not apply to drugs.

Mr. MACLEAN (*Queens*): There might be justification for having a different procedure, for example, in the patenting of pharmaceuticals that might apply to foods or something else.

Mr. GODFREY: You would not get the enormous research costs in food that you do in drugs.

Mr. MACLEAN (*Queens*): I have the impression—I am not a lawyer—that you have in the same basket apples and oranges sort of ad infinitum in the Patent Act, and it must be extremely difficult to draw legislation, as has been attempted here, which will have the desired effect on each category of product.

The CHAIRMAN: Are there any other questions of the witness? If there are no other questions, we would thank Mr. Rogers and his associates for appearing before us and presenting their brief this morning.

Mr. ROGERS: Thank you very kindly Dr. Harley, for the great courtesy that you and your Committee have shown to us. Although an invitation to visit our facilities in Brockville which are only 65 miles from here is mentioned, in the brief I would like to restate it, particularly for the younger members of this committee. We would like you to come as a group or individually. Come any time without warning because the place is always clean.

The CHAIRMAN: Rather than the younger members you mean the newer members?

Mr. ROGERS: Actually I should have said that because some of the older Committee members have seen our plant.

The CHAIRMAN: The meeting is adjourned until Tuesday when we will have before us the Empire Drug Company.

BRIEF FOR PARLIAMENTARY COMMITTEE ON DRUG COSTS AND PRICES BY PARKE, DAVIS & COMPANY, LTD.

Montreal, Quebec

Mr. Chairman and Members:

This submission is presented to the committee by Parke, Davis & Company, Ltd. We have been specifically asked to comment on research, patents, and drug costs, and will endeavour to direct our comments towards these most important subjects. Before going further, we would like to assure you that we are fully aware of the responsibilities of your committee and are most willing to be of assistance to you.

Parke, Davis & Company, Ltd. maintains its Canadian Head Office in Montreal, with manufacturing facilities in Brockville, Ontario, and sales branches and warehouses in Montreal, Toronto, Winnipeg, Edmonton, Vancouver, and we have a distributorship in St. John's, Newfoundland. The company is a wholly-owned subsidiary of Parke, Davis & Company, Detroit, Michigan.

The property and buildings at our locations are owned by Parke, Davis & Company, Ltd., with the exception of the Edmonton and Vancouver branches, where we rent our premises.

As of December 31, 1965, our total investment in Canada was $8,959,000., and the net earnings (as shown in Appendix "2") of $386,130 for that year, show a return of 4.3 per cent on this investment.

We employ approximately 400 people, and practically all of these people, including management, were born and educated in Canada. The few exceptions would be those people who have recently arrived in this country from other parts of the world. In 1965, we paid to our employees the amountt of $2,012,669. in salaries and wages. In addition, the company provided employee benefits at a cost of $124,644. These included unemployment insurance; group life, accidental death and weekly sickness and accident insurance; workmen's compensation; hospital, surgical, medical and comprehensive (including drugs) premiums, and retirement plan programs.

We recognize the needs of the communities in which we are located, and we are proud of the calibre of our facilities. Our manufacturing plant at Brockville is one of the finest in the country. We extend to you a hearty invitation to visit our Brockville plant where you will be able to see, at first hand, a complete pharmaceutical manufacturing operation.

Our operations are such that we make our own decisions regarding products and marketing planning. It is also our decision as to where we purchase our raw materials as long as they meet our rigid quality control standards. Our Brockville operation employs approximately 50 per cent of our total personnel. The remainder are located across Canada in the fields of distribution and selling.

One of the founders of Parke-Davis was a physician, pharmacist and chemist. He founded this company, one hundred years ago, for the purpose of manufacturing quality pharmaceuticals. The quality of our products is of the highest standard, and this standard is maintained through rigid quality control

methods. Not only are the products of our manufacture subject to quality control, but also all printed literature, promotion material and our advertising.

RESEARCH

It is rather difficult to discuss research without involving the parent company which, this year, is celebrating its hundredth anniversary having been established in October of 1866 in Detroit, Michigan. Just twenty-one years later, in 1887, we began our first manufacturing operations in Canada. This makes Parke-Davis the oldest pharmaceutical firm in Canada—a fact of which we are very proud. We went on full-scale production in January 1 of 1891 in Walkerville, Ontario. We remained in Walkerville until 1956 when we opened our present manufacturing facilities in Brockville, Ontario on June 15 of that year.

From its very inception our company has been oriented towards research. In those early days, medical research was not devoted to chemical synthesis, gland function or biological therapy. Botanical drugs engrossed the attention of physicians. Our efforts were directed, for many years, to the discovery and study of these agents.

We sent expeditions all over the world. One of the earliest was to the Pacific Northwest, including British Columbia, and in 1877, we introduced Cascara Sagrada, still a widely-used drug. The world's source of supply is still the Pacific Coast, ranging from Northern California to mid-British Columbia. As well as discovering new drugs, possibly the greatest step forward was in 1879 when we introduced CHEMICAL STANDARDIZATION for drugs. In 1897, we introduced PHYSIOLOGICAL STANDARDIZATION. In 1901, we established the first organized systematic method of subjecting medical agents to CLINICAL PROOF before marketing them. These three steps introduced by Parke-Davis are now recognized as "musts" by reputable manufacturers before any pharmaceutical preparation is offered for sale.

In 1893, we introduced "DESICCATED THYROID GLANDS" which is still widely used by the medical profession. In 1894, we were the first to manufacture and market biologicals on a commercial scale in North America. We hold biological license No. 1 in Canada as well as in the United States. Parke-Davis manufactures many life-saving vaccines and serums and the search continues for new biologicals.

Prior to 1900, our research was not carried out under one roof. In that year, it was realized that something more elaborate and complete was needed in the way of a research laboratory and we established the first research laboratory for industry in the Western Hemisphere. This laboratory was completed in 1902, and has been enhanced by the addition of new research facilities at Ann Arbor, Michigan.

These laboratories are augmented by research facilities in Hounslow, England, Mittagong, Australia, and Rochester, Michigan. These are among the finest homes of science throughout the world.

Transfer of research information from one centre to another, and from country to country, has helped to raise health standards throughout the world by making available to all peoples the results of our research. We, in Canada, have always shared in the discoveries made in these laboratories.

Some of the outstanding discoveries which have come from the Company's research laboratories are:

"Adrenalin" (*epinephrine hydrochloride*)—Still a widely-used life-saving drug to which physicians all over the world will testify.

"Mapharsen" (*oxophenarsine hydrochloride*)—This is mentioned primarily to bring your attention to what can happen in the pharmaceutical industry. Prior to the discovery of penicillin, a considerable amount of money was spent in perfecting the ideal arsenical for the treatment of syphilis. From our research laboratories came "Mapharsen", which, prior to the discovery and availability of penicillin, was the most widely-used arsenical for the treatment of syphilis in the world. Overnight, this drug was replaced with the more efficient penicillin, which we also market.

"Dilantin" (*diphenylhydantoin sodium*)—It has been estimated that one person out of every two hundred people living in Canada suffers from epilepsy. Dilantin has been termed the drug of choice for the treatment of the Grand Mal type of seizure, which is the most prevalent and serious type of epilepsy. If it were not for Dilantin, many people from all walks of life would not be able to earn a living. Through continuing research, we developed several other anticonvulsants for the treatment of other types of seizures so that now we have a total of five such products supplied in a total of fourteen product forms to accommodate the widest range of patient requirements.

From 1940 through 1966, increased labour costs have contributed to a 21% increase in our price for an average year's treatment with Dilantin. When you compare this modest increase to the 100% and 300% increases in the price of such products as bread, milk, clothes, and automobiles, during the past twenty-five years, you will agree that even in the face of spiralling costs, we have held down the cost of our products for the treatment of Grand Mal epilepsy.

"Benadryl" (*diphenhydramine hydrochloride*)—This was the first antihistamine introduced to medicine in Canada and, although many more have followed, it continues to play a very important part the treatment of allergies.

"Chloromycetin" (*chloramphenicol*)—This was one of the first wide-spectrum antibiotics to be made available to the Medical profession and is still regarded as an outstanding life-saving drug. Even after many years of clinical use, it still retains an important position in medicine, and is unique in some instances.

"Vanquin" (*pyrvinium pamoate*)—This product is an anthelmintic for the treatment of pinworms. A Canadian physician who did considerable clinical investigation with this drug called it a "cure", a term which is rarely used to describe the efficacy of a pharmaceutical product.

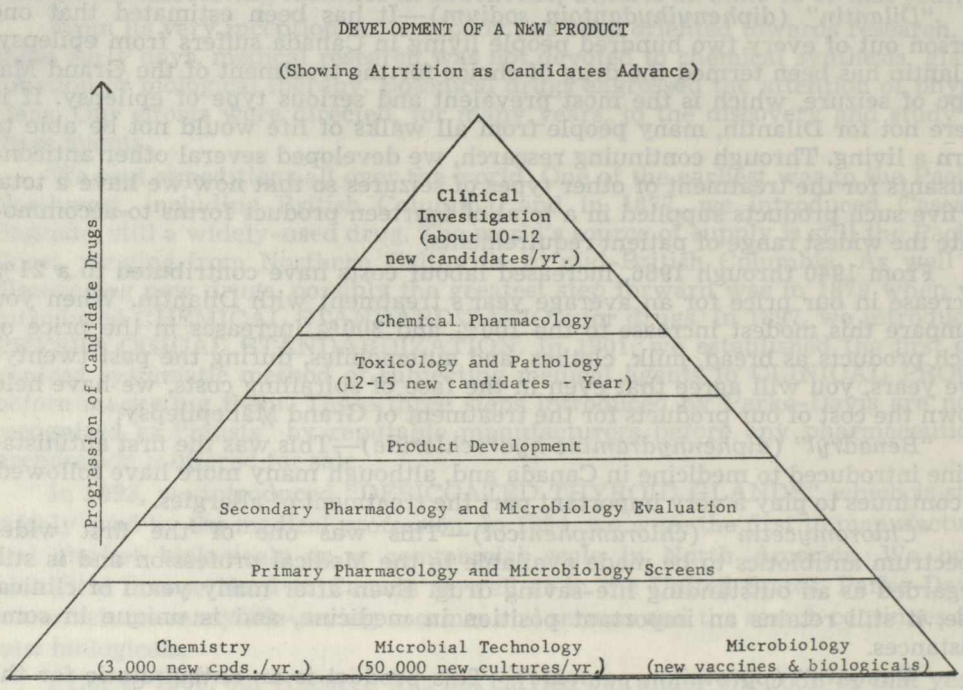
"Ponstan" (*mefenamic acid*)—Marketing of this new agent for the therapeutics of pain began in 1966. Ponstan represents another significant development by Parke-Davis which will be widely accepted and used for many years to come.

The foregoing are only some examples of the results of research. In our catalogue listing some 375 products available to all people in Canada, are many other products which are just as important, although not always as widely used as some of the examples. Many of these are retained at the request of physicians for the benefit of their patients even though the sales volume is very small. In some instances it is not unusual for us to supply products at no charge, as in

hardship cases. Also, there are many products which have come out of Parke-Davis research which do not appear in our present catalogue because they have met a fate similar to that of "Mapharsen"—product obsolescence.

That research is integral to the development of new or improved medications to treat disease is, I am sure, an accepted fact, that there are difficulties inherent in successful research is also recognized. The extent of these problems, however, is not immediately apparent, and I should like to devote some time in expounding on this in a non-technical sense.

As indicated on the following chart, our overall research program yields some 10-12 *candidates* annually. These candidates result from processing some 60,000-75,000 compounds and cultures.



As candidates advance, data accumulation accelerates on each candidate, but number of promising candidates sharply decreases. Information on successful candidates is eventually used for New Drug Application; information on less successful is used in development of future candidates.

Our experience is probably comparable with that of other pharmaceutical houses. It has been estimated that, based on total annual research costs, each new pharmaceutical entity introduced over the past three years has required an expenditure of approximately 16 million dollars.

The cost of research (in excess of $14 million for Parke-Davis in 1965) and the necessity for a unified approach to obtain optimum value from the dollars spent, results in the centralization of major research activities at Ann Arbor, Detroit, and Rochester, Michigan, Hounslow, England, and in Mittagong, Aus-

tralia. It is important to note however, that discoveries from these modern and well-equipped research laboratories have always been made available to us.

Extensive clinical research programs have been carried out in Canada since 1932, under the direction of Parke-Davis Department of Clinical Investigation. Over the years these programs have involved evaluation of a large number of pharmaceuticals and biologicals in major medical institutions and clinics in various areas throughout the country.

Research is a continuing matter with Parke-Davis. It does not end with the marketing of a product. Many products that are now on the market are receiving further study with the objective of providing new uses and improved performance.

In summary, then, I should like to point out that:

1. Research is an absolute requirement to the discovery of new drugs and the effective treatment of disease.
2. The field of medical science has broadened to the point that effective research requires a considerable investment on a continuing basis.
3. Present products must pay for current research.
4. The more effective the research, the shorter the life of existing products.
5. We in Canada benefit from research conducted by our parent company, Parke, Davis & Company.

Research is very costly; but is also must be stated that it is very gratifying, because our research has brought forth many health-giving and life-saving drugs. Canadian physicians use these drugs according to medical needs, and they are dispensed by the pharmacists in retail drug stores and hospitals of this country according to the instructions of the physician. We, in Canada, are fortunate to have such high-principled people in the professions of medicine and pharmacy, and in the administration of our hospitals. It is only natural that this would follow, due to the fine personnel that we have on our teaching staffs in our schools and universities of this nation to prepare our professional people so adequately.

PATENTS:

I am not a patent expert and consequently I have had to turn to our Legal Department for assistance on this subject. They have provided me with the following statement which expresses our views on the present Patent Act.

Our company firmly believes that a strong patent system is not only necessary to encourage research and ensure continued scientific progress but also to create and maintain a strong and sound local industry. We feel that the present Canadian Patent Act is one of the important factors responsible for the small amount of drug research and basic drug manufacturing carried out in our country and that any further weakening of this Act would definitely be contrary to the public interest. It is well known that drug research is extremely expensive and that the odds of success are minimal. Obviously, no private institution or individual can afford to create the research facilities, carry out the very expensive research to devise, develop and thoroughly test a new drug, create the facilities to produce the drug commercially, and bear the burden of acquainting

the medical profession with the uses and limitation of the drug, unless he is given some reasonable means by which he can recover his expenses and be compensated for the risks involved. We submit that the present Patent Act does not provide such necessary reasonable means since, for practical purposes, it permits the grant of patents only on processes for making medicines and makes even such limited patents subject to immediate compulsory licensing to almost anyone applying for such a license.

We consequently endorse the views of the Pharmaceutical Manufacturers Association of Canada, expressed in its submission of June 1966, that the Patent Act should be revised to eliminate Section 41(3) and establish a properly qualified tribunal to deal with compulsory license applications in those instances where the patent is being abused, for example, by failure, in the absence of a satisfactory reason, to manufacture locally. We are firmly convinced that if the grant of compulsory licenses were limited to those instances where the patentee failed without good reason to ensure manufacturing in this country, Canada would soon have a strong basic industry capable not only of supplying our domestic needs but export markets as well. However, under the present circumstances there is no incentive for a patentee to undertake manufacture in this country. Under Section 41(3) his patent is subject to the grant of compulsory licenses bearing only a modest royalty almost as a matter of right, regardless of whether he is manufacturing in this country and whether his manufacture is adequate to supply the market on reasonable terms. Thus, the present law seems to benefit the copiers rather than the originators of new drugs.

Those who wish to see the present unsatisfactory state of affairs continue will of course argue that restriction of the grant of compulsory licenses to those cases where the patentee fails to manufacture locally would allow patentees to produce locally and charge exorbitant prices for their products. Such an argument, however, will not bear critical examination.

When it comes to pricing of medicines it must be recognized that there are practically no drugs which possess a therapeutic monopoly. For almost any means of treatment, patented or unpatented, there is an alternative or several alternatives and hence a patentee must price his product so as to be competitive with these alternative treatments. Additionally, our present law prohibits the grant of patents on substances prepared or produced by chemical process and intended for food or medicine. As a practical matter, this means that anyone who invents a new medicinal substance is only permitted to protect his process for making it and that others are free to produce the identical substance by a process other than the patented process. Modern chemical methods are so numerous and diverse that there are many such other non-patented methods available, or readily devisable. Thus the protection afforded to an inventor of a new medicinal, even if compulsory licenses were to be restricted to those instances where the patentee does not manufacture locally, would largely be illusory rather than real. In view of this we are of the opinion that if research and the establishment of a strong local industry are to be encouraged it would be in the public interest to modify the Patent Act to remove the prohibition of granting patents covering new medicines and foods. Removal of this prohibition, I am told, is consistent with the modern trend against such limitations as evidenced by the patent acts enacted since World War II in Great Britain, Ireland, South Africa, New

Zealand, the Philippines, and the proposed Common Market and Scandinavian Patent Acts.

In summary, we believe that one simple and effective way for Canada to encourage and stimulate local research on drugs and to provide the incentive for the creation of a strong local drug manufacturing industry would be to revise the present Canadian Patent Act to remove the restriction against the patenting of new medicinal substances and to limit the grant of compulsory licenses to those cases where the patentee fails, without a good reason, to ensure local manufacture.

DRUG COSTS:

It is realized that your committee is charged with the responsibility of exploring ways and means of reducing the cost of drugs. I believe, rather than going into a long discussion on this important subject, if you will refer to the appendices that are included in this brief, you will realize that Parke, Davis & Company, Ltd. has tried to bring about a blend of reasonable prices, service, availability of drugs and research. When prices have gone up, they have not risen to the same degree as those of other commodities in the past number of years. In general, newer drugs are reduced in price as volume of production permits. Sometimes, older drugs must rise in price to compensate for increased costs in supplies, labour and other influencing factors.

APPENDIX NO. 1 shows the comparison of our over-all unit selling prices and as compared to our hourly labour costs for the years 1958 to the present time.

APPENDIX NO. 2 shows the net profit that Parke, Davis & Company, Ltd., made in 1965. It should be mentioned that the parent purchased goods and services in Canada which are not for resale here, but for use in other countries represent a value of $116,770. This appendix also shows where we spent our money, and in reviewing it, it is our belief that we have been most conservative in the promotion of our products. Never to be forgotten, however, is the fact that without promotion drugs would not get into country-wide use. Promotion basically informs the medical profession of the intended uses of drugs and suggests to pharmacists that they should have the drugs available in anticipation of their being prescribed by doctors. THERE IS NOTHING MORE EXPENSIVE THAN A DRUG THAT IS NOT THERE WHEN NEEDED.

APPENDIX NO. 3 briefly covers the source of our products. It should be noted that we maintain a very high Canadian content which will be increased as conditions permit.

APPENDIX NO. 4 has been placed here solely for the purpose of illustrating the reason why the development of the fine chemical industry in Canada has been limited. However, as increasing research creates new possibilities, and as the Canadian market grows, and is encouraged to grow, further development in the fine chemical industry may be expected.

APPENDIX NO. 5 Here is shown what a pharmaceutical company, with a net sale of $9,444,757. generated in taxes at all levels of government, in 1965.

APPENDIX NO. 6 We are including with this brief the 1965 Annual Etatement of Parke, Davis & Company for your further information.

In conclusion, let us point out that all of this information is furnished in an effort to cooperate with your committee and its valuable work. It is our opinion

that when you have given careful study to this brief you will agree that Parke, Davis & Company, Ltd. carries on a fair and equitable operation in Canada and that our profits are consistent with our investment, taking into consideration the risk inherent in marketing substances which do not have an unlimited life.

Rest assured that we will continue to manufacture and make available to all Canadians the products of our manufacture as efficiently as possible, but we shall never allow economies to interfere with the quality of our products. This assurance is given with the full knowledge that we are in a highly competitive market and must always be looking for ways and means to reduce costs so that we can remain competitive.

We support the recommendation proposed by the Pharmaceutical Manufacturers Association of Canada that the cost of drugs to the consumer can be lowered by the elimination of the 11% sales tax. You may rest assured that we will pass this savings on to our customers, if and when this tax is removed.

We would like to point out that in all fairness to the retail pharmacist the people of Canada should be informed that they cannot expect this reduction overnight because it would be impossible for us to adjust the prices of our merchandise which would be on the pharmacists' shelves at the time of such legislation.

We support the recommendation of the Pharmaceutical Manufacturers Association of Canada that patent laws be strengthened.

We will continue to explore the possibilities of enlarging our research in Canada and these explorations would be greatly accelerated if we could be assured that the patent laws would be strengthened.

We do hope that the information we have provided will be helpful to this committee in bringing your work to a successful conclusion.

Appendix No. 1
to the Brief

Comparison of Hourly Salaries of Production Workers with the Average Unit Price Received for our Products in 1958 with 1956:

As of December 31, 1958, the following average hourly wage rates were in effect:

Male	$1.759 per hour
Female	1.456 per hour
Average All Hourly	1.619 per hour

The rate as of June 30, 1966 is:

Male	$2.262 per hour
Female	1.863 per hour
Average All Hourly	2.085 per hour

The above represents an average hourly increase of $.466 or 28.8 per cent. In 1958, the average unit price received for our products was $1.859. In 1965, the average unit price received for our products was $1.417[1]. This shows a decrease in unit price of $.442 or 23.8 per cent.

[1] The figure for 1966 will not be available until December 31, but the figure shown here will be comparable.

Appendix No. 2
to the Brief

NET EARNINGS

During 1965 we invoiced our customers a total of $9,444,757 and after the following expenses and disbursements for the year we realized net income of $386,130, or 4.09 per cent of the amount involved.

	Amount	%
Cost of Goods Sold	$4,486,660	47.50
Marketing Salaries	633,520	6.71
Marketing Travel Expense	281,612	2.98
Transportation on Merchandise	257,699	2.73
Samples, including Stock Packages	174,981	1.85
Representatives' Equipment and Exhibits	18,959	0.20
Public Relations	151,969	1.61
Advertising Journals (Medical, Hospital Nurses and Pharmaceutical)	89,381	0.95
Advertising Retail Promotion	129,667	1.37
Therapeutic Notes	35,176	0.37
Patterns of Disease	66,500	0.70
Direct Mail	34,119	0.36
Product Brochures, file cards and other information media for Physicians	110,604	1.17
Branch Operations	976,725	10.34
General and Administrative	395,927	4.19
Discounts and Other Sales Adjustments	20,606	0.23
Federal Sales Tax	546,522	5.79
Income Taxes	648,000	6.86
Net Income	386,130	4.09
Total	$9,444,757	100.00

Appendix No. 3
to the Brief

Our product line consists of 375 products which are packaged in 637 dosage forms and package sizes (oral, parenteral, topical, in various sizes).

	% of Packages	% of Sales
Bulk imported from parent represents small lot tablets or capsules; also certain steri-vials and ampoules. These are then finished completely in Brockville and this is carried out either due to special manufacturing procedures or economic reasons	18.2	8.9
Imported Finished from Parent—Biologicals ..	15.2	9.2
Imported Finished from Britain	0.5	0.1
[1] Completely Manufactured in Canada	66.1	81.8
Total	100.0	100.0

[1] Source Raw Material—The majority of our raw materials are either synthesized or extracted in Brockville or purchased from Canadian suppliers; the balance is from various countries in the world.

Appendix No. 4
to the Brief

FINE CHEMICALS

We are continually searching for ways and means to produce, or procure, the fine chemicals which we require to formulate our products. Of course, the number-one consideration is QUALITY AND PURITY. Thereafter comes the ECONOMIC factor. Naturally, if the quality does not meet our standards, we are not interested in the product, regardless of price. In Brockville, we are in a position to synthesize fine chemicals, but in many instances, it is more economical to import them from our chemical plant in Holland, Michigan.

A certain product of ours, which we can completely synthesize in Brockville is also synthesized by our parent company in the United States, and, to the best of my knowledge, it is not offered for sale by anyone else in Canada—this product provides a typical example.

We produced this product in Brockville for a period of eight months, maintained a very close study, and during this period of time we gained considerable know-how and our production yields compared most favourably with any of our world wide locations, including the United States. During this period, we were able to reduce our costs of manufacturing by approximately 30 per cent and had reached a point which we considered complete efficiency.

But, unfortunately, we could import this from the parent, pay the duty and allow for the 7½ per cent exchange on the Canadian dollar at a cost of 70 per cent less than we could produce it in Brockville.

The question is WHY—it is a straight case of production. Our production lot in the United States is slightly greater than thirteen times that of the required production run in Canada. Yet it takes the same equipment, the same amount of labour, the same supervision, the same clean-up time, the same employee fringe benefits, the same non-production departments, such as Inventory Control, Purchasing, etc., to make the larger lot in the United States as it does the small lot in Canada. Hence these costs are multiplied by thirteen. Since our selling price for this product was based on the American import cost, we now have two choices to make—manufacture in Brockville and increase our selling price or import from the United States without increasing our selling price.

Appendix No. 5
to the Brief

In 1965, Parke, Davis & Company, Ltd. paid to the Receiver General, Provincial Treasurers and Treasurers of Municipalities, $1,809,727., representing sales taxes, customs duties, income, property and withholding taxes. Through purchase of supply and expense items, we indirectly paid federal, provincial sales, and other taxes, but the amount of such taxes is not practical to obtain.

The payments were as follows:

Federal	$1,560,620
Provincial	154,826
Municipal	94,281
	$1,809,727

We are not in a position to assess the full impact of our operation on the economy of Canada, but the above schedule shows a considerable direct contribution to tax revenues.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 16

TUESDAY, NOVEMBER 8, 1966

WITNESS:

Dr. George F. Wright, Ph. D., of Toronto, President of Empire Laboratories Ltd.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1966

25162—1

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

MINUTES OF PROCEEDINGS

TUESDAY, November 8, 1966.,
(23)

The Special Committee on Drug Costs and Prices met this day at 9.50 a.m. The Chairman, Mr. Harry C. Harley, presided.

Members present: Messrs. Forrestall, Goyer, Harley, Howe (*Hamilton South*), Howe (*Wellington-Huron*), Isabelle, Mackasey, MacLean (*Queens*), Orlikow, Tardif (10).

In attendance: Dr. George F. Wright, Ph.D., of Toronto, President of Empire Laboratories Ltd.

Also in attendance: Mr. A. M. Laidlaw, Q.C. of Ottawa, Legal Counsel for the Committee.

The Chairman presented the Second Report of the Steering Subcommittee on Agenda and Procedure as follows:

> "Your Subcommittee recommends that during discussion on patents, all those interested in this matter be available for questioning at the same time."

Agreed,—That the Steering Subcommittee Report be adopted.

Also agreed,—That Dr. Wright's Supplement to a brief submitted on July 7, 1966, and the brief presented today, be printed as part of today's proceedings. (*See Appendices "A" and "B"*)

The Chairman submitted to the Committee a communication received from The Chemical Institute of Canada, dated November 3, 1966, in answer to a Brief presented by Dr. George F. Wright on July 7, 1966.

Agreed,—That copies of this correspondence be made available to the members immediately, and that it be printed as part of today's proceedings. (*See Appendix "C"*)

The Committee proceeded to the consideration of Dr. Wright's presentation.

During the course of questioning, Dr. Wright tabled, for the information of the members, a Memorandum dated October 31, 1966, sent to him by Mr. Kalman F. Roller, Control Chemist, on the subject of Quality Control. Copies of this document were distributed to the members.

The Chairman informed the Committee that, as promised by Mr. Bethel, of Smith Kline & French Inter-American Corporation on October 27, 1966, material dealing with the relative potencies of "Stelazine" and other trifluoperazine tablets has been forwarded for the information of the members.

25162—1½

Agreed,—That the statement be printed as part of today's proceedings. (*See Appendix "D"*)

Dr. Wright was further questioned.

The Chairman thanked the witness for having made a presentation on behalf of Empire Laboratories Ltd.

At 12.45 p.m., the Committee adjourned to 3.30 p.m., Thursday, November 10, 1966.

Gabrielle Savard,
Clerk of the Committee.

EVIDENCE

(Recorded by Electronic Apparatus)

TUESDAY, November 8, 1966.

The CHAIRMAN: Gentlemen, before we proceed this morning, the steering committee had a meeting since the last meeting of the Committee and I would would like to read you that report.

(See Minutes of Proceedings)

The background of this is, as you know, on November 24 we are going to have at least two or three different groups who are interested in varying aspects of the question of patents. The subcommittee felt that perhaps it would be in the best interest of the Committee to have all of these people here together at the same time in order that the Commitee migh ask them the same questions, hear their argument in answer to each other. Is there any discussion on this?

Mr. MACKASEY: Who are the personalities, whom do they represent?

The CHAIRMAN: The Canadian drug manufacturers and the P.M.A.C. There may be one or two other individuals who are interested. For instance, the witness the day before that, Mr. Smart, from the Patent and Trade Mark Institute of Canada, might also be interested in coming. Is that agreed?

Agreed.

Is it agreed that today's brief be printed as an appendix to today's proceedings?

Agreed.

Mr. HOWE (*Hamilton South*): Mr. Chairman, was there not more than that suggested by our steering committee?

The CHAIRMAN: I can remember there was discussion about the timing of our meetings, and it is obvious from the schedule before us that we will be sitting into the New Year rather than being able to submit a report by December.

Mr. HOWE (*Hamilton South*): Mr. Chairman, I had suggested a name having to do with patents which I have lost at the moment, I will have to remind you of it afterwards.

The CHAIRMAN: Can we discuss it later? I must admit it has slipped my mind.

Mr. HOWE (*Hamilton South*): You said his name had come up. I am sorry I have forgotten but I have a poor memory.

The CHAIRMAN: There is a gentleman who is to let me know today whether he wants to come or not. He had expressed a desire to attend earlier but apparently he has not decided whether he will come.

Mr. HOWE (*Hamilton South*): Could you name him now?

The CHAIRMAN: Mr. Kircher?

Mr. HOWE (*Hamilton South*): No, that was not the name.

The CHAIRMAN: It was another name?

Mr. HOWE (*Hamilton South*): I will have to tell you afterwards because it was a man we had agreed on and it was to do with patents. I am sorry I have forgotten.

The CHAIRMAN: It was not a gentleman in the armed services?

Mr. HOWE (*Hamilton South*): No, no.

The CHAIRMAN: There was other thing—

Mr. HOWE (*Hamilton South*): Just a moment, Mr. Chairman, I have the name here, a Mr. Henry.

The CHAIRMAN: Of the Restrictive Trade Practices Commission?

Mr. HOWE (*Hamilton South*): He is the Combines Commissioner.

The CHAIRMAN: He is head of the Restrictive Trade Practices Commission.

Mr. HOWE (*Hamilton South*): I named him and we agreed on it, at least I understood we had.

The CHAIRMAN: I do not remember actually. I know this was discussed, whether the Committee wished to have him appear. I am not sure that it was during that discussion that it was decided he should appear.

Mr. HOWE (*Hamilton South*): I would like to suggest him now, in view of that having been omitted.

The CHAIRMAN: Can we discuss that later?

Mr. HOWE (*Hamilton South*): Yes.

The CHAIRMAN: There is one other piece of correspondence that I think probably should be printed as part of today's minutes. It would be very apropos. The last time Dr. Wright was before us he enclosed a brief on research and the Chemical Institute of Canada have written us a letter and made several comments on Dr. Wright's brief. I think they are very pertinent to the discussion today and I would suggest it be included as part of today's minutes. Is it agreed?

Mr. HOWE (*Hamilton South*): Is it too lengthy to read?

The CHAIRMAN: It is 4 pages.

Mr. MACKASEY: If it is pertinent, how can we question Dr. Wright on it if he has not seen it?

The CHAIRMAN: Well, we can read it into the record.

Mr. MACKASEY: Could we not get the young man to photostat copies. It would not take more than an hour.

The CHAIRMAN: Then it ought to be included as part of today's record but in order that Dr. Wright may be questioned on it we will have it produced right away.

Have you an opening statement that you wish to make, Dr. Wright?

Dr. GEORGE F. WRIGHT: No, not really, particularly except to say that I have heard, over a period of 35 years opinions about the pharmaceutical industry and an intimate concern in the last couple of years revealed these and these are some of which in my brief that have been presented. Basically I think the industry has

several impediments at the moment for healthy existence which could be ameliorated. One of these involves what I call the over-sanctity of research, with all that goes with that. The other is the harm that I consider is contributed by the extreme use of brand names, as they are used today.

In trying to ascertain some way to bring about this amelioration I would say I have not been very successful in my thinking. The best thing I have been able to come up with is my proposal which I had set out partly in my brief submitted July 7th. You have accepted a supplement to it today—my proposal is the establishment of a drug institute for Canada. When I first had the idea I thought it was unique. I now find that other people in other parts of the world also, at least are playing with the idea. As I envisage it, it would be an institute much like many of the institutes we find in countries like the United Kingdom, in this field, the glass business and others. These institutes are essentially governed by a committee of the profession or professions that are involved. For the pharmaceutical industry I consider these four professions are: medicine, pharmacy, pharmacology and chemistry. My proposal is that out of the professional organizations representing those disciplines a council be established and that this council be able to find funds in order to establish an institute.

I do not want to go all through all of this, brief but I would like to enumerate the terms of reference that I would consider proper for such an institute and they are on page 4 of this supplementary brief. These terms are, first, to examine the areas of therapy in which new drugs may or may not be needed, essentially to find out what the public needs in the line of new and necessary medication.

The second point is that I would like to see such an institute regulate some of the preclinical examinations for new drugs, and supervise all clinical trials.

The third functions would be to solicit, receive and correlate all reports of side effects, contraindications and alternative uses of drugs, and I say both new and old, although I realize I am encompassing a very wide area here.

The fourth function would be to solicit and correlate all reports about efficacy of drugs. The fifth term would be to establish the official, that is to say the generic, name for a new drug; the sixth, to participate in multiple-screeening tests for discovery of new drugs; seventh, to accomplish fundamental research in pharmacology and medicine and finally, to promote the development of preventive medicine in Canada. I have developed each one of these points later in this brief but I see no need to go over them now. I merely present at this time the idea of the main functions, but I would point out that I preface this with the fact that as a chemist I do not feel competent to choose functions for such a complex institute. These are my ideas, but they are certainly subject to adjustment and to alteration if such an institute were to be established. Thank you, Mr. Chairman.

The CHAIRMAN: I should have introduced you although I am sure most people were aware that Dr. Wright comes today as the President of the Empire Drug Company in Toronto.

Mr. WRIGHT: Empire Laboratories.

The CHAIRMAN: Dr. Wright's background is a doctorate in chemistry rather than a medical degree.

Mr. WRIGHT: That is correct.

The CHAIRMAN: The meeting is open for questioning.

Mr. MACKASEY: Mr. Chairman, I have just one question I would like to ask and then I intend to leave the floor for somebody else. Dr. Wright, the products that Empire produce are what we normally call generic products. I mean this is the terminology being used here; you are a generic house as opposed to a brand name house and you express the opinion, I think, in one or two of your briefs, that brand names are costly and unnecessary.

Suppose we take as an example a product you are selling in pill form. Is there anything on that product to distinguish your generic pill from another company's pill? Do you have a symbol, a mark, or a trade mark?

Mr. WRIGHT: I would like to answer the first part of your question and then I will most certainly answer the second part. In the catalogue I have before me, which is the Empire catalogue, I make this statement. "We are not a generic house, whatever may be meant by that term. When a generic designation is not available, as in the case of mixtures or special excipients we do resort to a trade name but we use trade names as sparingly as possible. This is our policy because we believe that a drug should 'speak for itself' under its Christian name and not under an alias." When one sells drugs by the official name, then he should identify it in some way and the way I feel is that we are not a trade name house; we are a trade mark house. For example we sell Tolbutamide-Empire. We sell Colchicine-Empire, and whenever possible, and more and more as it is possible, we inscribe, either imprinting or impressing on our tablets or capsules, the letter "E".

Mr. MACKASEY: That leads me up to the point, Dr. Wright, that your firm could be one of the more reputable firms in Canada and I cannot for the life of me see how you could fall down on safety factors in dealing with millions of dollars worth of value. But the very fact that you imprint the letter "E" on your product seems to indicate to me that you are creating a brand name. You mentioned Tolbutamide. What you are saying to the doctor is not to fill a prescription of Tolbutamide itself but the doctor can go further and fill out a prescription of Tolbutamide-Empire. I do not see the distinction between buying a pill with the letter "E", knowing that it comes from Empire, and buying the same pill stamped, say, with the trade mark of Hoffman-LaRoche or Smith Kline and French. It seems to me that you are falling into precisely the same type of operation as these firms we have been discussing.

Mr. WRIGHT: Oh, I think so, yes, and more and more I should try to do that insofar as I can.

Mr. MACKASEY: Do you put the "E" on the Tolbutamide tablet to distinguish it from some other firm which also may be making a generic pill or a generic tablet?

Mr. WRIGHT: I am obviously trying to sell pills. In order to do that I have to have a good product. I spend a lot of time making sure that I have a good product, including very careful quality control. When I put the "E" on the tablet I am bragging that I have good quality control.

Mr. MACKASEY: Right, and I do not blame you because if you are proud of your products you put your name on them. But how do you differ from Smith Kline and French who do precisely the same thing?

Mr. WRIGHT: I do not, in so far as the medication is concerned. I do not sell it under a name that is different from the generic name except, of course, where, as in the case of mixtures, it would be much too clumsy to make a composite generic name.

Mr. MACKASEY: I am asking these questions in real sincerity. Having listened to testimony now for several years, I find one of the arguments the generic houses use is that by specifying a product of a particular firm you will pay more for it. That particular firm in rebuttal always says, "Well, you are buying our reputation when you buy something with our brand on it." Now, apart from the fact you mention you use the generic terminology rather than an artificial name, something that is more catchy, I fail to see the difference between your operation and Horner or Smith Kline and French because you are branding your product just as much as they are with their symbol; whether it is a triangle or it has the owner's face on it, it is the same thing.

Mr. WRIGHT: Yes, although I call it trade mark. If you use the terminology correctly, I am trade marking.

Mr. MACKASEY: But you are also distinguishing your product from a generic house down the street?

Mr. WRIGHT: Yes.

Mr. MACKASEY: Which is exactly the charge that is constantly laid against the so-called ungeneric houses?

Mr. WRIGHT: Yes. But I do not use an alias, as I call it, and therefore I can sell drugs more cheaply.

Mr. MACKASEY: You put an "E" on your Tolbutamide tablets, but knowing the efforts and the pain and the expense of your quality control, would it not be more logical that your Tolbutamide tablet with the "E" on it should sell for a little more than the Tolbutamide tablet that has no marking on it?

Mr. WRIGHT: Oh, to be sure, Mr. Mackasey. We are by no means the lowest-priced.

Mr. MACKASEY: Why are you not the lowest price? This is important.

Mr. WRIGHT: When my salesmen come around and cry on my shoulder, I ask myself that question a lot of times. Are the others better businessmen or are they less careful, and I do not like to make accusations unless I can demonstrate—

Mr. MACKASEY: It is not an accusation.

Mr. WRIGHT: Well, I just do not know the answer.

Mr. MACKASEY: What you are telling me—you are being very honest and I appreciate it—is that you are not the lowest selling drug. For example, you sell Tolbutamide at so much, and there are people who sell it at less. You sell it as low as you think you can and stay in business?

Mr. WRIGHT: That is correct.

Mr. MACKASEY: Because you have to include in your operation safety, quality control, you have to follow the Food and Drug Directorate regulations and, in fact, you have to go beyond the bare minimum of the law and this costs money and justifies in your opinion—and logically, I am sure—the fact that you

are selling your tablets dearer than the next fellow. Then, how can we criticize those who are selling even more expensively than you do? Why should not the doctor go all the way down the scale? I am just taking the arguments that have been presented here because I would rather have facts. It seems to me the argument, that buying brand names is costly and unnecessary, has a great deal of substance. You can buy the generic. By your admission a moment ago there are various degrees of quality and safety factors. This is one reason you put the letter "E" on your product and, secondly, it is another reason why you charge a little more than the man who does not want his product identified.

Mr. WRIGHT: All right. If I may act like a scientist for a moment, I would say the gradation is not linear.

Mr. MACKASEY: All right, I agree, but who points out the proper position on the gradation? How do you justify your increase and at the same time castigate a brand house for theirs?

Mr. WRIGHT: I do not—

Mr. MACKASEY: Well, I am speaking generally now.

Mr. WRIGHT: I always try, to strictly, not castigate anybody.

Mr. MACKASEY: Yes, I know. I have been reading some of your letters to the editor.

Mr. WRIGHT: Well, I mean competitors.

Mr. MACKASEY: The point I am trying to get at, and I think it is important to the whole concept because this is the argument that is advanced more and more in the briefs coming in, that as long as doctors insist on prescribing brand names the patient is paying unnecessarily for a product which can be acquired less expensively if the doctors would get into the habit of prescribing generic names. Certainly there is ample evidence that this is true, but I just do not understand why you put an "E" on it unless you are proud of your product, as you should be, or unless you want to differentiate your Tolbutamide tablet from that of the man down the street who has nothing on it and whose product is not as good as your product. In other words, what you are telling us is that there are different degrees of quality even in a simple pill. Now, that is precisely the same argument—

Mr. WRIGHT: Mr. Mackasey, I did not say that. I analyse competitors' products which sell below me; I analyse competitors' products which sell above me. I have found faults with both.

Mr. MACKASEY: Let us analyse the one which is below. There is a logical reason why you are higher, and that reason has to be some of the cost of manufacturing, something that the man who is lower than you is eliminating.

Mr. WRIGHT: One can suspect that, yes. In those competitors' products which I have analysed, I probably find more fault in the ones in the lower category than in the higher.

Mr. MACKASEY: This is precisely the basis of all the briefs we have been getting from the so-called PMAC boys. They are selling their product dearer because they claim their particular pill or tablet contains some degree of safety or some degree of quality that is not included in the product which is less

expensive. Their argument is, "Yes, we sell dearer but the doctor knows what he is getting". You are using exactly the same argument, and realizing the quality that is built into Empire you are branding your products with the letter E to make certain.

Mr. WRIGHT: I would say this, Mr. Mackasey, that he cannot exceed a certain level of quality control. As of the present state of the art or science, chemists cannot go further than a certain point and it is my opinion that what the fellow whose prices are higher is putting into it is promotion which I think is unnecessary.

Mr. MACKASEY: I see. Now, what is it you are putting in which the man who is lower than you is not putting in?

Mr. WRIGHT: Either poorer business practice or poorer control.

Mr. MACKASEY: I do not think Empire could be accused of poor business practice.

Mr. WRIGHT: I am not so sure.

Mr. MACKASEY: They have a successful business in a very competitive field.

Mr. WRIGHT: I know. There are lots of successful businesses, but they could be more successful.

Mr. MACKASEY: You are too modest. Let us take the other alternative, then, which is that possibly the less expensive product is not building in as much quality control as you are. Is this possible?

Mr. WRIGHT: Yes, or he may have a cheaper way of doing it. It costs me a lot to do quality control and I am not so sure I should not be looking for economies in so far as they will not prejudice quality.

Mr. MACKASEY: I am glad you qualified it, because I was gaing to ask you where the safety of the public comes into the picture.

Mr. WRIGHT: I thought perhaps there might be a question asked about this so I brought some copies of a document. I did not make them up for you. I made them up because some salesmen said, "Let us have something to give our customers which shows what you do on quality control." So, this is sort of a rigged job. It is something which we agreed to write. It is a memorandum to myself from my control chemist and essentially it sets out the steps which we take.

Would you distribute it? I do not want it to go into the record, I do not think it is proper.

Mr. MACKASEY: I will not pursue it much longer. I just want to make sure that I understood what you said, and vice versa. In other words there are people who sell Tolbutamide—we will use that as an example—which is more expensive and there are people who sell tolbutamide which is less expensive. You do brand your product, you have a trade mark on your particular tablet to make certain that it cannot be mistaken for somebody else's?

Mr. WRIGHT: That is correct, wherever possible. We do not put this on all our products.

Mr. MACKASEY: That is right. You feel that you cannot sell your products less expensively without lowering the safety factor which is built into your product?

Mr. WRIGHT: I would certainly cut my margin of profit below what, in the interests of the people who own this business, I think it ought to be.

Mr. MACKASEY: Thank you.

The CHAIRMAN: Gentlemen, there is one thing which I omitted and it was brought to my attention by some of the testimony which was brought out. I have in my hand a document from Smith Kline and French which was written by Mr. Sheldon, Assistant to the General Manager, and it says:

> I enclose the material dealing with the relative potencies of stelazine and other trifluperazine tablets which Mr. Bethel promised to prepare for the Special Committee of the House of Commons.

In other words it is a document showing the different assays on different kinds of tablets made by different companies as performed by Smith Kline and French and an independent chemist.

Is it agreed that this should become part of today's record?

Agreed.

Mr. HOWE (*Hamilton South*): Dr. Wright, has Empire Drugs ever discovered and produced a new drug on its own?

Mr. WRIGHT: No.

Mr. HOWE (*Hamilton South*): You rely on the copying of other drug houses' discoveries. Is this correct?

Mr. WRIGHT: I certainly will look at a drug which has become one which is needed.

Mr. HOWE (*Hamilton South*): It is still the discovery of another drug house.

Mr. WRIGHT: If you looked at my first brief last July, this word "discovery" takes some qualification. Let us put it this way. I have been publishing scientific papers now for about forty years and it is customary, as you know, when one publishes these, for people who are interested to ask for reprints. I find that the drug companies' services are very efficient on this. Of all the people who write for reprints, they are right in there. Now, are they copying my discovery? I think that one can use this word loosely. In the normal development of knowledge it is a little hard to establish any one plateau.

Mr. HOWE (*Hamilton South*): The plateau is very simple, either you do or you do not manufacture drugs of your own innovation or discovery or by your own research and development. You admit you do not. Do you do research in an attempt to find new drugs?

Mr. WRIGHT: Not at this stage. This is an objective which we would try to reach.

Mr. HOWE (*Hamilton South*): Do you think, then, that compulsory licences are necessary in the public interest or do you think they are necessary to permit such houses as yourself to stay in business?

Mr. WRIGHT: I certainly do not think that they are necessary to permit houses like Empire to stay in business.

Mr. HOWE (*Hamilton South*): You could stay in business without compulsory licensing?

Mr. WRIGHT: That is right.

Mr. HOWE (*Hamilton South*): On what basis could you stay in business without compulsory licensing?

Mr. WRIGHT: Well, I can make drugs which are not patented.

Mr. HOWE (*Hamilton South*): What drugs are not patented? Dou you mean drugs on which the patents have expired?

Mr. WRIGHT: Some of them never were patented. It would be a little hard to patent colchicine, for example, because only God knows how to make it.

Mr. HOWE (*Hamilton South*): And Empire.

Mr. WRIGHT: Empire does not know how to make colchicine. It has never been synthesized; its structure is not even fully known.

Mr. HOWE (*Hamilton South*): So it is not a synthesized drug?

Mr. WRIGHT: But a very useful one.

Mr. HOWE (*Hamilton South*): I am not questioning its use but it is not synthesized by you or anybody else, therefore it has no patent. Is that right?

Mr. WRIGHT: That is right.

Mr. HOWE (*Hamilton South*): There is no process to patent because, as I understand patents, you only patent the process of arriving at the end product, not the end product per se, is this correct?

Mr. WRIGHT: In Canada.

Mr. HOWE (*Hamilton South*): Yes, I was referring to Canada.

Mr. WRIGHT: There are others. I mentioned one in one of these briefs I submitted here, penta-erythritol tetranitrate. I do not know if there ever was a patent on penta-erythritol tetranitrate. Certainly if there was it was a patent on the compound as an explosive and not as a pharmaceutical. I do not know but I will see what others I can find. One does not always remember these. There never was a patent on ascorbic acid; I think that was given by its discoverer, who was—the man who always used to beat me by about two months before every publication—Reichstein of the University of Basle.

Mr. HOWE (*Hamilton South*): Can you explain the variance in price of ascorbic acid from the different drug houses?

Mr. WRIGHT: There is very heavy competition.

Mr. HOWE (*Hamilton South*): It is very heavily competed for, yes, but there is also a great variance in the price of ascorbic acid in different drug houses.

Mr. WRIGHT: There are people who like the coated product and think it makes a better pharmaceutical. We do not. We buy ascorbic acid uncoated. We also try to buy sharply, I must say. We are looking for prices which are perhaps better than somebody else and, of course, we may buy in quantity. Of course, this has to be regulated because it can be carried too far.

Mr. HOWE (*Hamilton South*): I would like to ask you some medical facts. What would you do, for example, if you were to get a compulsory licence for diazepam?

Mr. WRIGHT: I would first write to the Food and Drug Directorate and ask if I had to make a new drug application. I know the answer on this one, I think. If they said that I would have to do so, then I would formulate a tablet or a capsule, whichever I chose, describing to them all my sources of material, active

and inactive ingredients, my way of putting it together, my method of labelling, because these are all required. I would submit actual samples to them. Presumably they would examine those out at Tunney's Pasture and make another decision as to whether I would have to have preclinical and then clinical examinations for this material. Then I would do these things and hope that I had done a job which was satisfactory to them, in which case, I hope, I would be granted permission to manufacture this drug in dosage form.

Mr. HOWE (*Hamilton South*): How would you go about arming yourself with as much information as Roche has about the drug? What would be your source of information, presuming that you would have this information available?

Mr. WRIGHT: Of course, this word "drug" is used twice.

Mr. HOWE (*Hamilton South*): Yes, with different meanings.

Mr. WRIGHT: In the first we are not talking about the chemical.

Mr. HOWE (*Hamilton South*): I will resort to the word diazepam, then.

Mr. WRIGHT: Diazepam is a chemical. I would go to the open literature on this.

Mr. HOWE (*Hamilton South*): That literature being Roche's literature.

Mr. WRIGHT: Correct. Articles which have been published by Roche in the Journal of the American Chemical Society and the Journal of Organic Chemistry.

Mr. HOWE (*Hamilton South*): Do you think you could arrive at as comparable a state of knowledge as Roche?

Mr. WRIGHT: I am a professional chemist, yes.

Mr. HOWE (*Hamilton South*): I am not questioning your ability, but you could arrive at the same—

Mr. WRIGHT: But it is open to any professional chemist to do this.

Mr. HOWE (*Hamilton South*): You would then largely copy what Roche has done, both in the knowledge that you would pass out to the medical profession as well as the manufacture and pharmacological aspects of it, and this sort of thing. This would all be gotten from Roche's?

Mr. WRIGHT: Roche gave it to the world when they put it in the Journal of the American Chemical Society. If that is copying, all scientific pursuits are copying.

Mr. HOWE (*Hamilton South*): Would you expect doctors to refer to you if they have some, shall we say, puzzling conditions with regard to a patient in using this chemical?

Mr. WRIGHT: Of course, the doctors are not going to receive the chemical. The doctors are going to receive the dosage form which I make out of this. According to the Act of 1963, I would expect that I would be responsible for any questions or any complaints which resulted from my introduction of that dosage form on the market.

Mr. HOWE (*Hamilton South*): I am suggesting that a doctor has prescribed this to a patient and he is getting an unforeseen or unwritten reaction to this chemical. Would you be able to help the doctor as to what the cause was or be

able to help him by suggesting changing dosage, or whatever the problem was? Would your company be able to provide this information for the doctor?

Mr. WRIGHT: I certainly would not advise him about changing the dosage. All the others, yes, I would have sources of information to send him. Of course, this happens all the time, quite aside from this drug.

Mr. HOWE (*Hamilton South*): You do not have a doctor on your staff?

Mr. WRIGHT: No.

Mr. HOWE (*Hamilton South*): Then precisely what would you do if a doctor were to enquire as to any side reaction which a patient may be getting?

Mr. WRIGHT: We would cover the pharmacological literature; we would consult with doctors who might be friends or who might be consultants for this certain purpose.

Mr. HOWE (*Hamilton South*): Who would have specific information on this drug?

Mr. WRIGHT: We would obviously choose doctors who were—for instance, in the one we are talking about, diazepam—interested in tranquilizers or a related field.

Mr. HOWE (*Hamilton South*): But you do not have the direct information available at your company to be able to provide first hand information on the strength of a telephone call in the case of something urgent?

Mr. WRIGHT: Yes.

Mr. HOWE (*Hamilton South*): Do you have a doctor who is available to you immediately?

Mr. WRIGHT: The first thing we would do would be to go to our library and gather all the pharmacological information. We would already have known this before we put out the description card on the drug, but we would review it and also bring ourselves up to date on side effects. As you know, there is a regular publication involved in new discovery of side effects. We would go through those.

Mr. HOWE (*Hamilton South*): You realize that a doctor in practice, who has a patient on a drug or chemical provided by the brand name house which discovered the drug, has immediate access to that company by virtue of a telephone call to get in touch with a medical research man who can provide immediately, from information at his finger tips, a possible solution to reactions or side effects from this drug. Have you anything comparable to this?

Mr. WRIGHT: I am not sure that is always true. In the first place, the doctor that they have is not necessarily a practising physician. We definitely have a feeling that these physicians are the people that we should try to get out to, but I do not know whether he could work faster than we could. It is a little hard for me to compare. I know that when we get complaints it will probably be within two days that we have coverage. It would depend upon the intricacy of the question or complaint. But in all those cases that I remember in the last year, within two days we have been able to—

Mr. HOWE (*Hamilton South*): A patient can die in a lot less than two days.

Mr. WRIGHT: Yes, but I do not know whether the other fellow does better than this or not. Perhaps we should accelerate that. I would like it if there were something like a drug institute which could carry on the interests of every drug

manufacturer, and could aid in a question like this. One of the things that I wanted them to do was to provide a central clearing house.

Mr. HOWE (*Hamilton South*): This would be a central body from which information on any drug could be obtained by the doctor?

Mr. WRIGHT: Yes, but I do not know whether the other fellow does better although my feeling is that it would be good for such an institute to send out requests for observation of side effects and efficacy.

Mr. HOWE (*Hamilton South*): I have two more questions, Dr. Wright. One is on page six of your brief, line five, and I will read the two lines preceding it. It reads:

> Many brand names have found their way into scientific articles and texts, and into courses of the curricula of medical schools.

then you ask next how they got there.

> How they got there is best not discussed.

Would you care to discuss it?

Mr. WRIGHT: No, sir.

Mr. HOWE (*Hamilton South*): Why would you avoid that question, if I may ask?

Mr. WRIGHT: Because I do not really know.

Mr. HOWE (*Hamilton South*): So it is best not discussed.

Mr. WRIGHT: I do not want to make a statement that I cannot back up.

Mr. HOWE (*Hamilton South*): But this statement leaves a lot to intimations that you are not sure of. Is that correct?

Mr. WRIGHT: Yes.

Mr. MACKASEY: Why did you put it in?

Mr. WRIGHT: I think it is something that people ought to think about.

Mr. MACKASEY: We can think of it, and we can think of it until doomsday, but if we do not get information from people like yourself who have some opinion on it, who are experts on the question, thinking will not do us much good.

Mr. ORLIKOW: We might get a lot more information if, instead of representatives of special companies and special interests we had some government or university people here who could give us an unbiased view. If we want to question every statement of every drug company that comes here, we would be here until doomsday.

Mr. MACKASEY: Mr. Chairman, Dr. Howe raised the question only because it was suggested in the brief. If it had not been in the brief we would not have wasted our time on it.

Dr. WRIGHT: I have been trying to find out what is written here. This is on page six?

Dr. HOWE (*Hamilton South*): Drug prices and costs is the purpose of this Committee. This is a rather realistic brief discussing the advantages and disadvantages of brand names and generic drugs, and does not deal with prices at all. However, this statement is made in the brief and I think either a description or a discussion is indicated. You will find it on page six, line five.

Mr. WRIGHT: I do not know why it is that in some courses in a single university there will be professors who will be very careful not to use the brand name in describing the medicines. In another division of the same university one will find these names used very largely.

Mr. HOWE (*Hamilton South*): Are you intimating that there is a drug company influence on some universities which is not exerted on others?

Mr. WRIGHT: I think there are ways of persuading men to do things just on the basis of saying he is a good fellow, I like him.

Mr. HOWE (*Hamilton South*): This is a nebulous assumption rather than a statement of fact, is it not?

Mr. WRIGHT: Many things in the realm of marketing are nebulous.

Mr. HOWE (*Hamilton South*): There is one other statement that I would like to make a comment on, and that is at the bottom of page seven, where you refer to medicare as a "hastily-conceived" scheme. This is a scheme that has been on the books since 1919. It can hardly be considered as "hastily conceived". That is a comment.

Mr. WRIGHT: I accept the reproof. I do not think it was a very good thing to say.

Mr. HOWE (*Hamilton South*): Thank you, Mr. Chairman.

Mr. ISABELLE: Dr. Wright, at the bottom of page four of your brief you say that the higher price of the brand-named drug is, in great part, owing to the expenses of promoting and maintaining the brand name. Do you mean that if other companies were to save on promotion we could lower the price of drugs?

Mr. WRIGHT: Yes.

Mr. ISABELLE: What percentage of the prescription dollar do you allow for promotion?

Mr. WRIGHT: I must say that Dr. Harley asked me to collect these numbers to be able to answer such a question, so I have done so.

Mr. ISABELLE: I could tell you that the other companies are within the range of 28 per cent. What would yours be?

Mr. WRIGHT: Well, I have a number of things worked up here, which is what I understood the Committee would want. I have researched our control, salesmen, institutional advertising, and promotional advertising. Let us just take the sales part of this first. Salesmen with their expenses amount to 8.4 per cent of gross sales. Institutional advertising, that is, magazines indicating that Empire makes good products, some letters to doctors which are non-specific with respect to a certain material, our so-called file cards, and entry into such advertising media as the Vademecum—now it will be the expense of putting these things into the Compendium—is six-tenths of one per cent.

Now, I gave you the actual expense of salesmen, which is 8.4 per cent.

Mr. ISABELLE: Would you say, then, that you could cut the price by 50 per cent to the consumer? Would you say that the figures you gave us is the reason you are able to sell your drugs cheaper?

Mr. WRIGHT: That is right. I have another item here, promotional advertising; then under that I include letters in which we are saying, this is the product we want to sell. Samples are included in this, entertainment, conventions and our order forms requesting catalogues—that is 1.65 per cent. And, finally, my

last item, a catalogue is .4 per cent. When you add those up it comes to just a fraction over 11 per cent.

Mr. ISABELLE: So you would not say you could reduce the cost of the drug by 50 per cent on the generic names.

Mr. WRIGHT: Let us say on the average. We have some that are at the 50 per cent level, and there are others that are at the 90 per cent level.

Mr. ISABELLE: But generally you would say that you would be able to lower the cost of drugs by 50 per cent, if doctors prescribe on generic names instead of brand names?

Mr. WRIGHT: At the present ime, I do not think I could reduce prices any more and still maintain the other necessary controls in the company. Someone might come along and do better later on.

Mr. ISABELLE: I have another question. Suppose a hospital buys a lot of one kind of generic drug—let us call it brand X—and after two or three weeks of using this drug there are side effects, who is going to be responsible to the Food and Drug Directorate?

Mr. WRIGHT: We are. It is written right into the Act.

Mr. ISABELLE: It is not the innovator of the drug or the one who found the formula.

Mr. WRIGHT: It is the man whose label is on the drug.

Mr. ISABELLE: Are you sure of this?

Mr. WRIGHT: I am positive, because this is how the Act reads.

Mr. ISABELLE: Do you sell to country doctors?

Mr. WRIGHT: To some extent, yes; to what we call dispensing doctors.

Mr. ISABELLE: Would you have the percentage?

Mr. WRIGHT: I think this comes under what we usually call "direct sales". I would say that it was about 5 to 6 per cent of total sales. I did know it, but I do not have it with me.

Mr. ISABELLE: With your experience, would you say that dispensing doctors buy more generic drugs that brand name drugs?

Mr. WRIGHT: This I do not know. I know they buy a lot of brand name drugs.

Mr. ISABELLE: Why?

Mr. WRIGHT: Probably because we have not been able to get a representative up in that town.

Mr. ISABELLE: Is it not because they pay less for drugs?

Mr. WRIGHT: Some doctors may wish to pay less. Doctors I think have different feelings about this. We do not expect to brainwash every doctor in the country into our way of doing this. We want to look for those who happen to agree with our principles of operation.

Mr. ISABELLE: I hope they are not like the government and buy drugs only at the lowest prices. I hope they do not do that in the country, because I do not think that people in the country are allowed the best education possible. If the doctor acts like the government, and buys the drugs at a lower price, he does not care about quality.

Mr. WRIGHT: I read in the paper something that went on in these hearings in that respect, and it certainly is not the same government with whom I deal. The government is very strict indeed about quality, as I discover sometimes to my unhappiness.

Mr. ORLIKOW: Mr. Chairman, I wonder if I could interject here. I missed the last meeting because I was out of town. I noticed Dr. Brand's statement and which I think Dr. Isabelle is repeating in part today. I think it is a very serious charge against government hospitals to presume they bought or that they buy drugs simply on the basis of price, and they have not taken any real precautions to ensure that the drugs which they are dispensing are not up to the proper standards. I think the charge, having been made, that this Committee as quickly as possible should ask the representatives of the veterans hospitals, or whichever hospitals are supposedly involved, to come in and to explain their position. I think it is a very serious charge made against anyone.

The CHAIRMAN: We had discussions in the steering committee meeting about this matter. The government people who purchase drugs are coming before this Committee on December 1. These people are from the Department of Defence Production. It is my understanding, from talking with some of them, that this condition may have been in existence prior to 1964, but since the government brought in its new specifications, this has not continued.

Mr. MACKASEY: Mr. Chairman, are you saying that Dr. Brand is talking about something that took place prior to the new specifications?

The CHAIRMAN: The evidence I have seen suggests that, and I have discussed this with Dr. Brand and he said that he would have to go back and get the specific instance he had evidence of. When he had done this, he would report it to the Committee.

Mr. MACKASEY: Was Dr. Brand a member of the Committee when we were discussing safety.

The CHAIRMAN: No, Dr. Brand was not a member of Parliament at that time.

Mr. ORLIKOW: Mr. Chairman, if that is the earliest date the representatives of the Department of Defence Production can appear, that is fine; but I think that the charge having been made, not only should we ask them to be here, but I think they would welcome the opportunity of explaining to the public what their procedures are.

The CHAIRMAN: As I say this has been arranged for December 1. Representatives from both the Department of Industry and the Department of Defence Production will be here on that date.

Mr. WRIGHT: Mr. Chairman, as I say, it is not the government that I deal with. There is no argument allowed. They do not say they do not like this; they say it is being shipped back, and you come and get it. And, we do. Sometimes it is very minor. I had an occasion in the last three weeks of a shipment of chlorpromazine syrup. The caps on these had not been up to quality with respect to the varnish on the inside. When one took the cap off the bottle, there were yellow spots inside the cap. We did not argue with them, we told them it was nothing but slightly oxidized chlorpromazine which represented perhaps 1/10,000 of the whole bottle. In this case they agreed that we should replace the

caps. They have the power; there is no argument here. I think D.D.P. is a pretty strict organization with respect to this kind of thing.

Mr. ISABELLE: I have one more question. Dr. Morrell said in March 1962, I think, that he was very disappointed at the government's failure to strengthen the act even further by demanding compulsory licencing of all manufacturers. Are you in accordance with this, sir?

Mr. WRIGHT: I personally think that it would be better for reasonable men to get together and establish a principle in this country of voluntary licencing, much as is done in other chemical industries.

Mr. MACKASEY: Mr. Chairman, on a point of order, what are we talking about here? This is confusing to me. What do we understand by compulsory licencing?

Mr. WRIGHT: I realized when I was saying this that there are two kinds of licences, one to manufacture the chemical, and the second, to manufacture the dosage form. As I say, I would like to see a great deal of dialogue with respect to this and discussion that would finally bring the industry around to a more liberal sort of licencing, as, to be sure, has happened in other industries.

Mr. FORRESTALL: Mr. Chairman, I wonder if Dr. Wright would mind going back to the first part of the questioning today. I would preface it by one simple question which, perhaps, would commend itself to a yes or no answer. The title of your brief to us today is, "Are Brand Names for Drugs a Menace"—and that is my question.

Mr. WRIGHT: I consider that they are.

Mr. FORRESTALL: Perhaps I should qualify my role in this. I am a new member on the committee and I am not familiar at all with what has gone on in the past. Dr. Brand, who was unable to be here today has asked to put a series of questions to you, Dr. Wright, in the hope that some light might be shed on some concerns that he has. First of all he is concerned as to whether or not there is a place for generic houses in our over-all Canadian structure.

Mr. WRIGHT: By generic houses you mean a firm that sells by generic name without brand name.

Mr. FORRESTALL: Yes.

Mr. WRIGHT: —Because everybody sells by generic name, by law.

Mr. FORRESTALL: Yes, but sometimes the print is so small you can hardly read it. That is Dr. Brand's observation, not mine. Is there a place in our Canadian structure for generic houses?

Mr. WRIGHT: I would say, yes.

Mr. FORRESTALL: Is there a considerable difference then between the P.M.A.C. and the members of the Canadian Drug Manufacturers' Association?

Mr. WRIGHT: The Canadian Drug Manufacturers' Association is not organized to the extent that the other organization is. But I would say, that even so far as it is organized, they have the same objectives.

Mr. FORRESTALL: Are you saying they have the same over-all objectives, and they are trying to serve the same purpose?

Mr. WRIGHT: I believe so.

Mr. FORRESTALL: In other words, perhaps what you are saying is that the difference is not merely a matter of size, that there are some other differences,

but they are heading toward the same general principle and goal, let us say, in service to Canadian people.

Mr. WRIGHT: Yes, because all profitable businesses should have that objective.

Mr. FORRESTALL: Do you believe that in this context—and I have to accept this; I am not sure of it myself—that the drug business must continue always to be largely international?

Mr. WRIGHT: Oh, I do not think so.

Mr. FORRESTALL: Do you think that there is room in Canada, through research, for the development of our own base source of these chemicals?

Mr. WRIGHT: Yes.

Mr. FORRESTALL: What is being done about that in Canada today. Is it widespread or are some companies beginning to move in this direction?

Mr. WRIGHT: Yes. In the first place, it has been relatively slow—and this applies to the chemical business as a whole, not only to the drug business—to induce foreign held companies to do some of their investigations up here. It has been slow with respect to completely Canadian based organizations, firstly, because of lack of funds and, secondly, because of the bane of Canadian education, which means that we do not always have the people.

Mr. FORRESTALL: In your own particular firm, Dr. Wright, are all of your ingredients or all of your chemicals imported?

Mr. WRIGHT: No.

Mr. FORRESTALL: What percentage would be imported?

Mr. WRIGHT: I would say that of the active ingredients, probably 80 per cent were imported; of the inactive ingredients, very few.

Mr. FORRESTALL: Where would most of these active ingredients come from? Would they come from the United States or Europe?

Mr. WRIGHT: They usually come from Europe.

Mr. FORRESTALL: Is that something that could be said generally or is that just specifically. I realize, of course, that you have no insight particularly into your competitors' business.

Mr. WRIGHT: Well I know that many of my competitors, even those who hold patent rights on some of the things, import them from Europe.

Mr. FORRESTALL: From the same places that you are buying it, Dr. Wright?

Mr. WRIGHT: In some instances, yes. It would be those instances that I know of.

Mr. FORRESTALL: Is there a relatively small number of basic manufacturing concerns that supply the great percentage of basic chemical elements that go into your final packaging form.

Mr. WRIGHT: Excuse me; I did not follow that question closely enough.

Mr. FORRESTALL: I am wondering, doctor, whether or not there are perhaps three or four firms in the world that produce most of the basic compounds or elements that go into your final product.

Mr. WRIGHT: No, there are many more than that.

Mr. FORRESTALL: There are hundreds of them perhaps.

Mr. WRIGHT: Yes. But of reliable concerns there are probably 40.

Mr. FORRESTALL: To revert may I ask you specifically if you think that generic houses and firms should achieve a greater share of the Canadian market? Is this a worthwhile objective?

Mr. WRIGHT: I think it would be good for Canada.

Mr. FORRESTALL: Do you think that generic houses could or should displace the international drug firms largely, if not wholly?

Mr. WRIGHT: No, I do not think so. I think it is much healthier for business to have international firms as well as our own here in Canada.

Mr. FORRESTALL: In so far as generic houses might displace international firms, would they not have to replace the capital invested by those firms in supplying drugs to the Canadian public; that is to say, if there was an encroachment and a growing share of the market on the part of generic houses would they have to duplicate that capital for, I suppose, any one of a number of purposes, such as research, development and so forth. Is there a potential capital investment posture inherent in the growth of the generic houses?

Mr. WRIGHT: Yes.

Mr. FORRESTALL: Might that be extensive?

Mr. WRIGHT: This depends on the time period you have allotted. Just as the largest companies in this field up their organization by ploughing back some profits into the future development, so this would happen here as well.

Mr. FORRESTALL: Just a basic question, what happens to these profits today that are not being ploughed back in? Are they directed into returns to the shareholders?

Mr. WRIGHT: Yes, who then probably plough them into something else of benefit to Canada.

Mr. FORRESTALL: In 1964—and this is just a figure that I have—the P.M.A.C. indicated that their members had some $80 millions invested in Canada. It could be more now but do you think the generic houses as such, in striving to achieve a greater proportion of the Canadian market, could afford to move in terms of that type of money?

Mr. WRIGHT: I think they could gradually. All these other build themselves up.

Mr. FORRESTALL: So, then again it comes back to a question of sales and promotion?

Mr. WRIGHT: Yes, in some countries, as you know, the patent laws give them much more protection than it does even in Canada.

Mr. FORRESTALL: Under existing legislation, within the context of existing conditions in Canada, and in light of an earlier reply, how long do you think it might take at the present growth rate for so-called generic houses to achieve a greater proportion or a substantial proportion of the Canadian market? Are we talking in terms of 15 years?

Mr. WRIGHT: It would depend on a matter of luck, I suppose. It took Empire seven years to get to where they are now.

Mr. FORRESTALL: And, in this context, you are a substantial firm in the Canadian market.

Mr. WRIGHT: I think so.

Mr. FORRESTALL: Consequent upon what you have said then, for practical purposes at this moment, you are suggesting that it is necessary for the Canadian public to accept the status quo for a period of at least ten years, given the assumption that others in the generic field might be as enthusiastic about their own development as you and your firm have been. In short, there is nothing that can be done overnight?

Mr. WRIGHT: No, because as an immigrant into this country I am rather rabid against Canadians accepting any status quo. I just like to think in that way.

Mr. FORRESTALL: In the national firms, a doctor claims that there is no equality of the competition between them and the generic houses because of their cost structures. They suggest that they are totally different from the generic house and that possibly this accounts generally for the widespread, and I think there has been evidence from what I have read to substantiate this, disparity of prices. Given this, how then do you think these two totally different kinds of businesses could and possibly should exist in the common market side by side, going down the road. Is this what you envisage as part of the role of the drug institute?

Mr. WRIGHT: Yes. The drug industry properly has only one function and that is for the benefit of the Canadian public and notably, with respect to the benefit in pharmaceuticals, and the actual goods to the Canadian public. I would not think that they would in any way prejudice the existence of the present organizations. If these organizations that have the large investments the large operations, are sound and not top heavy (a situation which has in the past developed in some businesses), they should survive and operate alongside growing Canadian interests. Of course, if they are top heavy then maybe the competition would make them fall on their faces; but this, of course, is the way the business world should operate, for the good of everybody.

Mr. FORRESTALL: Mr. Chairman, I will just keep going, and I am sure you will cut me off when my time has run out.

Dr. Wright, the P.M.A.C. firms tend to assert also that because the generic house firm turnovers are so much smaller than theirs in any comparable costing formula that you might want to turn to, their costs per unit sale would be much less than yours. Is this a generality? Is this accurate, in your own terms?

Mr. WRIGHT: It does not seem to be in the figures that I presented.

Mr. FORRESTALL: But as a generality, in this one side of the picture as opposed to the other, is the contention of the P.M.A.C. firms a misleading one?

Mr. WRIGHT: I do not think it has very much meaning.

Mr. FORRESTALL: It is meaningless in terms of your own experience.

Mr. WRIGHT: That is my judgment.

Mr. FORRESTALL: I would not want to put you on the other side of the stove. Is a large part of the difference in costs and prices explained, as again the P.M.A.C. firms tend to assert, by the fact that generic houses do not do research and particularly do not carry the full burden that perhaps the other houses do in keeping doctors informed?

Mr. WRIGHT: We certainly are not doing as much research as I would like to be doing, and as I intend to do. Our costs for this year for research amounted to 3.4 per cent of our sales.

Mr. MACLEAN (*Queens*): Might I ask a supplementary here. I think, in answer to an earlier question, you said at the present time you do not manufacture any pharmaceuticals that you have innovated yourself—that is, new drugs that you have discovered, at this point.

Mr. WRIGHT: That is correct.

Mr. MACLEAN (*Queens*): But I think you said that in the future you would hope to do more research with a view to possibly discovering new drugs.

Mr. WRIGHT: This would be a policy but I would be reluctant, although it may be bad business, to introduce a new drug simply because I felt I could foist it on the market. I have the feeling that perhaps these new drug developments have rather gotten out of hand. I do not think that I am alone in thinking that. I think many of the members of the larger drug houses feel the same way about it. There have been a lot of very enlightened ideas that have come from this.

I was talking with the Director of Research of one of the biggest of these, when he was visiting here from the United States a couple of weeks ago, and he himself voiced this opinion. Undoubtedly, it has done a great deal of good over the period from 1945 to 1960, or perhaps even 1965, in invent new drugs, but it may be time to slow down this process, and to take what we have now, consolidate our positions and perhaps concentrate more and more on excellence and elegance of what we have. Also, perhaps we could even weed out some of the things that have come out as new drugs which experience has shown would be better not to have appeared. In answer to your question, I would like to bring in new medicaments as they are needed, but I would not do it just to put another tranquilizer on the market.

Mr. MACLEAN (*Queens*): I gather, perhaps incorrectly from your evidence, that you would expect to do more research of some sort in the future.

Mr. WRIGHT: That is correct.

Mr. MACLEAN (*Queens*): Assuming that you do more research in the future this will cost money. How would you recover the cost of this research?

Mr. WRIGHT: By being able to market products perhaps more cheaply or, after all, if I had something that was really new and was the first one who had it, I would expect to get some benefit from that, simply because I introduced it.

Mr. MACKASEY: May I ask a supplementary question. How long would you expect to have that advantage of being the first to introduce it?

Mr. WRIGHT: About two or three years.

Mr. MACKASEY: You would be satisfied then to hand it over to your competitors through compulsory licensing.

Mr. WRIGHT: I would say, yes, because in the long run the amount of money that I would have to spend to defend my position would be better spent to do other things.

Mr. MACKASEY: Is that the only reason?

Mr. WRIGHT: I think that is a good business reason.

Mr. MACKASEY: Yes, but it is not a good ethical reason. I would have been happier had you said that you had recovered at the end of two and a half years, all your costs that you had spent in research to find this product.

Mr. WRIGHT: I think it comes to essentially the same thing.

Mr. MACKASEY: No. The reason you gave me was that it would cost you so much time to defend yourself against people applying for compulsory licence that the cost would not be worth it.

Mr. WRIGHT: I would be better off to use those costs of defence for doing new research.

Mr. MACKASEY: Do you feel that when the day comes and you discover a new product, and thus become first on the market with it, you could recover all your costs in two years?

Mr. WRIGHT: Yes—well, let us say, three years. I talk this way as a chemist because I know other products are being manufacturered and I know what one expects, for example, if he brings out a new polyethylene.

Mr. MACLEAN (*Queens*): Suppose as a result of this research you discovered a new pharmaceutical for which there was a real need and a market, what would you propose to do with this? This is a very simple question but I want to get the basic thinking on the matter. How would you proceed?

Mr. WRIGHT: The first thing I would do is patent it.

Mr. MACLEAN (*Queens*): And then what? Would you sell the manufacturing rights to others, or would you hope to manufacture it yourself for the total market for a period.

Mr. WRIGHT: I would first manufacture it myself. I would have obtained a new drug application for this, or if I did not I would not be marketing it. Of course, I would get considerable advantage out of this because it takes time to do these things.

Mr. MACLEAN (*Queens*): You would manufacture it under the generic name, I presume, with a trademark.

Mr. WRIGHT: Empire's product is a generic name which has been assigned to the product, yes, but not by me.

Mr. MACLEAN (*Queens*): Yes. I know. This is perhaps an unfair question. Over these three years how much would you have to add, as a shot in the dark, to the actual cost of manufacturing to compensate for the costs of discovery?

Mr. WRIGHT: This would depend, of course, on whether it was needed so much by the public that the sales would be very good but, normally, judging again from my experience of other chemical industries, I would say that the price probably would be about 25 per cent above that which I would finally arrive at. I suggest, as an example, a material like nylon.

Mr. MACLEAN (*Queens*): I would like to ask a supplementary question in a different category. Earlier on I think you said that you thought about 6 per cent of your sales were to dispensing physicians.

Mr. WRIGHT: Yes, that is the best I can remember.

Mr. MACLEAN (*Queens*): I presume that you have considerable sales direct to hospitals and another block of sales to pharmacies.

Mr. WRIGHT: Yes. The principal sales are to pharmacies.

Mr. MACLEAN (*Queens*): Do you suggest to the pharmacy a retail price for your product?

Mr. WRIGHT: We use a list price which, of course, is subject to a discount. I do not tell the pharmacist what he is to charge.

Mr. MACLEAN (*Queens*): Have you any way of knowing or comparing the relative cost to the patient, if there is a difference, in the case of the same drug that he purchases as a result of getting a prescription from a doctor, that he purchases from a pharmacy, and one that is dispensed directly by the doctor? In other words, does the consumer, in the end, pay more or less for this 6 per cent that goes to the dispensing physician, or have you any way of knowing this?

Mr. WRIGHT: I might have a way of knowing if I wished to do so, but I have felt I should stick to my last, that is, stick to the manufacturing of drugs and the offerings to those who were called—

Mr. MACLEAN (*Queens*): I realize this, but the purpose of the Committee is to study the cost of drugs to the consumer, and I was just wondering if you have any opinions to express as to the most efficient way of the consumer getting drugs.

Mr. WRIGHT: I do not think I am competent to go into that.

Mr. FORRESTALL: To carry it one step further, and to finish out the first responsibility that I had, Mr. Chairman, could I ask the doctor this. The P.M.A.C. members that have appeared and have been examined so far have been quite prepared to detail their total unit costs of sample packages, to explain in detail the reason for the various elements of cost and what their percentage or actual dollars and cents are. Could I ask you, Dr. Wright, if you are prepared to do the same? Are you prepared to state precisely the degree and extent of the savings to the public that you think that could be achieved by replacing international drug firms by some form of growth of the generic house in Canada. You told us quite freely of your promotional and research costs this morning, what goes into the other 86 per cent. What is made up by the other 86 per cent of the total cost?

Mr. WRIGHT: One buys materials, one hires people to make things and one finishes up, in our case, with about 8 per cent, after taxes.

Mr. FORRESTALL: Could you perhaps detail for us the percentage of the total cost, generally? I realize this will vary from item to item, but as a generality; or could you name a specific item and give us an example of the total cost of that? How much do the elements cost, what is your overhead, what are your taxes and what is your profit?

Mr. WRIGHT: I am afraid that I am not empowered to do that, for the reason, that this company, at the moment, is in the hands of trustees for the late Mr. Winter. One anticipates that this company will pass into other hands, and under these circumstances the trust company has instructed me that they do not want to give any details with respect to the actual financial structure. This will be a matter that will be made public very shortly.

Mr. FORRESTALL: For example, I would like to find out the breakdown of the cost for an aspirin tablet. I did not mean to suggest that I was interested in your financial structure at all.

Mr. WRIGHT: This will come into the thing also. Wait a minute, now. Let me see what I can do with this. Here is an item for 100 tablets of Digoxin, .25 milligrams. Our material and direct labour on this is 55 cents a hundred. Our net price to the customer is 91 cents. That is roughly 80 per cent difference.

Mr. FORRESTALL: On top of that 55 cents went your sales, research, overhead and taxes?

Mr. WRIGHT: They differ, of course; sometimes they look better than others. Our materials and labour on phenylbutazone come to 45 cents a hundred tablets.

Mr. MACKASEY: Mr. Chairman, could I ask a supplementary question? If you have these things in such detail, Dr. Wright, are you producing anything under compulsory licence?

Mr. WRIGHT: Not at the present time.

Mr. MACKASEY: Have you applied for compulsory licence?

Mr. WRIGHT: Yes.

Mr. MACKASEY: On what product?

Mr. WRIGHT: On diazepam.

Mr. MACKASEY: In your submission, did you include a suggested price at which you were going to sell the product. Under what clause of the Patent Act have you submitted your request?

Mr. WRIGHT: Under section 41 (3).

Mr. MACKASEY: On price; at what price did you suggest you would sell this product if you were granted a licence?

Mr WRIGHT: We made a suggestion on this. We gave examples of what we had done with other materials, and until we knew what the commissioner would allocate with respect to royalty, and until we—

Mr. MACKASEY: We mentioned earlier—

Mr. WRIGHT: I cannot be positive, but I do not think we did. There is a gentleman here who could answer that more quickly than I can. Did I suggest a price? I do not remember.

Mr. MACKASEY: Can we find the price, Mr. Chairman.

The CHAIRMAN: Probably this is already in the evidence.

Mr. MACKASEY: I would like to know what it is.

Mr. WRIGHT: It is all right with me, but Mr. Goldsmith, my attorney on this, says that this sort of thing is *sub judice*.

Mr. ORLIKOW: Mr. Chairman, I wonder if we can proceed in an orderly manner?

Mr. MACKASEY: I agree, Mr. Orlikow. Mr. Chairman, I cut myself off at precisely 10 minutes. We started at 9.55 a.m., it is now 11.30 a.m., and we have heard two people. I agree with Mr. Orlikow and I agree with Mr. Howe.

The CHAIRMAN: The only thing the Chair can do, then, is to disallow all supplementaries and let everyone take a certain amount of time.

Mr. MACKASEY: We started off with 10 minutes.

The CHAIRMAN: I began by giving everyone 15 minutes, including you, Mr.

Mr. MACKASEY: Thank you. I will take 15 minutes later on. I apologize.

The CHAIRMAN: All right. As far as this point is concerned, if Dr. Wright does not know offhand—

Mackasey.

Mr. MACKASEY: I will hold it until my turn comes around again.

Mr. ORLIKOW: Mr. Chairman, I would like to ask Dr. Wright—if he gave a breadkdown of this, I did not hear it—if he could tell the Committee, approximately, of the sales that Empire makes, what percentage is to doctors, what percentage is to druggists and what percentage is to hospitals? I presume these are the three big categories of sales.

Mr. WRIGHT: I did not bring this type of information with me.

Mr. ORLIKOW: Could you give us an approximate percentage?

Mr. WRIGHT: Direct sales to doctors at the present time are about 6 per cent. We do not have as much hospital business as we would like to have, but a lot goes to government hospitals, and that would be about another, say, 8 per cent; and the remainder is to pharmacies and to the wholesalers involved with the pharmacists.

Mr. ORLIKOW: You mentioned a few minutes ago that your price to the customer for 100 digoxin tablets was 91 cents a hundred. You were going to tell us what the price of phenylbutazone would be.

Mr. WRIGHT: Phenylbutazone is 45 cents for materials and labour; it would be $1.66 net to the customer.

Mr. ORLIKOW: Without mentioning any names, can you give the Committee an approximate cost that one of the big companies would charge for a similar product?

Mr. WRIGHT: That $1.66 is our list, less 50 per cent, less tax. That brings our listed price in the catalogue to $3.50. The reason I have to do this is that I have to compare it to lists of other people, and there is one major company here listed at $10.30.

Mr. ORLIKOW: Compared to your $3.50?

Mr. WRIGHT: Yes; and another company is listed at $6.50.

Mr. ORLIKOW: What about the digoxin?

Mr. WRIGHT: Digoxin in our list is $2.00. The competitor's list is $2.90. Of course, there are competitors who charge more. There is . . .

Mr. ORLIKOW: When I say "competitor" I mean one of the name companies—one of the big companies.

Mr. WRIGHT: That was the figure—$2.00 against $2.90.

Mr. ORLIKOW: I would like to ask you a question and get your opinion on it. If generic drug companies like yours have a use,—of course, their major purpose. like the purpose of any company, is to make a profit for their shareholders. —would it, from the point of view of the public, be to act as a policeman on price?

Mr. WRIGHT: I would not want to put myself in the category of being a self-appointed policeman, although I think it undoubtedly works out like that.

Mr. ORLIKOW: I have only one other question to ask you and I do not know whether you would care to comment or not. You are the first person who has appeared before this committee to admit to employing salesmen. None of the other companies has salesmen. They all have something euphemistically called a detailman. What is the difference, in your opinion, between a salesman and a detailman.

Mr. WRIGHT: Mr. Winter had a very definite principle, and I acceded to this —it is possibly one of the reasons why I became associated with him—that we do not prescribe. We do not tell the doctor how to prescribe. Therefore, we have salesmen who tell the doctor that we can make good material and we hope that he will prescribe it; but we do not tell him what to prescribe, or that we think it is better than another product.

Mr. HOWE (*Hamilton South*): Mr. Chairman, I was rather interested in a reply to one of the earlier questions. Dr. Wright mentioned that they imprint their tablets and products with the letter "E". Why do you do that?

Mr. WRIGHT: There are two reasons. One is a marketing reason, having the doctor recognize this and know the "E". There is less chance of substitution. The second reason is simply a matter of identification, because more and more in this business this seems to be a good thing to do for the public. These are the two aspects.

Mr. HOWE (*Hamilton South*): What do you hope that "E" stands for?

Mr. WRIGHT: Let me read you one of my more blatant advertisements and see what "E" stands for—

Mr. HOWE (*Hamilton South*): No. What I mean is do you put that "E" on there to build up confidence in your products?

Mr. WRIGHT: That is correct.

Mr. HOWE (*Hamilton South*): That is very important, is it not?

Mr. WRIGHT: That is right.

Mr. HOWE (*Hamilton South*): I am rather interested in this statement which you made: "I suggest that brand name drugs are a potential menace to the Canadian public". You also say that you make only 6 per cent of your sales to doctors and that the rest goes mainly to drug stores. You are very proud of these Empire drugs. You build up this confidence with research and with facts.

I have one other question in connection with the confidence you have developed. You mentioned that you have withdrawn some of your products from the market, from time to time, did you not?

Mr. WRIGHT: Yes.

Mr. HOWE (*Hamilton South*): For what reason?

Mr. WRIGHT: I withdrew the long-acting sulphas because I felt, as a result of speaking with certain doctors of my professional acquaintance and others, that these had had their day and, frankly, I did not want to continue to be mixed up with some—

Mr. HOWE (*Hamilton South*): Is it not that you want this "E" to be a brand that the public have confidence in?

Mr. WRIGHT: I took sulfamethoxypyridazine out but we were making good sulfamethoxypyridazine tablets. There was nothing the matter with the quality of the tablets. It was just that it was a medicine about which there had been unfavourable discussion in medical circles and especially in pharmacological circles.

Mr. HOWE (*Hamilton South*): You mention the word "Bayer" in connection with aspirin here in your brief. Has the sale of Bayer aspirin dropped appreciably because there are cheaper substitutes on the market?

Mr. WRIGHT: Oh, certainly.

Mr. HOWE (*Hamilton South*): But they are still able to produce and promote? They do a lot of advertising, so it must still be profitable.

Mr. WRIGHT: Yes. Of course, most of their profit is in the packaging. I sometimes do not understand why somebody will buy from Empire 5,000 aspirin tablets. What are they doing with all these aspirin tablets? I do not know how many buy them, but they do. I am told that farmers out in the country will buy a supply of this kind, and they get them much more cheaply.

Mr. HOWE (*Hamilton South*): Farmers need tranquilizers these days. I guess.

This statement of yours that brand name drugs are a potential menace to the Canadian public disturbs me because it is not only the drug business, it is in the food business and everything that people have come to depend on brand names as standing for quality and excellence and this is where this slogan "Buy with Confidence" came in. I think it is probably important that we control this type of thing, but I do not want to see this confidence destroyed.

Mr. WRIGHT: I see what you mean.

Mr. HOWE (*Hamilton South*): You believe in it yourself because you put that "E" on your products.

Mr. WRIGHT: I mention in the brief the case of nylon and I added the comment, "do you know what kind of nylon is in your tires?"

Mr. HOWE (*Hamilton South*): Well, of course, as far as nylon is concerned there have been a lot of things come up since nylon. Acrilan and Orlon and all these things have come up since that time. This does not mean too much to me. We think of the Heinz products, the Aylmer products, the types of shirts we buy, the cars we buy. They are all branded, and if we are going to lose confidence in the drugs we buy because they are branded where do we go?

Mr. WRIGHT: I suppose the way I want them to be branded is by the generic name. I want this to be a public-owned brand. That is what I really have been saying.

Mr. HOWE (*Hamilton South*): Some of those generic names would make great slogans.

Mr. WRIGHT: I know, and I do not know who started this sort of thing. I suppose it is too late at this time really to re-name drugs. It would be just about as hard as changing from pounds, shilling and pence to dollars and cents. But they are going to do that, come to think of it, so perhaps we could change.

Mr. HOWE (*Hamilton South*): I have one more question, Mr. Chairman.

In connection with the conclusion that you draw, that the pharmaceutical field in Canada has grown without much cultivation, you suggest that this should be changed, and that a drug institute should be set up, with medicine, pharmacy, pharmacology and chemistry banded together. Have you ever approached any of these other organizations to set it up yourself, without the government.

Mr. WRIGHT: I am a member of the Chemical Institute and its council. This is the only profession to which I belong and I have brought it to the attention of the Chemical Institute, and we expect to discuss the matter in directorate meetings this fall.

Mr. HOWE (*Hamilton South*): It would be a definite advantage to all organizations if this were set up.

Mr. WRIGHT: That is right. I just discovered the other day that one finds that other people have the same ideas. A professor of pharmacology in this country has had this idea. I found this out only last Sunday, or Saturday. I am going to contact this man and say, "In your profession would you do something?"

Mr. HOWE (*Hamilton South*): You make two statements in this conclusion. You mention that these directors ought to be professional rather than political, and then you ask the government of Canada to provide funds. You might have a problem keeping it out of the political field if you ask the government of Canada to supply funds.

Mr. WRIGHT: I realize that, of course, I am thinking of similar institutes in the United Kingdom. Funds were provided, partly governmental and partly from the industries. In other cases, like the Meat Institute in the United States, this was provided entirely by the industries.

Mr. HOWE (*Hamilton South*): Thank you.

Mr. WRIGHT: I am not adept in the political field.

The CHAIRMAN: I wonder if I might ask Dr. Wright a question to clarify my thinking?

You said, in answer to a question, that the company did no research, and yet in the statement you gave you put down 3.4 per cent or something as the cost of research. Now, what is the explanation, under your heading of research, of the 3.4 per cent?

Mr. WRIGHT: The research, I believe, can actually be divided into two categories. One is chemical research and another one is pharmacological research and medical research. We have not reached the stage where I can maintain an animal laboratory and I hire people to do that work outside.

We will have to spend money on clinical investigations, and I will have to regulate my advancement to the extent that I can afford this. Therefore, up to now the research has been in making drugs more cheaply than they now would cost me and I have succeeded in several cases. From this I hope to reap an advantage by lowering the price of drugs and perhaps taking business away from those who are now underselling me. It seems to me that it can do nothing but good for Canada if I learn how to make a chemical more cheaply and use the advantage to sell more drugs.

The CHAIRMAN: Thank you; I just wanted an explanation.

Mr. MACKASEY: Mr. Wright, you mentioned in an answer, I think, to Mr. Howe's question that you have retired from the field of long-acting sulphas because you do not want to impose on the public something that is superfluous; but you also then went on to say that sulphas have had their day. Is it not more logical for us to conclude that there is no longer a market for them and this is why you have withdrawn them?

Mr. WRIGHT: There is a great deal to that, yes.

Mr. MACKASEY: Suppose everybody look the same attitude. There are some areas where we still need sulphas. Who would want to keep them in stock? Who is going to produce them, and who is going to sell them?

Mr. WRIGHT: The fellow who does not want to retire as fast as I do, I guess.

Mr. MACKASEY: Exactly. Now, you mentioned salesmen and detailmen—

The CHAIRMAN: Could I make a clarification here? I do not think Dr. Wright ever made a statement about retiring from the field of sulpha. He said he was retiring from the field of long-acting sulphas. There is still a large field for sulphas.

Mr. WRIGHT: That is right, sir.

Mr. MACKASEY: Now, salesmen and detailmen: What is the basic education of your salesmen?

Mr. WRIGHT: Of our salesmen, three of them are pharmacists and the remainder are people who have learned to sell drugs.

Mr. MACKASEY: They are not necessarily university graduates?

Mr. WRIGHT: No; but the pharmacists will be.

Mr. MACKASEY: What is the basis of remuneration of these salesmen? Are they on a straight salary, or—

Mr. WRIGHT: They are on straight salary.

Mr. MACKASEY: No commission? Now, in your submission with regard to the compulsory licencing of valium you suggested that you could sell it at about 60 per cent of the price being sold by the company which now has the rights to it. You go on to give examples. They are quite impressive. Coming back to tolbutamide, you mention that Horner sells it at $59.40 for 500 capsules of one-half gram. You can sell it at $23, and this is impressive. Why do you not sell it at $13 or $8 or $7 in view of the fact that Maney will produce it for $3.60 and Bell-Craig will do the same for $3.25. Why do you sell it at $23?

Mr. WRIGHT: Let us look at the breakdown here. Tolbutamide, 5 cents a gram, costs us, for 500 tablets, $5.69.

Mr. MACKASEY: And you sell it at $23?

Mr. WRIGHT: That is the list price, yes. Mind you, that discounts to $11.14.

Mr. MACKASEY: Then how can Bell-Craig sell it for $3.25?

Mr. WRIGHT: I do not have him on here.

Mr. MACKASEY: Yes; but I have him on here. Do you have Maney, $3.60?

Mr. WRIGHT: I do not have it.

Mr. MACKASEY: Who do you have on that list?

Mr. WRIGHT: I have Horner at $59.40.

Mr. MACKASEY: You have all the higher ones.

Mr. WRIGHT: Ayerst at $59.40, Lucas at $10, Kemo at $26.20 and one other fellow who is sitting here, at $8.50.

Mr. MACKASEY: The point I am getting at, Mr. Wright, is that as each brief comes to us they are becoming franker, which we appreciate, and Horner would no doubt tell you that they have to recoup research—

Mr. WRIGHT: Oh no, they are operating under licence from Hoechst.

Mr. MACKASEY: Well, then, Hoechst, selling at $59.40, have to recoup.

Mr. WRIGHT: But the question is how many times?

Mr. MACKASEY: When we get Hoechst here we will ask them that. But what is your reason for charging $11 and something when somebody else can do it for $3.25? You have admitted that you do not bill any research, you have not discovered anything?

Mr. WRIGHT: I beg your pardon?

Mr. MACKASEY: You admit that you have discovered nothing, that you do not spend money on research and that you would like to.

Mr. WRIGHT: I do, too.

Mr. MACKASEY: Is this 3.4 something not clinical testing of drugs?

Mr. WRIGHT: It is chemical research, to—

Mr. MACKASEY: Well, it is a matter of the definition of "research". You told us you do not carry an animal lab at all?

Mr. WRIGHT: That is right.

Mr. MACKASEY: So it is a matter of the definition of "research".

Mr. WRIGHT: I do not do animal work but that will be a research cost if I have to put it in there.

Mr. MACKASEY: Yes; but you do not do any at the moment?

Mr. WRIGHT: No; but I will as soon as I have a material that I think should be examined. I will deal with some firm in Montreal. I forget the name right now.

Mr. MACKASEY: The point I am getting at is that the big firms come back with the argument that they have to recapture the cost of research and the cost of promotion of a new product, and you have asked the very pertinent question: How many times? But I am just wondering what your reason is for arriving at a price of $11 odd when it is also available at $3.25 and when I think all of us realize that the material going into that is probably worth less than $1, particularly in view of some of the figures you read out earlier.

Mr. WRIGHT: I do not know. The price on this chemical has gone down very sharply in the last eight months.

Mr. MACKASEY: Are you going to resubmit a brief lowering the anticipated costs where you told the patent commissioner that you would produce, for instance, at the other end of the Canadian market at a certain price, approximately 60 per cent of what it is being sold at now by, I think, Hoffman-LaRoche?

The point I am trying to get at is that the main firms claim that they have to build in some form of amortization of the two or three million dollars that they spend in bringing a new product to the market.

You come along through compulsory licence and you make a valid case that the market is not saturated, that the price if is high, and that you can sell the product at a lower price. But how much lower? Why just 60 per cent? Why not 10 per cent? If you are basing it on material and the cost of marketing, which you have admitted on several occasions now to be very reasonable—10 or 11 per cent—

Mr. WRIGHT: This will not be uniform, but we try to operate on a certain markup. I did experimentation on the preparation of Diazepam and from that I decided that I could make it—the raw materials—at a certain amount of—

Mr. MACKASEY: How much would the raw material cost you?

Mr. WRIGHT: I calculate that it will cost me about $62 a kilo. As we do more investigation this will be revised downward.

Mr. MACKASEY: This is raw material?

Mr. WRIGHT: That is the active ingredients.

Mr. MACKASEY: Perhaps through the lunch hour I can find out the relationship, in the brief you submitted earlier, between raw material and the actual selling cost. I think you mentioned it earlier. You have material, you have direct labour which you mentioned earlier, you have marketing cost and you have markup. What is the relationship to the material in this case?

Mr. WRIGHT: This material is a relatively simple chemical and is, as I think you are implying, of comparatively low cost. Let us see. Five-tenths of a gram—and this tablet is mostly tolbutamide—so that means that from a kilo you get approximately 2,000 capsules. This is not exactly accurate, because you have to put some other materials in it. Two thousand, and the price of that kilo at the moment in thousand kilo lots is about $4.20.

Mr. MACKASEY: Are we talking about valium now or tolbutamide?

Mr. WRIGHT: I am talking about tolbutamide.

Mr. MACKASEY: Yes, let us stick to tolbutamide. What was the last figure you gave?

Mr. WRIGHT: Four dollars and twenty cents a kilo; so that would be $4.20 per 2,000 tablets; that is $1.05 for 500.

Mr. MACKASEY: Does that $1.05 represent your total cost?

Mr. WRIGHT: No; that is just the raw material.

Mr. MACKASEY: What about your cost of production? You mentioned the figures earlier and that is why I am asking. Direct labour to produce 500 certainly cannot be very big.

Mr. WRIGHT: Unfortunately, I bought this tolbutamide at about $5.50 a kilo; that was before the bottom dropped out of the market.

Mr. MACKASEY: You gambled on the future and you lost.

Let us go back, then, to valium. You have made an application for a compulsory licence, on the argument that you can sell, say, five hundred 10 milligram tablets for $58. I presume that is the retail; $29—am I right?

Mr. WRIGHT: You have me where I do not have the documents. I cannot even remember what I put in there.

Mr. MACKASEY: Well, you will have to trust me that this is what you put in. $58, less—I beg your pardon?

Mr. WRIGHT: You did something to me last time.

Mr. MACKASEY: I did?

Mr. WRIGHT: Yes.

Mr. MACKASEY: This is a good time to clear the air. What did I do to you?

Mr. WRIGHT: You read things out of the vademecum when I did not have a vademecum with me. I did not realize that I had been had.

Mr. MACKASEY: You had only to ask for it. You have an opportunity today, particularly in view of the publicity given to your statement, of placing on the record that you do advertise counterindications in the vademecum.

Mr. WRIGHT: But I am trying to find out here now what this contains.

Mr. MACKASEY: This is your brief; it is not mine. You read them back to me and I will trust you. How about that?

Mr. WRIGHT: Incidentally, I would say that I like to discuss these things so that we can clarify them. But I must say that my attorney pointed out that this brief is *sub judice.*

Mr. MACKASEY: You do not have to give it to me right away.

The point I am trying to get at, Mr. Wright, is this: How do you justify selling 500 of these tablets for $29, which is what you assured the courts you would do if granted a compulsory licence?

If we eliminate this very deceptive area of research, which is our battle all the time with the people who claim this, when we have a recommendation to make—if we eliminate research, which you admit, obviously, that you do not have to build into your cost factor, because these are not your products—you do not spend millions on them—how can you justify $29 as the sale price of something which must cost you about $5?

Mr. WRIGHT: Do you think it is going to cost me only $5? I have not got the total breakdown here, but I would guess it would probably cost me more than $5. Of course, I do not know what it is really going to cost me, because I do not know what the commissioner is going to tell me—

Mr. MACKASEY: —to charge for royalties; yes. But still you have come to up with your recommended prices. Would you add royalties to that? Is this the practice?

Mr. WRIGHT: I will certainly have to add them to my costs.

Mr. MACKASEY: Suppose that by some stretch of the imagination the royalties are $30? How would you maintain a price of $29?

Mr. WRIGHT: I might decide that I could not accept this compulsory licence after I got it. I have to hope that the commissioner will give me a certain rate, but I do not know what he is going to do. Of course, I also have to pay for the costs of applying for this compulsory licence. Somehow or other I have to slip them in—

Mr. MACKASEY: Mr. Wright, if we meet this afternoon—and I hope we do—I fully intend to pursue this line of questioning, and probably so will Mr. Blakely, so perhaps between now and when we do meet you might be able to get some facts and figures where that is possible.

Mr. WRIGHT: I do now know whether I could or not.

Mr. MACKASEY: Well, perhaps you would like to come back with them.

Mr. WRIGHT: I do not think I should do that, in justice to the patentee here and to myself, and because of what my lawyer advised me this morning.

Mr. MACKASEY: I mention this, Mr. Wright, because our mandate is to try to get drugs sold more cheaply to the public, and I think you agree with the reason for our existence.

That mandate does not extend only to the P.M.A.C. members, but also to the members of the generic houses, including your own, and I would like to know why you are recommending in your request for compulsory licence that you sell a product at $29 when, to my untrained mind, it could be sold for $5.

Mr. WRIGHT: I do not think it can be sold for $5.

Mr. MACKASEY: Well, let us go back to tolbutamide which you are selling for—I have forgotten the figures, but you have them in front of you. I think you mentioned that you were selling half grams, or 500 milligrams, for $11 a hundred?

Mr. WRIGHT: Net, yes.

Mr. MACKASEY: Eleven dollars. Now, Mavey can sell them for $3.60; Bell-Craig can sell them for $3.25. They make no pretense, of course, that they are amortizing anything, I am sure, but neither are you. Therefore, why are you so much higher than Bell-Craig, or Mavey?

Mr. WRIGHT: Maybe I do not see them. Maybe I think they are having a war.

Mr. MACKASEY: They are having a price war.

Mr. WRIGHT: Maybe I am not going to bite on that.

Mr. MACKASEY: How long do you think you can keep the price war up with these figures and stay in business?

Mr. WRIGHT: Well, we depend, like reputable houses on the fact that doctors will think that maybe Empire stuff is good and they will continue to prescribe them.

Mr. MACKASEY: I am not arguing with your prices. I think what you are saying, and in regard to what Mr. Howe mentioned before, you put a letter "E" on your particular generic tablet to emphasize that it is not Bell-Craig, and that for something you built into your product, reputation, safety control, and so on, your pill was worth $9.00, whereas it is only worth $3.00, because you have

that mysterious "X" in your product. Now, do you sell chlorpromazine? Excuse my pronunciation.

Mr. WRIGHT: Yes.

Mr. MACKASEY: At what price do you sell one hundred 25 milligram tablets?

Mr. WRIGHT: Well, $3.80 list $1.69 net.

Mr. MACKASEY: Then you are cheaper than Bell-Craig. They sell it for $2.10.

Mr. WRIGHT: I have a notation here that they sell it for $2.09.

Mr. MACKASEY: What about tetracycline tablets?

Mr. WRIGHT: Our cost on them is $6.95.

Mr. MACKASEY: I do not have the prices of the other firm.

Mr. WRIGHT: The Empire net is $9.56.

Mr. MACKASEY: Are other firms selling them for less?

Mr. WRIGHT: Yes, Lucas sells for $9.00.

Mr. MACKASEY: That is not really less.

Mr. WRIGHT: Chemo sells for $9.50 and Nova sells for $7.20. So, they are doing better than we are.

From the standpoint of business principle, I chose to buy material which does not infringe the patent. Unfortunately, that costs me more money than if I bought another material.

Mr. MACKASEY: Do you do business with a company called Strong Cobb Arner?

Mr. WRIGHT: No. I would not have any reason not to, but we make our own tablets and, therefore, we do not need, at the present time, their services. From the many which I have seen, I think they make good products.

Mr. LAIDLAW: Mr. Chairman, I have two short questions to direct to Dr. Wright. The first deals with his thoughtful brief on a drug institute for Canada. I am wondering whether the functions he suggests that the drug institute should perform, and which functions are set out on page 4 of that brief will have anything to do with lowering the cost of prices of drugs in Canada. I am wondering, Dr. Wright, whether this brief falls within the terms of reference of the Committee.

Mr. WRIGHT: Mr. Laidlaw, I think that it will, for one thing, because I think it will lower the costs of clinical testings. This is one of the main things. I think it will also lower it if, as a result of an institute, all companies decide that maybe we have too many things on the market right now and that we can decrease the number and therefore the promotion.

Mr. LAIDLAW: I want to place this on the record to be sure that it did fall within the terms of reference.

Mr. WRIGHT: I really thought it was apropos when I mentioned it.

Mr. LAIDLAW: My second and last question I would like to set out merely to put it on the record because I do not think any witness who has appeared yet before the Committee has been asked this question. It deals with recommendation 70 of the Hall Commission's recommendations, which reads:

> 70. That the Trade Marks Acts should be amended to make clear that no infringement can be claimed where imported drugs are manufactured by a "related" company.

Now, I wonder if you have any comments to make at all about that recommendation.

Mr. WRIGHT: I am not sure that I understand it. Perhaps you could read it to me again; it is new to me.

Mr. LAIDLAW: It reads as follows:

> 70. That the Trade Marks Act should be amended to make clear that no infringement can be claimed where imported drugs are manufactured by a "related" company.

In other words, an importer from Canada, importing a drug made by a parent corporation in the United States, and the parent corporation has assigned its trade mark to its subsidiary in Canada. Up to this moment the subsidiary could bring an infringement on the grounds of trade mark in a trade mark action. Do you have any comments at all?

Mr. WRIGHT: It could very well happen but, of course, nobody is going to fight with himself. It could occur in the trade mark field, although I am not an expert in this field.

Mr. LAIDLAW: The prime reason for my question was merely to put it on the record. We will be asking other witnesses the same thing.

Mr. WRIGHT: My thought is one that I mentioned in the brief which was my comparison with cigarette trade marks, which have some significance in this regard.

The CHAIRMAN: As the Chairman, I wonder if I could ask one question. I will use your company as an example. In comparison with P.M.A.C. you spend roughly a little bit less on what you classify as research; you have a certain marketing cost, and I assume you are paying approximately the same price for your labour; you are not paying too much more for raw material and you are roughly making the same profit as these other companies? Why are your drugs cheaper?

Mr. WRIGHT: I do not promote, and I think this is the answer. I do not try to support a brand name.

The CHAIRMAN: One of the drug companies that was here before us, I think it was last week, had promotional and marketing costs of something like 18 per cent, which was very low in proportion of what some have. Now, yours is 11 point something per cent and yet your drugs are a lot cheaper than 7 per cent.

Mr. WRIGHT: Well, I think by and large this can be made to work. It is obvious that I am not going to be able to sell nearly as much diazepam as the patentee from who I am requesting a licence. It will be just another item in this catalogue for the doctor to choose or not, as he wishes. This means I will not sell as much of it but it also means that it is not going to cost as much to sell what I do. I must also admit, as a business man, that I am expecting that the public will become more and more interested in buying by the official name, and of course I will have taken an advantage from that, which is obvious.

Mr. MACKASEY: You have not promoted the generic name?

Mr. WRIGHT: Yes.

An hon. MEMBER: In other words, the generic name becomes the brand name.

Mr. WRIGHT: Well, it is the same as the brand name belonging to the public.

Mr. FORRESTALL: Doctor, I too, am interested perhaps in following up the suggested line of the Chairman. I want to ask you a series of questions which will enable me to come to a conclusion. To your knowledge, do the generic houses operate generally on a national basis? What about your company? It is not fair to ask you about others.

Mr. WRIGHT: Well, I would say we operate principally in Ontario. We operate also in British Columbia and, through our direct mailing, we get accounts in between, but we do not cover these accounts at the present time by a sales force, although we hope to do so.

Mr. FORRESTALL: At some later stage you will have expansion. It is true, then, what you say, that generic houses such as yours consequently find your business in a small number of large selling lines in some of the more densely populated centres.

Mr. WRIGHT: Certainly I have to make a salesman's effort pay and I have to choose places where the most can be gotten from that salesman.

Mr. FORRESTALL: This is not a generality with the larger houses who endeavour to cover the nation and provide a national service.

Mr. WRIGHT: I do not think their coverage is uniform per square mile. We will certainly have more people in Toronto than they have at Red Deer, but this does not preclude the fact that they have salesmen on the road, for example, in our less densely populated areas in Nova Scotia.

Mr. FORRESTALL: But you are not down there at all.

Mr. WRIGHT: Well, in effect, we may be in six months.

Mr. FORRESTALL: What effect did this have on the cost of your drugs? For example, are you, as a generic house, prepared to sustain the loss which might be incurred over a period of time while you built up a trade in a less densely populated area such as Nova Scotia and New Brunswick?

Mr. WRIGHT: Of course, we would have to do that.

Mr. FORRESTALL: Is this something which you intend to do?

Mr. WRIGHT: We would have to do this, yes. Of course, there are houses down in Nova Scotia which are local houses as well—or so I understand.

Mr. FORRESTALL: Generic houses?

Mr. WRIGHT: They are smaller houses. I do not know whether they sell under their own trade names or under the official names.

Mr. FORRESTALL: What effect will this have, then? We are talking now as if we are at a border line. I presume you have not had any great expansion of your business during recent years.

Mr. WRIGHT: Oh, yes; we went into British Columbia just about a year and a half ago.

Mr. FORRESTALL: Where do you operate in British Columbia? I am thinking specifically in terms of the cost of having people on the road and the basic expenses of your salesmen. Do you have one salesman in British Columbia?

Mr. WRIGHT: At present one salesman is covering British Columbia.

Mr. FORRESTALL: Then this does not have any real over-all effect on costs. You are suggesting then that this expansion will not drive up your costing factors at all?

Mr. WRIGHT: If it brings me the business at the time I put it in, it is not going to because it will pay for itself.

Mr. FORRESTALL: This would be a generality. You would not move until you were reasonably sure that returns would meet the costs. You said a few moments ago you were prepared to go in over a period of years and sustain a loss.

Mr. WRIGHT: I might move a little bit, yes, if not a lot.

Mr. FORRESTALL: Would this be because the cost of selling is a substantial factor in the cost of drugs?

Mr. WRIGHT: Of course it is in the sale of any product.

Mr. FORRESTALL: It has been suggested, doctor, that some samples were spot-checked in pharmacies located in Manitoba and that the prescription drug stock ranged from 1,300 to 5,700 different items. In this survey possibly 5 per cent of all drugs stocked bore an expiry date—this is, after a given date I suppose they would degenerate or would not measure up to the label performance. What effect does this have in your suggestion to me that through the process of competition you are going to have to go into a druggist's shop and put on his shelf, perhaps, the identical thing, one under a generic name and one under a brand name. Do you suspect that the pharmacists in Canada will permit this in light of what appears to me to be a tremendously high number of different items they have to carry, particularly when they are items on which I do not think you could have a penny sale to dispose of them? Do you believe that the pharmacists will do this?

Mr. WRIGHT: Of course, if the doctor asks for our drugs, then he will do it. If the doctor prescribes Empire, of course he will do it—not entirely; he might then talk to the doctor again and say, "Look here, I do not have this; would it be all right to substitute a trade name drug for it on the prescription."

Mr. FORRESTALL: This question is my last, Mr. Chairman. Do the great percentage of doctors prescribe by brand name or by generic name?

Mr. WRIGHT: I would say that the great percentage of them prescribe by brand name as opposed to generic name.

Mr. FORRESTALL: In short, you have a costly venture ahead of you to try and break into this market.

Mr. WRIGHT: Either that or some clever bit of marketing will be required.

Mr. FORRESTALL: You would hope that possibly organizations like your Drug Institute might provide that type of educational service as a fringe benefit to the institute, which would bring to the attention of the Canadian public that there are, indeed, ways in which drugs can be made available to them at lower cost?

Mr. WRIGHT: So far as my concept of the Drug Institute is concerned, I would consider this to be purely professional.

Mr. FORRESTALL: Purely professional.

Mr WRIGHT: That is my opinion.

Mr. FORRESTALL: What effect would the Drug Institute have on the cost of drugs? I am sorry, but I thought there was some logical connection.

Mr. WRIGHT: It is my feeling that it would lower prices because it would lower the expenses of introducing new drugs.

Mr. FORRESTALL: Would it remove competition? Or are you referring specifically to certain areas of research and control which the institute would police themselves?

Mr. WRIGHT: I was thinking of the latter. I did not have any idea of its effect on the market. To me, this was quite separate.

Mr. FORRESTALL: Doctor, to further this question of the role of the dispensing pharmacist who must fill out these drugs in the dosage forms prescribed by the physician or the doctor, is he today, in your understanding of the industry, taking what you would consider a reasonable markup of profit?

Mr. WRIGHT: I do not know enough about this business to answer that question.

Mr. FORRESTALL: My feeling is that he is not making an enormous profit, but I do not know enough about the practice of pharmacy to go too far into what Mr. Mackasey wants to get into later.

Could we just go back to diazepam for just one final question, for the time being, Mr. Chairman. Do you think this afternoon you could give us a general breakdown of your costing in this. The figures which Mr. Mackasey has raised, and which were so very well outlined and detailed by Dr. Brand in his request for me to do some work for him this morning, would seem to indicate that there is a tremendous vague area in here about which we know nothing—and I am interested in that because we do have certain other information with which we could compare this cost infrastructure to determine, indeed, if the high cost of drugs is as closely related, as some of us think, to promotion. Could you give us this information?

Mr. WRIGHT: I must confess that Mr. Winter and I had the idea of applying for a licence. At that time we had the idea of applying for a licence for both chlorodiazepoxide and diazepam, and this was written up before his death. I took his evaluations pretty much as he had given them. I was concerning myself with rewriting so that the submission would come from me about the other matters, especially about the chemistry. This is what I was covering anyway. I am not sure where he arrived at these figures. Of course there are details back in the files.

Mr. FORRESTALL: I am sure that is all, just now, Mr. Chairman.

Mr. MACKASEY: Mr. Chairman, if I could have just another five minutes, it may eliminate this afternoon's meeting. In all fairness to Mr. Wright, he does not have this information at his fingertips. Why subject him to a number of long distance calls to his head office this afternoon to try and provide these figures. I think it is unfair to Mr. Wright to ask him to do that.

I would just like to ask a few more questions of Mr. Wright so that when the Committee goes over its evidence we can get somewhere. I appreciate Mr. Dan, who is a very objective and neutral observer here, working out the

mathematics for me. Never being too familiar with the decimal system I have had a little difficulty.

Again, I come back to your submission for compulsory licensing. On page 8 it says: "On the basis of laboratory preparations the applicant estimates the over-all labour and material costs of the diazepam which it proposes to manufacture, would be approximately $68 per kilo." According to that, this $68 a kilo includes the material in the over-all labour—I presume this means direct labour—but what has to be added, of course, is marketing, which you do very reasonably. By the addition of overhead and profit, the price at which the applicant would be in a position to sell diazepam in bulk to others, not including any royalty of course, is anticipated to be in the neighbourhood of $170 per kilo. Furthermore, if you go down to section 25, you specify the price at which you would be able to sell this product in capsule form, at $58 less 50 per cent or $29, which is quite a saving over the original. Now, working out the $29, with no allowance for wastage, which there is bound to be, presuming you have ultimate production, and you get as many tablets of 10 mgs. out of a kilogram as feasible—I will then leave it to everybody's logic to make a mental deduction—you would get $5,800 back for this $68 investment in material and direct labour. Naturally, on top of the $68 you have promotion costs; you have wastage; you have overhead; you have profit, and you have the royalty yet to be determined.

Looking at the brief in which you took part and which was submitted earlier in the year, I find that the relationship between that figure of $68—that is cost plus material—and the retail figure, which is beyond my ability to come up with out of this very elementary balance sheet—and I imagine the P.M.A.C. brief is exaggerated in many respects, at least by your definition—this should represent 30 per cent of the manufacturing dollar in material and direct labour. They broke it down into material, labour and plant costs, adding up to 30 per cent of the manufacturer's dollar.

Applying that same criterion to you people, $168 should represent approximately one-third. Then you add on your marketing, which is less than their 30 per cent—and if I recall this brief, in your case it probably averages out at about 20 per cent—and I just do not understand, even allowing you, as generously as I can, say, $300 for all these other services compared to $668, why your overall cost for material, direct labour, promotion, profit et cetera should average out to $500. Yet, this thing sold to the druggist or the wholesaler, or whoever you sell it to, could bring you back as much as $5,400. This is equally true of Hoffman-La Roche, and in their case the gap is probably even greater because you are selling at a lower price. But they come back with the argument that that intangible in between is the amortization of the $2 million or $3 million which went into the development of the product in the first place. You have asked a very good question which we are trying to determine, "How many times do they regain it?"

But let us take your case because you are on the stand. You do not have to regain it and you admit it. You are going to the courts and are saying, "I would like to produce or reproduce valium as the result of a compulsory licence because Hoffman-La Roche have the market to themselves and they are overcharging the Canadian people. I can come along and manufacture an equal product and sell it at half the price at which Hoffman-La Roche are selling it." I think you

can; but my point is, does that justify you getting as much as you can get. Why do you not come along and regain $2,700 or $2,900 rather than $5,400, for your $500 investment? I would like your opinion on that.

Mr. WRIGHT: I think your point is well taken and in some ways I do not see why we even mentioned the selling price of the other. The compulsory licence is not a licence to make a dosage form.

Mr. MACKASEY: Could I explain why you do it—because you are applying under a clause of the Patent Act on the argument that a compulsory licence granted to you is valid because you can bring down the cost to the Canadian public.

Mr. WRIGHT: If I get a compulsory licence for this material, I think that I can sell this to other people too.

Mr. MACKASEY: That you can do what, sir?

Mr. WRIGHT: That I can sell this to other people. Is it not true, Mr. Nowotny, that if I get a compulsory licence to manufacture diazepam and I manufacture it, can I not sell it to other Canadian dosage form manufacturers?

Mr. C. A. NOWOTNY (*Assistant Secretary, Hoffman-La Roche Ltd.*): You mean the substance?

Mr. WRIGHT: Yes.

Mr. NOWOTNY: You can sell the substance to others, yes.

Mr. MACKASEY: I do not appreciate the fact that you are going to sell to someone else who, again, is going to sell it to the Canadian public.

Mr. FORRESTALL: You are speaking of competitors.

Mr. WRIGHT: The competitor is the fellow I sell it to.

Mr. MACKASEY: The more I see of the businessman on the stand, the more I realize there is a pattern in everybody's behaviour. Yours is no different than, say, Mr. Fralich's when he was up there or the gentleman from Cyanamid. The point I am getting at is that I am not interested whether you can sell it to somebody else; I am interested in why you are going to sell it to the Canadian public through the druggist at $29 for 500 capsules when, according to my mathematics which can be out 10, 20 or 30 per cent, you could be selling the thing under $10 to the druggist and consequently that much cheaper to the Canadian people. You cannot rely on the pretence—and I will use that word until we get a better one—that you have anything to recoup in the way of research or development.

Mr. WRIGHT: Business being what it is, if I get a compulsory licence for this material and somebody sees that I am still selling it for too much, then I imagine there will be somebody else apply for a compulsory licence to sell it.

Mr. MACKASEY: What you are really saying, Mr. Wright, is that it is a little like an auction, you are going to the courts to ask for compulsory licence and you are including a price to the Canadian people as high as you think you can get and not jeopardize your possibility of getting the compulsory licence. There is not really any true relationship between the $5,400 and what it costs you to produce and market the product.

Mr. WRIGHT: The price that Mr. Winter and I mentioned in there, need not have any relationship to the price that finally appears in here. It is a price that was established to show that we could do better than the other fellows.

Mr. MACKASEY: But do you not think that perhaps it is time that we changed the law in view of the circumstances of people applying for compulsory licences, and that through some government organism the cost of material, the cost of production—which you have been kind enough to put in your brief—and the normal overhead, should determine the final price to the Canadian people. The reason that I imagine the government will grant you a compulsory licence is not because they want to increase the profits of Empire but because they want to protect the Canadian public against monopoly; they want competition to bring down prices. But you are not doing that. I would imagine, from the briefs I have read, that you are making more profit in selling this thing at $5,400 a kilo than the original Hoffman-La Roche is because they have got to amortize $2 million to $3 million which they expended in discovering valium. Am I right there?

Mr. WRIGHT: I think you are right. I think they have recovered these costs already.

Mr. MACKASEY: Yes, well we will argue that with them. But you do not have any cost to recover.

Mr. WRIGHT: Oh, I have some.

Mr. MACKASEY: But not with regard to the discovery of valium.

Mr. WRIGHT: Not toward the discovery of the chemical. As a research man, I happen to know that you can tuck a lot of things into the cost of development which may contribute to another development later on.

Mr. MACKASEY: This is the argument that the brand companies always use —the P.M.A.C., "We have to finance past research that went sour; we have to finance the research that did go well, and we have to finance future research."

Mr. WRIGHT: In my experience as a research man, past research does not go sour. Somehow or another it becomes useful for something.

Mr. MACKASEY: Yes. But the point is that you are honest enough to say that none of these factors should enter into your pricing policy, that this type of argument will perhaps be used in the foreseeable future of Empire, but at the present moment you differ from Hoffman-La Roche, Smith, Kline & French, Horner, or Ayerst basically in research facilities they have as opposed to what you have. This is your break, other than that little section of marketing.

Mr. WRIGHT: Well, that has not done anything for Empire. This is a formative thing and I go along with some of the ideas in it.

Mr. MACKASEY: Then am I right in so far as Empire is concerned, that this is one of the basic differences between Empire and, we will say—and I like to give them all a little publicity—Cyanamid with their research lab—in the United States, of course; it is not up here unfortunately.

Mr. WRIGHT: Well they do some here.

Mr. MACKASEY: Not in pharmaceuticals. But, anyway let us say they do. Would you say that that is the basic difference between your firm and their firm, apart from size. Is this one of the costs they have that you do not have?

Mr. WRIGHT: Cost in what?

Mr. MACKASEY: This type of research that leads to a product.

Mr. WRIGHT: I do not think that question can be answered.

Mr. MACKASEY: Well let me be fair because I am not being fair in using Cyanamid as an example. Let us get back to the people who discovered valium in the first place.

Mr. WRIGHT: I think it is Hoffman-La Roche's product.

Mr. MACKASEY: That is right. I think you are honest enough to admit that they did incur some expenses in producing valium.

Mr. WRIGHT: That is correct.

Mr. MACKASEY: Therefore, when they set their prices they want to recover the sum of all these expenses over a particular period of three, four, five or six years—and some of us suspect that perhaps they have recovered it more than once. It is the purpose of this committee to discover this. But, coming back to yourselves, you do not have this excuse. You do not have this reason, because you have not contributed one red cent to the discovery of valium. Therefore, how can you justify the markup between $300, $400 or $500, which seems to me to be ample in view of the fact that your material and direct labour costs $68. You have to add marketing profit and the rest of it—let us say 300 per cent—which would bring you up to $500. How do you justify the jump from $500 to $5,400? In all fairness, you did say, that you may sell at a lot less in the price book than appears in this document. This being the case, I am wondering why you did not put the price you intend to sell it at in the document.

Mr. WRIGHT: I do not really know it, do I? I do not really know what it is going to cost.

Mr. MACKASEY: What ingredient is missing—royalty?

Mr. WRIGHT: Yes, royalty and the cost of applying for this compulsory licence.

Mr. MACKASEY: Which is legal fees.

Mr. WRIGHT: Yes.

Mr. MACKASEY: By past experiences, how much can legal fees run into?

Mr. WRIGHT: I am not a lawyer.

Mr. MACKASEY: I am not a lawyer either. But why are applications not worded in such a manner that you establish a price plus the royalty.

Mr. WRIGHT: Perhaps we should have presented it in this way.

Mr. MACKASEY: Secondly, if you do not know the cost of legal fees and you do not know royalties, then it is very obvious that by setting the price at $29 for the 500 tablet, you have left a lot of leeway for yourself.

Mr. WRIGHT: I have played it safe, yes.

Mr. MACKASEY: Very safe. Well, Mr. Chairman, the only questions I would have wanted to ask this afternoon would be to determine what figures had to be added to $68 for marketing, profit and so forth, based I would say on last year's

balance sheet. Most of the witnesses have deposited their balance sheet here. Do we have Empire's balance sheet here?

Mr. WRIGHT: No.

Mr. MACKASEY: Could we get a copy of that?

Mr. WRIGHT: Not until this company is freed from probate.

The CHAIRMAN: I think Dr. Wright said it was under a trust company.

Mr. WRIGHT: There is one point I would like to check up on, Mr. Mackasey. I have a very great respect for Hoffmann-La Roche and for their research.

Mr. MACKASEY: I do not have as yet.

Mr. WRIGHT: But I do not say that they discovered anything anew. These things are all a matter of borrowing somebody else's stuff, perfecting it—

Mr. MACKASEY: What you are doing right now.

Mr. WRIGHT: —blending it with new ideas and so on. It is a continuing thing. I do not think I ever discovered anything new in my professional life, although there are people who consider that I did. But I do not think so.

Mr. MACKASEY: Well, I appreciate your frankness and honesty, Mr. Wright, because it perplexes me even greater how you can justify the markup between $500 and $5,400. Hoffmann-La Roche will have to search their own conscience and will have to answer the questions that come out of our review of the testimony. But you, according to your request here for the right to produce valium, were honest enough to state that the material cost direct labour in producing a kilo cost you no more than $68.

Mr. WRIGHT: Well, I guess I will have to search my conscience too, but only half as much as the patentee.

Mr. MACKASEY: Yes. In the meantime the Canadian people over-pay not only the brand but the generic with the "E" on it.

Mr. WRIGHT: Well I do not know what it is going to appear at in this catalogue. Maybe the work you have done on my conscience will make a lot of difference.

The CHAIRMAN: So far as royalties are concerned, it is my understanding of the patent offices that lately they have been granting 15 per cent of the bulk cost. In this case 15 per cent of $70 would be $10.50.

Mr. MACKASEY: It is unbelievable. So then you would be up $80.

Mr. WRIGHT: No.

Mr. MACKASEY: I am sure when I see your balance sheet that the relationship between the end price to the druggist and that area known as direct labour and material, is not going to be 400 per cent or 500 per cent. But let us say it is 400 per cent. According to the Chairman's information, when you add royalty you will then be into $80. And then if we add 400 per cent—and I am very generous that way—at $320 added to $80 means that your total cost including profit and everything here would be $400—and yet you are going to get $5,400 which is nine times.

Mr. WRIGHT: Not after you have worked on me. I am not going to get that much.

Mr. MACKASEY: I will be watching.

The CHAIRMAN: Are there any other questions? Is it the intention of the committee to excuse Empire at this time or does the committee wish to have Dr. Wright back this afternoon?

Mr. MACKASEY: Not for me, Mr. Chairman.

The CHAIRMAN: Is it agreed then that we now adjourn?

Some hon. MEMBERS: Agreed.

The CHAIRMAN: Before I thank Dr. Wright, I would like to tell you that we were to have two witnesses for our meeting on Thursday, Mr. van Ular from Quebec and the Canadian Consumers. Mr. van Ular phoned and said his brief is not yet completed and he will not be appearing. We have been unable to move the Canadian Consumers to the morning session, as they have a prior commitment in Ottawa at that time. Therefore, the next meeting will be Thursday at 3.30 when we will hear the Consumers brief, which is already in your possession.

On behalf of the Committee I would like to thank Dr. Wright for coming on behalf of the Empire and for answering our questions.

APPENDIX "A"

A DRUG INSTITUTE FOR CANADA

supplementary to a brief

submitted to the Committee on July 7th

(by George F. Wright, Ph.D.)

The controversies today over pharmaceuticals are not unexpected. History teaches us that any betterment in the lot of man always has been accompanied by some disadvantages: what we might call social side-effects. Sometimes the detriments have been severe ones that gradually ameliorated with time. But often they began as minor maladjustments which festered into catastrophes. So it is not surprising that the introduction of modern drugs into the repertoire of prognosis has augmented the health (if not the happiness) of mankind while at the same time it has bred problems. It is characteristic of the professional man that he involves himself with such problems, and tries to solve them. I am writing this article because I have faith in professionals.

It is axiomatic that there is no such thing as an absolutely safe drug. Quite aside from the physiological hazards (which I shall mention later) are the social dangers. One of these is the intrusion of the drug between the doctor and his patient. It is garish that the practitioner who is so busy at his profession that he is hard-pressed to read the newspapers, not to mention magazine articles, may be confronted with a patient's insistence that he be treated with a drug which has somehow (?) been touted in a human interest article. In this circumstance it is hard to balance one's professional caution against the patient's confidence in the spectacular, which may go far to effect a cure. But it is dangerous journalistic practice because neither journalist, patient nor the manufacturing chemist who must have "leaked the news" is qualified to prescribe. Nor should a doctor in the chemist's employ intrude between the practitioner and his patient in this devious manner.

Another social hazard for drugs involves their cost. It is an axiom of business to get the most that competition will permit. In most business contests the public is the referee. But the regulating effect of competition is lost when a person is sick. This is amply demonstrated by the high cost of drugs in Canada. High drug prices hurt the little people, those of median and low income who forego medication because they cannot afford it. There are more prescriptions written than are filled.

Those who try to justify prevalent drug prices are wont to remark (privately!) that the low-paid profligate who spends his earnings on whiskey deserves scant sympathy because he cannot afford to buy available drugs. The argument, of course, is specious. It is not sympathy for the individual Canadian that concerns us but, instead, empathy for Canada as a whole. Canada can toler-

ate classes of wealth, ability, education, etc. but she cannot tolerate classes of health. Drug prices must be set for the needy, not for the affluent. And we know it can be done. We have only to consider the relative prices to hospitals versus those to doctors and pharmacists. The social hazard of high drug costs deserves the attention of the professions.

Besides the social hazards a drug can be dangerous because it is manufactured improperly. If Canadians suffer from this fault they have only themselves to blame. Canadian law amply authorizes regulations which the Food and Drug Directorate have put into force and still are devising. The penalties for disregarding these regulations include criminal indictment and are sufficient to make drug manufacturers do the job properly. If there are still evasions it is not nowadays for lack of diligence in the Directorate but, instead, because of insufficient appropriations and public cooperation. Those who, for one reason or another, conjure up the mirage of low drug quality in Canada are implying an insult toward the directorate which ought to be turned on themselves. Citizens should support our pharmaceutical police force with adequate funds and (especially when they are doctors) with mature information about improperly-manufactured drugs.

Safety in manufacture is not the problem. It is safety in use. Properly this aspect is in the province of the medical profession but in recent years the area has become so complicated that the doctor has had to seek help outside his profession. The plethora of new drugs, each with a non-standardized clinical qualification when multiplied by new therapies and then multiplied again with ever-increasing numbers of patients has placed the practitioner in a position that is somewhat sardonically called "busy". Faced with this acme of understatement the medical profession has shared control of its traditionally-exclusive province, the therapeutic aspects of drugs. No doubt this sharing is necessary today. But it should be sharply limited to exclude non-medical individuals or groups except when they are obligated to the sister professions that are involved with drugs.

The significance of drugs in the practice of medicine has changed markedly in the last generation. Despite the alarms that I have sounded I do not believe that the situation has gotten out of hand. But here is evidence that it may become a Frankenstein monster unless it is brought back entirely under professional supervision. For this reason I suggest the establishment of a Drug Institute in Canada, to be administered by a council drawn from the professions of Medicine, Pharmacy, Pharmacology and Chemistry through the respective professional organizations. This dream is so attractive to me that I hope I may be pardoned if, in the ensuing pages, I act as if this Institute under the aegis of the professions already exists!

This juncture of disciplines is particularly advantageous to Canada. Because Canada is diffuse in terms of population-*versus*-area the potential of any one profession is low when pressure must be brought to bear upon a problem such as that of drugs. A group of four will command more attention. The mutual advantage is a cement that may be expected to bind the professions into a virile administration of the Drug Institute. At least that is the way that it has worked for the National Research Council.

The establishment initially would have to be subsidized by government. It would be maintained by a combination of government grants and of charges for services to profit-making organization. It should not be a part of the Department of Health and Welfare because its functions should be such as to supplement but not to complement or duplicate the functions of the professional leadership. It should not be a branch of federal or provincial government at all.

As a chemist I am not competent to specify exactly and completely the functions of the Drug Institute. These functions must be the combined choice of the disciplines, Medicine, Pharmacy, Pharmacology and Chemistry which will comprise the Council. However, I am proposing and discussing some functions tentatively for consideration by my peers. Following are the functions that I suggest:

1. To examine the areas of therapy in which new drugs may or may not be needed.
2. To regulate some preclinical and all clinical trials of a new drug.
3. To solicit, receive and correlate all reports of side-effects, contraindications and alternative uses of drugs, new and old.
4. To solicit and correlate all reports about efficacy of drugs.
5. To establish the official (generic) name of a new drug.
6. To participate in multiple-screening tests for discovery of new drugs.
7. To accomplish fundamental research in pharmacology and medicine.
8. To promote the development of Preventive Medicine in Canada.

I shall discuss separately the significance of these several functions.

AREAS OF THERAPY IN WHICH NEW DRUGS MAY OR MAY NOT BE NEEDED

Few would doubt today the advantages to Medicine of new drugs that have been introduced during the past thirty years. Not enough persons give thought to the concomitant disadvantages. One of these disadvantages is unnecessary duplication. Ideally each person's illness would have a drug tailored to his own malady but the total number would equal the population of the world. Obviously this number of drugs is absurd (although the number of drugs claimed in certain "Canadian" drug patents exceeds this two billion!) but it does point up to an important conclusion. All too often it may be forgotten that drugs are only a part of the doctor's armament against disease. This part may well be met by an old drug of moderate efficacy and high safety. By contrast oftentimes the physician's choice of drugs with rival claims converges on the ridiculous. Some have said that a therapeutic index of "wonder drugs" is a list from which one wonders which to choose!

Not only is the multiplicity troublesome to the doctor, but also it is expensive for the patient. Each new drug takes its toll of wealth during its development. Whether or not it is successful, or even necessary, its cost must eventually be paid by the patient. Part of the onerous cost of drugs is due to duplicate drugs.

I have mentioned earlier the problem that can arise when ill-advised "news" about a drug may intrude between doctor and patient. There is a converse

problem where the prescription may lead to sociological detriment. A Drug Institute can guard against this danger. Let us remember that Meprobamate in 1956 seemed to be an answer to many of the doctor-patient problems, but few of us expected a long-term effect on society. Nowadays when my Sales Manager tells me that we sold a million of these tablets last month I am troubled. Who swallows these tablets, and how many, and why? Am I contributing to Canadian delinquency? Who is responsible for the unusual upsurge in purchases of this drug? The answer is: all of us.

We cannot cancel the past but we can behave in a more enlightened manner in the future. I say that we should delineate the fields of therapeutic necessity very carefully, and the Drug Institute will be in a position to do it. The little problem in 1960 that was solved by a "MEP" prescription should not return as a monster in 1966.

PRECLINICAL TRIALS

When one reads in the advertisements of pharmaceutical manufacturing chemists that they have established laboratories for pharmacological and medical research these statements may be translated as the installation of animal colonies. Such colonies are necessary for the biological screening studies that must be made during the developmental research toward a novel drug. The results are valuable during this work and they can be valuable in preclinical studies if they are entirely communicated to an authority like the Food and Drug Directorate. But they should not be definitive as complete preclinical trials.

The Drug Institute should maintain animal laboratory services which the manufacturing chemist would be compelled to use on a fee basis if he contemplated clinical studies on his novel substance. In effect the Drug Institute would be responsible for preclinical testing. The extent of this testing would depend upon the amount of biological information which the originator supplied but the final decision to permit clinical trials should be made on the basis of the Drug Institute findings.

This function of the Drug Institute ought to widen the field of new drug discovery because it would provide biological testing services for the small Canadian manufacturers who are not sufficiently capitalized to maintain their own animal laboratories for screening tests but who have novel ideas as well as good chemists and biologists on their staffs. Inventors are individuals, not groups, and they need not (perhaps best not) be concentrated in one place.

CLINICAL STUDIES

It is customary today for a manufacturing chemist with a novel drug that is successful in preclinical trials to arrange for clinical trials with a teaching hospital or its equivalent. I believe arrangements for clinical trials should be made by the Drug Institute. The results should be reported to the Drug Institute for its final recommendation to the Food and Drug Directorate who is legally empowered to grant a new drug application.

This jurisdiction is not intended to reflect on the competency of those who make the clinical studies. It is intended to reflect upon one of the most dreadful activities of civilized man, the evaluation of danger to mankind by subjecting men to that danger. The responsibility for risk from hitherto untried drugs

should be borne by whole professions and not a few professionals who are immediately involved. Those who protest that irregularities such as occurred long ago in the study of human anatomy could not occur in our present civilization have only to remember what happened in Nazi concentration camps in 1943 . . . and in New York in 1965! The experimenter with his eyes in the sky sometimes does not see that he is standing in filth.

In the best moral tone there is still the alternative accent on safety versus efficacy. It is not a choice between Kill or Cure, for the ultra-safe drug may be a silent killer if it is ineffective. Proximity to the project is often disadvantageous in the judgment about the balance between safety and efficacy; the perspective from a candidate committee of the Drug Institute provides a more seasoned view.

There is another, less dreadful aspect of clinical trials which is important, at least, to the ultimate patient: the cost of clinicals which must be reflected in the price of drugs. While many alligator tears are shed by the interests who originally pay for the trials (costs are tax deductible at 150 per cent!) the fact remains that the expenses of clinical trials are exorbitant. The company who goes, cap in hand, to the hospitals is not in a good position to remonstrate about efficiency but the Drug Institute, as a financial intermediary between the chemist and the hospital, can analyse costs to find how they may be ameliorated. One of the economies may occur simply because the candidate committee of the Drug Institute can make a decision, pro or con, about the clinical fate of the substance through direct communication with the participating hospitals.

CORRELATION OF REPORTS FROM PRACTITIONERS

A candidate drug can never be declared free from hazard when clinical trials finally permit approval. The best that can be said is that the investigation under the controlled conditions in the clinical hospital has defined an acceptable minimum or risk to the public under a different set of conditions than those which prevailed in the hospital. The residual hazard inevitably appears during the next few years as side-effects and contraindications. The sooner these are known the lesser the overall hazard. Some successful applicants for new drugs have realized this importance by solicitations inviting the practising doctor to report his adverse reactions. The paucity of replies indicates that the average Canadian doctor has little faith in the proper utilization of his information; perhaps he is right. I submit that he is going to report side-effects more frequently and rigorously if he has some assurance that his data are going to be collated with others to assure a meaningful statistic. This collation should be effected by the Drug Institute.

Of course the collation of observed side-effects is not new. The medical and pharmacological literature is replete with pulications. These reports in turn are summarized in annual publications of great merit. In order to minimize the time-delay before the profession is aware of these publications a new monthly abstract service has begun this year. All of these activities give evidence that knowledge of side-effects is becoming of increasing importance.

Valuable as are these contributions to knowledge of toxicity and adverse-effects they all partake of the nature of post-mortem. The deed has been done

many times before the publication appears from a Clinic or an Institute. It is the G.P. who encounters these effects in the raw, and who is most competent to report them. I know that personal reminiscences are inane but I cannot forget my oil that yielded to the Penicillin G only to cause the allergy that seemed to need Diphenhydramine for relief. Then after a tortured two hours from the latter drug, when I finally resumed natural breathing, I asked my G.P. if he would please try to give me back my boil! Levity aside, it was two years hence before I saw a mature consideration of this reaction in the literature. The report should come at once from the practitioner.

EFFICACY OF DRUGS

All of us are so safety-minded that we oftentimes disregard efficacy. Yet a relatively useless drug, however safe, can be dangerous if it supplants an effective therapy. Much information is needed, say, to decide whether or not Dicumarol is actually effective in thrombosis. Likewise with new drugs, say in the oral antidiabetic field, there is a strong suspicion that there are drugs on the market which persist largely because the originator has to recoup his original ill-advised investment. So we are met with claims of greater potency (a profitable delusion which really means that the percentage of lactose in the tablet is greater) that may have no relationship to the hypoglycemic action in average practice.

Unsafe drugs are quickly discovered but a useless drug may persist for years. Enquiries in the form of a questionnaire should be issued by the Drug Institute (conveniently with the safety mailing!) to accumulate data that will put to pasture the useless old drug and new drug alike. If this arbitration were to cause financial loss to the originator of the condemned "new drug" then it is good sociology to recommend some compensation for the loss.

NOMENCLATURE

The Drug Institute ought to assume the responsibility for officially naming a new drug. The originators in pharmaceutical houses may have the traditional privilege of naming their new children and dogs but the privilege should not extend to drugs.

The choice of many of the official (generic) names is senseless. They seem to have been derived by pharmacologists and chemists as an approximation of the true chemical names. But they are not translatable into chemical names; in any case the persons who use them (doctors and pharmacists) have no need to use even a pseudo-chemical name. Doctors and pharmacists ought to have the principal voices on the committee of the Drug Institute which supervises the naming of new drugs. When the generic name of the drug must by law be shown on every bottle it might as well be pronounceable.

Before tradenames became the vogue about twenty-five years ago there may have been some reason in the idea that the name of a drug should be chosen so that it would not become familiar to the public. But the tradename has emasculated this possibility. The public now talks about Relasma and Algiatran with the same familiarity with which they discuss their Nylons and their Frigidaires. In this circumstance the official name ought to be at least as

euphonic as any of the tradenames used as substitutes for it. Instead we have a tradename like Isoxyl R′ to describe a drug with the generic name of diisoamyloxythiocarbanide hydrochloride. Who chose this pseudo-chemical monstrosity?

DISCOVERY OF NEW DRUGS

Although many of us grouse oftentimes that there are too many drugs on the market none of us want research toward better drugs to abate. Also we realize that there must be an incentive for this continuing search, so we understand why novel drugs emanating from chemical industries are almost always new and therefore patentable substances. Such companies deserve a profit *via* the patent monopoly, although the amount that they deserve may be a matter of controversy.

While the profit-motive does provide an important incentive toward discovery it does seem to exclude from consideration as new drugs any chemical compounds which are already known and thus not patentable. There is little commercial incentive to search among the two million known chemical substances although the majority of this large group have not been subjected to rigorous pharmacological examination.

There are two main reasons why this large number of compounds has been neglected as a source of new drugs. First was the early success of Ehrlich with his Salvarsan and the theory of molecular specificity which arose from it. The belief that therapeutic action was due to key groups of atoms discouraged random choices of compounds for animal tests. The second reason was the high cost of testing, say for hypoglycemic activity among randomly chosen compounds with little chance of success.

The first of these reasons is fading before the realization born of experience that the "magic bullet" concept of Ehrlich is oversimplified and, in part, fallacious. The second reason is less significant now that a large number of physiological tests, not necesarily related to specific therapy, are carried out on each animal and later correlated mathematically for specific therapeutic properties. This procedure, known as multiple screening, becomes economical if the programme is sufficiently extensive.

In consequence the "shotgun" approach to chemotherapy has been revived in terms of multiple screening. Many substances are being tested by pharmaceutical houses for no reason other than that the substances exist. But we never seem to hear about any discoveries involving non-patentable compounds. Why should we when the inclusion of a chlorine atom or a methyl group will provide a new and patentable substance?

The majority of the two million compounds are now in the public domain. If the major pharmaceutical houses choose to prospect this international resource they have a right to profit from their prospecting activities. But it is a lush field which need not be left for them to exploit alone, especially if the cost of a drug discovered in this way is higher than it would have been without patentable foliage. It would seem that some competition from a non-profit organization would at least temper the market.

The Drug Institute will maintain animal colonies in order to accomplish preclinical testing. It ought also carry out a multiple screening program by use of this facility on substances which it may choose "on a hunch" or which may be

sent to it by Canadian chemists, pharmacologists and pharmacists who have in hand chemicals or biologicals which have never been tested pharmacologically.

FUNDAMENTAL RESEARCH

That search for knowledge called a scientific pursuit is best done just for the fun of it. However, it is a fact of life that someone must pay for this fun. We justify the expenditure by the well-demonstrated truism that scientific achievement is of benefit to man. But are we speaking of past, present, or future man? Excluding our ancestors, who are beyond help, we can call only on man today or man tomorrow for the funds to play the game. For this reason research divides itself into the developmental type for man today and the fundamental type for his progeny. Despite the frequent display of heart-bleeding remonstrations the fact remains that man of today, by and large, demands the benefits for himself and not for his progeny. This leaves truly fundamental research in the impossible position of seeking support from those yet unborn!

In this impasse developmental research would languish from one generation to the next if fundamental research did not exist to nurture it. Fortunately there are several ways in which fundamental study is maintained. First it is a by-product of university education especially at the graduate level. Second it is a byproduct of the academic atmosphere which some employers try to create in order to attract the best men into their organizations. But byproducts are unreliable as sustaining sources. Fundamental research should be a full-time occupation for those who are competent to do it.

This means that unless an interested philanthropist can be found (they are becoming scarce) we must revert to the unborn for financial support of fundamental research. Of course this is a well known device only we call it by another name...government grant-in-aid. I have elaborated the situation only to show that fundamental research should be supported directly and not by subterfuge. Also I am suggesting that fundamental research in the Drug Institute should be supported in this way.

Grants-in-aid support research in other institutions but the Drug Institute may well be unique in that the permanent staff would be minimal. The research would be done by competent visitors, perhaps for a three year term, who would find a haven in the Institute while they pursued research for which they personally had been awarded grants. In other words the Drug Institute would seek researchers instead of researches. It is not certain that this method would bring forth another Banting, but it is worth the chance.

PREVENTIVE MEDICINE

In a few hundred years when illness will be a social sin the medical historian will probably call our era the age of curative medicine. His world ought to be a happier one than ours because of highly developed preventive medicine. The surface of this field has barely been scratched. At best our gains up to now have been in immunology and nutrition. With a few exceptions like quinine and perhaps The Pill the field of preventive chemotherapy is almost untouched. Our methodology concentrates upon cure and there is little time or demand for

prevention. Today the public is still anxious to have the devil driven out but is reluctant to let the angel in.

For this reason the field of preventive medicine will be largely of interest professionally rather than commercially. As such it ought to be centered in the Drug Institute. Since much of the activity will be fundamental, its support will be a lien on the future and thus to be derived from government funds or from philanthropy.

One may wonder why I have dissociated this function of the Drug Institute from that of fundamental research which I have mentioned before. I have done this because preventive medicine is to me so important that I am reluctant to leave the choice whether or not to pursue it to the discretion of the independent researcher whom I envisioned for fundamental studies in general.

Besides that, there is an epidemiological aspect to the study of preventive medicine which may be more mathematical than medical. The long range correlation to discover side-effects which are beneficial may well lead to preventive therapies. All of these discoveries may not be as easy to discern as the apparent diminution of cervical cancer among those who take oral contraceptives. Is there already hidden evidence of chemotherapy to prevent mammary malignancy. Such studies must enjoy continuity only possible in a separate division of the Drug Institute.

Finally there is an educative aspect in preventive medicine which may relate this division of the Drug Institute more closely to the public than will occur with other functions of the Drug Institute and which must make it a separate entity. It will probably be easier to guide the hypochondriac into acceptance of preventive medicine than the person who tends to "let well enough alone" with disastrous consequences known to every doctor. Indeed the word "hyperchondriac" is unknown to describe the man who must learn the lesson of preventive medicine: that it *is* possible to correct the deficiencies in his physiological inheritance and to arm himself against his environment.

CONCLUSION

The pharmaceutical field in Canada has grown without much cultivation. If from now on it is going to keep up with the needs of public health it must be put into order and maintained under new directives. I believe that these directives ought to be professional rather than political. I recommend that the four professions, Medicine, Pharmacy, Pharmacology and Chemistry band together for the purpose of establishing and administering a Drug Institute. It is expected that this administration would be accomplished by a Council chosen by the four national professional organizations. This Council will obtain from the Government of Canada the funds to build and equip the Institute which will be maintained partly by government grant and partly by fee-charges for services. Its terms of reference will include availability, safety, efficacy and the future of drugs in Canada.

APPENDIX "B"

ARE BRAND NAMES FOR DRUGS A MENACE?

by George F. Wright, Ph.D.

Among the pharmaceutical folklore of the past twenty years the concept has been nurtured that a drug sold under a brand-name is somehow safer and more reliable than the identical drug sold under its official (generic) name. One cannot doubt that this image is a remarkable achievement in the field of marketing. Moreover one cannot in fairness criticize the effort of a company to establish a symbol (the brand name) to signify its effort to turn out a good product in ordinary competitive business. But it should be quite clear that the symbol is purely a commercial device. When the product is a curative drug, where life or death may be involved, it is a fair question whether the rules of commercialism ought to apply. I suggest that brand-named drugs are a potential menace to the Canadian public.

The criterion for registration of a brand name has nothing to do with the excellence of the product. It must only not be in conflict with existing brand-names, or with commonly-used terms which it might corrupt. Once registered it becomes a piece of property to be held in perpetuity so long as it is protected with reasonable care. But nothing in this registration involves a standardization of the product that it designates.

A typical example is seen with brand-named cigarettes. If we buy a package of Players in England or in Switzerland, we find them to be quite different from our Canadian blend. Investigation shows that the brand name, once well-established, has become a marketable item quite unrelated to the constitution of the product. Drug brand names are relatively new, but who can say what they may signify in the future. Certainly Aspirin no longer refers only to the acetylsalicylic acid originally marketed by Bayer.

Bayer lost its proprietary rights to this trade-name because the Company allowed Aspirin to become a household word. At first this was advantageous for Bayer until the public began to ask for Aspirin as synonymous with any acetylsalicylic acid. Then they lost their exclusive privilege because they had "let the dog off the tether". It is a nice question how widely the dog can be allowed to hunt while still retaining ownership in him.

Sometimes the public appropriates the brand name despite the best efforts of the Company to protect it. Oftentimes the public does this to its eventual detriment. There are two recent examples. The first time back in 1940 that a young lady started to call her new hose "nylons". Dupont began to lose ownership of this euphonic brand name for a chemical of specific composition. Now the term may be found in the dictionary, but it refers to a great many different chemical compositions, some of which may be safer as tire-cords than others.

When you accelerate to 80 m.p.h. do you know the type of nylon used in your tires?

The other public appropriation of a brand name which caused a catastrophe involved the General Motors Corporation name, Frigidaire. The name soon came to be used to enquire about all mechanical refrigerators, some of which were less reliable than the GM machines. One night in a Chicago apartment house over thirty years ago a number of the occupants who had confidently rented living space equipped with "frigidaires" were quietly gassed to death because of failure in a defective system which was not manufactured by GM.

Supposedly there is a safeguard in Canadian law which would prevent misuse of a pharmaceutical brand name in the manners described above. When a new drug is approved for human consumption it is officially assigned a generic name which is permanently its true pharmaceutical name. This official name must by law appear on the bottle or in advertising copy; that is to say, every prescription drug in Canada must be sold under its generic name. A brand name must be supplementary to and not alternative to the generic name.

In actual practice this safeguard may not be as effective as the law intends. Although the generic name legally takes precedence over the brand name it is oftentimes printed as small as the law will allow, whereas the brand name will be as bold as possible. One consequence of this aggrandizement of the brand name during 1966 in Ontario was a wrongly-filled prescription because bottles with two similar brand names of the same company happened to be alongside each other on a pharmacist's shelf!

A greater danger occurs in practice because of the brand name sellers' tendency to deprecate the generic name. Misleading terms of little or distorted meaning, such as "generic drug", "generic drug house", "generic equivalent" and "equivalent sold more cheaply under a generic name" creep into the trade. The detail man who is enthusiastic about the product that his company sells under a brand name may be expected to extol it (why not the Company name instead?) but he ought not to denigrate the generic name at the same time. In doing so he is emasculating a safeguard established by law.

Perhaps the most misleading of the expressions mentioned above is the "equivalent sold more cheaply under a generic name". There are probably no two drugs sold under the same generic name, whether accompanied by a brand name or not, which are equivalent in any respect except for concentration of active ingredients. Invariably the type and amount of excipients, extenders, coatings, etc. will be different, either because one manufacturer has skills different from another or else because he is merely using different equipment. Also the dignity of the generic name should not be assailed simply because the non-branded drug is sold more cheaply. The higher price of the brand-named drug is in great part owing to the expense of promoting and maintaining the brand name. In fact the brand-sold drug would have to be inferior to that sold only under the generic name it it were offered at the same price. Money spent on promotion is not available for quality manufacture and control. What happens to the quality of brand-named drugs if, in future, public opinion forces down prices?

If a strenuous advertizing campaign establishes a pharmaceutical brand name that is associated with distinctive shape and colour then another danger arises. Such a brand-named drug can be counterfeited whereas the generic-named drug on the basis of principle cannot be. An example apparently of such counterfeiting came to my attention recently when an Alberta pharmacist sent to our laboratories some tablets which, from their shape, could be identified with a well-known brand of Tolbutamide. Our analyses showed that these tablets contained 10 per cent less than the lawful minimum of the active substance. Either we must assume that the Company using the brand name is selling a substandard product or else that his brand has been counterfeited. Because of our high opinion of this Company we prefer to believe that his product has been counterfeited. However, the counterfeit is the more dangerous because of reliance by the public in the brand-named drug. Under the generic name the public would look at the appearance of the producer, not the appearance of the pill.

There is a danger that the brand name will be debased, as sometimes has happened with currency, to the point where counterfeiting would be ridiculous. This can occur if an infringer of the brand name is interested in profit to exclusion of quality. Offhand it might be assumed that this would be impossible within the scope of our trademark law. But the law protects only those who protect themselves. Many brand names have found their way into scientific articles and texts, and into courses of the curricula of medical schools. How they got there is best not discussed. Certainly the owner of the brand name has not been averse to inculcation of the name into the mind of the medical neophyte. When this student becomes a medical practitioner he is likely to remember the brand name most easily when he writes a prescription. But this free and easy use of the brand name does not provide the protection which every owner must maintain if he is to retain his property.

Today it is doubtful that many popular brand names could withstand the onslaught of infringement of a determined competitor. When this occurs it is earnestly to be hoped for the sake of the public that the manufacturing facilities and quality controls of the competitor will be above reproach. If they are not the brand name will become a curse.

Up to now I have mentioned direct dangers to the individuals who comprise the public. There is an indirect danger to the professions upon whom the public depends. Death to the individual because of a misplaced or misrepresented brand-named drug is horrible, but it is miniscule compared with the effect on the public due to death of the professions. Yet there is a definite danger that this may occur.

The field of health involves individuals who become ill, and each personal illness is perceptibly different. The treatment of each illness requires discretion. The profession of medicine arose from a need to provide this discretion. As it became more sophisticated the preparation of curative agents became separated from medicine into a profession called pharmacy. Then, when the science of chemotherapy arose, another profession came on the scene. This is the profession of chemistry.

This would have been a smooth transition if the professional order had been maintained, with the chemist farthest from the patient. But the chemist decided that he should be top-dog, so he devised a methodology. The chief tool of his method is the brand name. With this tool he can tell the doctor what he shall prescribe and the pharmacist what he must administer. It has been done so smoothly, what with semi-professional advertizing at one end of the spectrum and golf-balls at the other end, that the professions of medicine and pharmacy don't yet realize that they have been had.

They have not noticed the spell that has been cast over them, because the patient-public has not disturbed them. But the day is here when the public is feeling the brunt of the chemists' aggression. The public is beginning to strike out, blindly, in such directions as hastily-conceived schemes like medicare and pharmicare. Unless the social malady is understood the public attempts to correct it are going to make the cure worse than the disease. The focus of the infection is the pharmaceutical brand name.

Let us put an end to this tomfoolery. I suspect that the brand-name owner himself is secretly disgusted with this symbol that he has erected between his own good company name and the user of his product. He knows what it costs to maintain his symbol among a babel of synonymous symbols for the same drug. I doubt that he alone is able to get out of this rat-race that he has devised. Let us help him.

APPENDIX "C"

THE CHEMICAL INSTITUTE OF CANADA

L'INSTITUT DE CHIMIE DU CANADA

MEDICINAL CHEMISTRY GROUP

November 3, 1966.

Mr. Harry C. Harley,
Chairman,
The House of Commons Special Committee
on Drug Costs and Prices,
The House of Commons,
Ottawa, Canada

Mr. Chairman,

On behalf of the members of the Medicinal Chemistry Group, Montreal Section of the Chemical Institute of Canada, I am enclosing a memorandum in answer to a Brief presented by Dr. George F. Wright (Minutes of Proceedings and Evidence Issue No. 8, Appendix "D").

This memorandum follows the resolution which was sent to you on October 24th.

Respectfully yours,

Encl.

R. Deghenghi, F.C.I.C.,
Chairman,
Medicinal Chemistry Group

c/o P.O. Box 6115,
Montreal, Canada

The members of the Medicinal Chemistry Group of the Chemical Institute of Canada, being scientists who are active in the field of pharmaceutical research, wish to correct some impressions which the reader of a Brief entitled "A Look at Canadian Pharmaceutical Research" submitted by George F. Wright (Appendix "D", Special Committee on Drug Costs and Prices, Minutes of Proceedings and Evidence Issue No. 8, page 537, Ottawa, 1966) may have received. Specifically, we wish to draw your attention to the following misleading and erroneous statements (italics or underlined) contained in Dr. Wright's Brief.

"It is my opinion that the pharmaceutical industry does practically no fundamental research" (page 538).

There are thousands of scientific contributions and publications from industrial research laboratories which prove that the pharmaceutical industry does a

great deal of fundamental research. Basic contributions have been made in chemistry, biochemistry, pharmacology and related fields. The total synthesis of cortisone realized by scientists at Merck at a cost of several million dollars is one example. The company never recovered its investment, but the scientific world was richer because of it.

At present, much fundamental work is being done in the pharmaceutical industry on the primary problem of the mechanism of drug action.

"Improved nutrition has contributed much more to human health than have drugs" (page 538).

Many drugs have been developed in recent years which save lives or alleviate suffering caused by disease states which bear little or no relation to nutrition. Drugs which are successful in the treatment of infections of all kinds, metabolic disorders, hypertension, and mental illness are obvious examples. Improved nutrition has certainly contributed to human health (although it should be noted that atherosclerosis and certain diseases of the heart are often associated with "well-fed" populations) but the enormously beneficial action of modern drugs must not be slighted.

"Modern drugs obstruct advancement in public health because they are not designed for avoidance of sickness" (page 538).

The recent vaccines against polio, measles, etc. and practically all antiviral drugs have been developed for the prevention of disease.

"Drug Research by Molecular Engineering" (page 538).

Very frequently if two substances differ in chemical structure, no matter how small the difference, they may exert different biological activities. For example, the family of antihistaminic agents has a variety of effects and by careful and systematic chemical modification it has been possible to develop drugs effective in the fields of Parkinsonism, gastrointestinal disorders, local anaesthesia, pre-operative surgery and most notably, in mental disease. Indeed the group of phenothiazine drugs which were developed directly from the anti-histamines and which have changed the scope of therapy of the anxiety disorders, have themselves by relatively small chemical changes been converted into remarkably effective agents for the treatment of mental depression. Furthermore, the sulfonamides, through similar chemical alterations, have given not only more effective antibacterials, but agents widely used in regulating blood pressure and fluid balance, treatment of epilepsy, tuberculosis, malaria and leprosy as well as yielding orally-active antidiabetic drugs. Work on the sulfonamides has also led to new concepts such as the antimetabolite approach to certain forms of cancer. Very often "small differences" are responsible for antagonistic effects. The difference between estradiol (a female sex hormone) and testosterone (a male sex hormone) is one CH_4 group! So-called "molecular engineering" has placed a vital role, not only in the development of new and better drugs, but also in providing basic understanding of life processes.

"Drug discovery by screening"

"Substances are chosen largely at random to be classified according to pharmacological action. It was this type of screening procedure which brought the sulpha drugs into existence" (page 540).

It is a well known fact that sulpha drugs were developed on a rational basis

(Erlich, Fourneau, Domagk) and not through random screening.

..."new drugs emanating from commercial drug research laboratories are almost always new and therefore patentable compounds, despite a reservoir of about two million known chemicals the majority of which have not been examined pharmacologically" (page 540).

Although over two million chemical compounds are known, the large majority of these are not available. Those that are, have largely been tested. However, the "reservoir" of known chemicals is not neglected in the search for new drugs. When an active compound is discovered, the structure is modified by medicinal chemists in the search for still greater activity; this leads to the synthesis of new compounds. Ultimately the most active compound whether old or new will be chosen for advanced studies.

"A Canadian Drug Institute"

"The small drug companies today are unable to support animal colonies in which preclinical studies may be made, nor is there sufficient commercial service testing with animals in Canada to which such companies may turn" (page 542).

Service laboratories are available in Canada and elsewhere. These are agencies that will screen compounds under contract and often free of charge.

"I do not believe that drug research in Canada is an unmixed blessing" (p. 542).

Canadian contributions in the field of medical and drug research are outstanding. Academic research has given much to the world, from insulin to parathormone to the early discovery of steroid metabolites and certain antineoplastic agents. Research done in a private company in Toronto has given processes to convert bile acids into valuable hormones, another private company in Montreal is the world leader, through continued research, in the field of estrogenic substances.

Only recently, spurred by government grants, more laboratories have started drug research work or have enlarged their existing research teams. Many products are in the final stages of clinical evaluation and F.D.D. approval or have reached easier markets abroad.

A great number of publications from private research laboratories in Canada have contributed to the world knowledge in the drug field and many companies from abroad are soliciting patents and processes resulting from research done in this Country. Drug research in Canada provides employment for several hundred people. Trends of reversing the "brain drain" are noted and many professional people are seeking employment "north" of the United States-Canadian border. The members of the Medicinal Chemistry Group look upon the future of drug research in Canada with confidence.

APPENDIX "D"

(By Smith Kline I. A. Corporation)

Trifluoperazine tablets as mentioned in the B.P. monograph are formulated in terms of the hydrochloride salt. "Stelazine" tablets (SKF's brand of trifluoperazine), are formulated in terms of the trifluoperazine base. Trifluoperazine tablets B.P., therefore, contain approximately 15 - 16 per cent *less* of the active ingredient than "Stelazine" tablets.

In a product line, a company may use different forms of the active component dependent upon the particular dosage form. We may use the base form of the drug or perhaps one or more salt forms to give the best physical characteristics for that dosage form such as stability, ease of formulation, etc. However, we always come back to an expression of the active portion in terms of the base, so that we have a common denominator for purposes of potency comparison and dosage determination.

Generally, the salt portion is inactive medically so that more of the salt form is required to produce the equivalent effect of a given amount of the base form. In the case of trifluoperazine, 1.18 grams of trifluoperazine dihydrochloride is required to equal the activity of 1.0 grams of trifluoperazine base. "Stelazine" tablets, while formulated with the hydrochloride salt, are declared as to active ingredient content in terms of trifluoperazine base; for example, "Stelazine" 1 mg. tablets contain in each tablet 1 mg. of trifluoperazine base as the dihydrochloride salt. Therefore, each "Stelazine" 1 mg. tablet contains 1.18 mg. of trifluoperazine dihydrochloride.

Trifluoperazine tablets as mentioned in the B.P. monograph are formulated in terms of the hydrochloride salt. A 1 mg. tablet in B.P. terms, therefore contains considerably less of the active base.

"Stelazine" tablets have been an international standard for the development of dosage levels and therapy regimens for the past eight years, in many countries including Canada.

Our analysis of the Paul Maney products have disclosed some disturbing anomalies. The first samples we assayed contained approximately 100 per cent of the trifluoperazine claimed on the basis of the B.P. monograph—that is, as the hydrochloride salt. The potency was therefore approximately 84 per cent in terms of the base. Later assays of three different strengths have disclosed an average of 92 - 93 per cent in terms of the base, that is 110 - 111 per cent in terms of the hydrochloride salt. These samples do not appear to meet properly either the base or the salt standards. A fourth lot of the product has assayed at 102 per cent of the base, which means 120 per cent of the salt. Thus the products assayed have covered a wide range of strengths without their basic formulation being clearly declared.

The Jules Gilbert products, which we have had assayed, have also varied widely in potency, and do not appear to meet consistently the acceptable standards in terms of either base or hydrochloride salt.

We require that our own products always fall within limits of 95 to 105 per cent of claim in terms of the base; the B.P. limits are 92.5 to 107.5 per cent in terms of the salt.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 17

THURSDAY, NOVEMBER 10, 1966

WITNESSES:

Representing The Consumers' Association of Canada: Miss Glenora Pearce of Winnipeg, National President; Dr. M. Pernarowski, of Vancouver, Associate Professor, Faculty of Pharmacy, University of British Columbia; Dr. H. E. English of Ottawa, Head of the School of Commerce, Carleton University; Mrs. A. F. W. Plumptre, of Toronto, Past President.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1966

25164—1

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

MINUTES OF PROCEEDINGS

THURSDAY, November 10, 1966.
(25)

The Special Committee on Drug Costs and Prices met this day at 3.50 p.m., the Chairman, Mr. Harry C. Harley, presiding.

Members present: Messrs. Asselin (*Richmond-Wolfe*), Côté (*Dorchester*), Forrestall, Harley, Howe (*Hamilton South*), Hymmen, Isabelle, Mackasey, MacLean (*Queens*), O'Keefe (10).

In attendance: *Representing The Consumers' Association of Canada*: Miss Glenora Pearce of Winnipeg, National President; Dr. M. Pernarowski of Vancouver, Associate Professor, Faculty of Pharmacy, University of British Columbia; Dr. H. E. English, Economist of Ottawa, Head of the School of Commerce of Carleton University, Executive Vice-President; Mrs. A. F. W. Plumptre of Toronto, Past President.

Also in attendance: Mr. W. J. Blakely of Kingston (Ont.), and Mr. A. M. Laidlaw, Q.C. of Ottawa, respectively Accountant and Legal Counsel for the Committee.

The Chairman introduced Miss Pearce who, in turn, introduced her associates.

The Committee proceeded to the consideration of the submission of The Consumers' Association, copies of which had been distributed.

Dr. Pernarowski made a preliminary statement.

Dr. English commented on Appendices B and C and related section 3 on effective government policy on drug prices, and explained the main points of Appendix C.

Agreed,—That the Brief be printed as an appendix to this day's proceedings. (*See Appendix I*)

Mrs. Plumptre, Dr. Pernarowski, Dr. English and Miss Pearce supplied information.

Mr. Laidlaw and Mr. Blakely also asked questions of the witnesses.

The Chairman thanked the Consumers' Association for its brief.

At 6.05 p.m. the Committee adjourned to 9.30 a.m. Tuesday, November 15, 1966.

Gabrielle Savard,
Clerk of the Committee.

25164—1½

EVIDENCE

(Recorded by Electronic Apparatus)

THURSDAY, November 10, 1966.

The CHAIRMAN: Gentlemen, I think we might start the meeting.

We have with us today the Consumers' Association of Canada. The brief has been in your hands for some time, although I think the last appendix arrived today.

I would like to introduce Miss Pearce, the national president and ask her to introduce her colleagues.

Miss G. PEARCE (*National President, Consumers' Association of Canada*): Thank you Mr. Chairman and Committee members. I somehow feel that during the last few weeks the subject of drug prices and costs has been rather upstaged by food prices. However I am sure that you, and most certainly the members of our Consumers' Association, are well aware of the fact that drug prices and costs are very important, and that our consumers have many unanswered questions. Therefore, it gives us great pleasure to have the opportunity to present a brief, on behalf of consumers, through the Consumers' Association of Canada, for your consideration this afternoon.

I would like to introduce our three witnesses: Mrs. A. F. W. Plumptre, past-president of the Consumers' Association of Canada, who is most conversant with the past activities and thoughts of consumers in the drug situation; Dr. M. Pernarowski, vice-president of the Consumers' Association of Canada, and a member of the faculty of pharmacy at the University of British Columbia; and Dr. H. E. English, our executive vice president, who is on the faculty of Carleton University as an economist.

I will ask Dr. Pernarowski to make the opening comments.

Dr. M. PERNAROWSKI (*Vice-President, Consumers' Association of Canada*): I do not think that there is any need to go through the brief in detail, and as a matter of fact if, at any point you care to ask questions you can interrupt me.

The subject of drug-marketing in Canada has been discussed thoroughly before this Committee and I think there is no need to go into it at this time.

The first comment I might make is with respect to drug quality. This is a subject, of course, which appears in any economic discussion of the problem and is something which must be settled quite quickly. We, of course, are aware of various statements that have been made, and we have presented some statistics in this brief to show that there are, in fact, probably some defective drugs on the market. However, we are at a point where really we do not know, and I must say that we must seek more information and must look to better specifications to evaluate drugs. With this in mind we look first to the Food and Drug Directorate. What, in fact, we are asking the directorate to do is, first, to make any information available to the consumer on the quality of drugs, if they, in fact, have it and in respect to such things as prosecutions and seizures we would like to see these published in respect of such things as compliance with 74-GP-1a.

With regard to the general question of drug quality I think again that it is the responsibility of the Food and Drug Directorate to make a clear statement on this problem and, if, in fact, they are happy with it, steps should be taken to ensure that our drug supply is adequate. I think part of the problem lies in specifications for drugs, which, of course, means research into this very important aspect.

From here on in we move into the general question of drug prices in this country, and this, of course, creates a problem for the consumer because really the consumer is a captive in a chain of events starting from the drug manufacturer and leading to the pharmacist. He does not necessarily want to purchase these drugs but of course he has to and this creates the first problem.

We have in this brief a number of prices both in Canada and in various parts of the world. These are simply the prices in other parts of the world having been converted on the basis of current rates of exchange, and there has been no attempt made to check for economic differences. The reason for this will be brought out shortly.

At this point I would like to say that I will avoid any discussions on the economics of the problem of drug prices, and page 6, dealing with the effect of government policy and drug prices, I will leave to Dr. English.

Next, of course, is drug prices and the manufacturer and here we cite several examples of what we feel are discrepancies in pricing. We try to stick to discrepancies between reputable manufacturers; in other words, not to bring in the question of the generic drug; but even so there are vast differences in drug prices. These drug prices, of course, come from a number of factors. The first, of course, is production. These are probably quite low, and we cite several examples of these which are quite low with respect to the final price of the drug. Quality control again is probably low with respect to the final drug price. We talk about research here, too, and most research, of course, is carried out in other countries, in the parent corporations. These research costs have to be paid for and as we say here: "We do not want something for nothing," but we wonder whether we are paying more than we should.

The next item we have here deals with drug promotion. This, I think, is being belaboured by many people who have appeared before this Committee. A number of quotations are given here by Dr. Goddard, the FDA commissioner in the United States, showing that he is unhappy with some of the promotional practices. These are there for your information. I think that one of the things that probably is of significance to this association is referred to on page 11, which deals with a comment that consumer organizations and such organizations as those responsible for *Medical Letter* be given more support; but the difficulty here is that they are non-profit organizations, and, of course, they simply do not have the funds.

Again we run into this business of the recommendation of the Royal Commission on Health Services which suggested there be a 15 per cent limit on the corporation income tax. As an alternative to this we suggest that there be an encouragement of independent consumer research and distribution of accurate information about the quality and value of commodities, and that we should operate through the anti-combines law. Only if other alternative methods do not work would we be in favour of this 15 per cent limit.

I come now to the question of the value of advertising in medical journals. This, again, is very controversial and at this stage we ask that both the editors of medical journals and the Food and Drug Directorate scrutinize these and introduce legislation, where required, on truth in advertising.

With respect to the physician, the physician, of course, does decide what drug a person is going to use and the consumer has no option but to get this particular drug. The physician is bombarded with all sorts of information and misinformation from manufacturers, and what we feel is that there should be alternative sources of information established. The first thing we ask for is a panel of experts, and we say that the physicians and pharmacists making up this panel must have an independence of mind and should be removed from the vested interests in the health care field, and that these people should create a formulary rather than go into technical details, which we did not think we had; this would have to be left to this panel. This would provide the first type of information that a doctor would have at his disposal.

The second thing is that we ask that the Food and Drug Directorate—we coin a little phrase here—create a pill—P.I.L.—a Professional Information Letter—which would provide current information to the physician as this becomes available.

Finally, in this section, we are aware, of course, that the professions are actively engaged in continuing educational facilities and we ask that the government look into ways and means of supporting these activities, because, again, if you educate this way there will be no need to educate through the detailing and other methods.

With respect to drug prices and the pharmacist, there are several ways of pricing. First, it is simply based on a list price, and to this is added a "breakages" or "dispensing" fee. I think these have all been brought to the attention of the Committee in the past. The second is based on a percentage of the list price plus a professional fee; and the last is the cost-plus system to which the cost of the drug and the professional fee are added. We realize that things are not as clear as they may seem, but, in general, we would favour this last process. This would tend to decrease the price of the expensive drugs, probably increase the price of the inexpensive drugs, but it would essentially make it much easier for the consumer to shop on a fee basis, rather than on a list basis.

We ask that the discount stores be investigated to see if, in fact, they do provide safe drugs.

We go on from there to the definition of the word "manufacturer". This creates a bit of a problem, because the definition of the word "manufacturer" in the Food and Drugs Act is such that it could include anyone who distributes a drug, and this we feel is not satisfactory. In fact, we would like to see this definition changed to its dictionary sense; in other words, so that both the consumer and the pharmacist should know where the drugs are coming from.

The question of substitution of one brand versus another: This is a difficult one, but again the association feels that a pharmacist has an obligation to inform the consumer about possible savings. I think the question of quality is something that has to be decided professionally, but, at the same time, this last man in the chain of events has some responsibility to the consumer.

Lastly, in this regard, we feel that the labelling of prescription drugs in the regulations to the Food and Drugs Act should be changed and that the label of

the prescription carry the name of the drug, and the actual name of the drug supplied; that is, if it is a brand name, it be put on; if it is a generic name, it be put on, as well as the manufacturer's name.

At this point I would like to turn back to the economic aspects and ask Dr. English to comment on this.

Dr. H. E. ENGLISH (*Executive Vice President, The Consumers' Association of Canada*): Mr. Chairman and gentlemen, I have two sections of the brief on which to make comments. These are appendices B and C, and the related section of the brief on the effect of government policy on drug prices.

First a word or two on appendix B. This appendix relates to certain measures that have been employed to indicate the importance of current prices and profits in the Canadian pharmaceutical industry.

In the case of drug prices, the comparison made in the submission of the Pharmaceutical Manufacturers Association of Canada is based upon a rather curious relation of costs in terms of labour income in Canada and the United Kingdom particularly. This kind of comparison, it seems to me as an economist, is almost meaningless and certainly most misleading. The fact is that if you convert any Canadian price, of any product, into labour income, you are most likely to find that it costs Canadians less to buy something than it would most foreigners. The Americans would be an exception, for obvious reasons. We have more income, more resources, more over-all productivity in this country, thanks to our large share of natural resources and the skills we put to work on them. But this does not give you any information that is relevant to assessing the efficiency of a particular industry. To do that, one should look at its real costs—the cost of labour, raw materials, research and the capital that goes into the making of the product in this country, as compared to the amount that goes into it in another country. You also have to look at the demand for a product. These are the considerations that are relevant to explaining the prices in, and price differences between, countries. If one does look at the price differences for pharmaceuticals between countries, one finds—and as this Committee well knows, because indeed it is the basis of its establishment—that they are among the highest, if not the highest, in the world. This is what we should be examining.

The other point in appendix B, relates to the profit figures. The profit figures used are related to sales—so much per dollar of sales. I would certainly admit that this is a common proportionate measure of profit often employed, but, again as an economist, I must argue that it is not a very meaningful measure, because, after all, people who earn profits are those who have invested their capital, and the meaningful judgment on profit is the level of profit per dollar of investment, not per dollar of sales.

The significance of this observation is that if you look at two industries, one of which involves a great deal of capital and the other much less capital, they may have the same earnings per dollar of sales, but the one with the very much greater capital invested will be making a lower rate of return. As it happens, the pharmaceutical industry, particularly the part of it that we have in Canada, making the final dosage forms but not the basic pharmaceutical chemicals, is an industry which is relatively low in capital intensity and, therefore, any given figure for profit per dollar of sales is likely to give a relatively higher figure for profit per dollar of investment compared to other industries. Therefore, these

two measures should not be taken at their face value, but should be converted into the more meaningful forms which I have just attempted to support.

We now come to appendix C and the related part of the brief concerned with the effect of government policy on drug prices. I want to apologize, on behalf of our association and myself, in particular, for the lateness of the appendix arriving here. I would be willing to read it, or parts of it, if the Committee wishes, in view of that, but, if not, I can summarize what I believe to be the most important points.

The CHAIRMAN: I think a summary would be fine, because I think most of the members have had an opportunity of reading it.

Mr. MACKASEY: Will you summarize the relative areas of the brief so that I can mark them off?

Mr. ENGLISH: Yes; in the early stages of my summary I think I will probably make some remarks that I cannot relate to a particular part of the brief, but I will do that at the end.

The basic point is that we feel that a variety of government policies is very important in explaining the level of drug prices in Canada, and that these policies should be viewed as a package. This is one of the difficult things about this analysis, that one has to look at the interacting effect of public policies, of tariff policies, anti-dumping duty policies, patents, trade marks and the sales tax. To remedy any one of what we would call the shortcomings of public policy in this area by itself would accomplish very much less than to remedy the whole group of policies together. This is the main gist of what we are trying to say about the public policy contribution of drug prices.

Having said that, let me illustrate the point. We are saying, in effect, that the evidence available—and of course we would not want to claim that all the evidence that we would like to have available is yet available—suggests that the existing producers in Canada can import the pharmaceutical chemicals, the bulk chemicals, at reasonably convenient prices and costs to them, but that it is very difficult for anyone to import the dosage chemical at low prices at all; and it is particularly difficult for anyone who wishes to go into competition with the present manufacturers to obtain the bulk chemicals and convert them into dosage form. The things that make this difficult are, in part, the level of the tariff on final dosage forms, and, in part, the valuation procedures and the classification procedures associated with the anti-dumping duty. We go into each of these in detail, and I can do that in discussing the issues in the brief.

However, this is not the whole story, because the effect of patents on the possibility of competition through imports is also very important. Those who may wish to import pharmaceutical chemicals, to convert them into dosage forms in competition with the Canadian manufacturers, will find it difficult to do so, not only because of the tariff arrangements, but also because of the fact that there can be a patent infringement threat—to put a rather too strong word on it—but a patent infringement possibility arising in this situation. They take this form. Apparently the basic chemicals can be patented only as to process, in most cases. If anyone wishes to import a basic chemical he will find that in most cases he runs the risk of having to prove that this chemical which he is importing was not produced by the patented process. The importer will have to prove that.

An hon. MEMBER: Will you repeat that for me?

Mr. ENGLISH: The importer who is attempting to bring in the basic chemical as a basis for production, in competition with the present manufacturer, will find that he is in danger of a patent infringement suit because of the necessity of proving that the chemical he is importing was produced by other than a patented process. This is a risk which, of course, the existing manufacturers—which are subsidiaries, largely, of United States firms—do not have to face because they, of course, have no risk of patent infringement in that form. So that the patent is involved in it.

The trademark legislation appears also to be involved in it, because it is not possible for anyone but the subsidiaries of the firms holding the trademark in Canada to obtain trademark drugs from outside the country. Again, this enables the industry in Canada to establish prices in Canada that are higher than those in the United States or elsewhere, and they are not subject to competition from independents.

Finally, the sales tax, of course, adds to the price of drugs, and this, taken with the other considerations, makes the price of drugs in Canada one of the highest in the world.

These are very abbreviated forms of summarizing the main argument of this appendix, and it does not, of course, summarize all of it. There are some references to the implications on quality, too, but these, I think, merely support the remarks already made by Dr. Pernarowski.

Would you like me to highlight the points in the appendices which bear out the argument? The first general point on page six of the main brief, and again on the first page of Appendix C, is the statement that the whole group of policies working together have certain effects on drug prices, which deserve very careful examination by this Committee and by government generally.

In concluding, on the first page of Appendix C, we say "We believe the legislation relevant to these areas should be amended so as to cut the drug cost to the Canadian consumers." Then it is pointed out in the next two or three pages that for reasons which have been made very clear, I think, in past hearings of the Committee, drug prices are subject to a situation of inelastic demand; that the consumer does not have much choice in buying drugs because his demand is determined by the doctor's prescription, and the doctor's prescription often has to be handed out to him without even the doctor's knowing the possibilities of prescribing cheaper drugs of equal quality which may be available.

This situation of inelastic demand means that any force, any factor, which raises the cost—whether it is a justifiable factor in terms of the economics of it or not—can be added on to the price without any feeling being brought about by consumer discretion.

Then we go through the particulars of the tariff, and here I think the most important consideration relates to classification and valuation practices. It is my understanding from the evidence available that drugs entering in final dosage form are classified rather broadly, so that if a producer in Canada is producing, say, one particular antibiotic, and another antibiotic, which is not really related to that one in its usage in Canada, comes in, it must face the duties applied to "class or kind made in Canada". This means that competition from the foreign product—even where the two commodities are not really substitutes for one another in the practical sense—becomes impossible, and the consumer pays a

higher price than would seem to be warranted by the needs of the Canadian manufacturer.

Then there are the effects of the valuation practices. Part of the valuation practice relates to the fact that Canadian producers are very often subsidiaries of United States or other foreign producers—but particularly United States producers. Therefore, many of the transactions which take place are not, in the customs parlance, at arms-length. They take place within firms; and, therefore, rather arbitrary methods have to be worked out for valuing the products that come in. As I see it, some of these measures work to the advantage of the subsidiary firm, because they can obtain basic chemicals at lower markups than they might charge in the United States, but it is not apparent that where that happens the advantage is passed on to the Canadian consumer. In fact, if anything, this assists the outcome of a higher level of protection in Canada.

Mr. MACKASEY: Mr. Chairman, so many intriguing statements are being made that I just cannot keep track of them all, and I would like explanations as we go along.

Is there any possibility that we may have the privilege of extending the number of sittings devoted to these very comprehensive and revealing briefs, or are we expected to do this brief justice in one session?

The CHAIRMAN: That is up to the Committee, Mr. Mackasey.

Mr. MACKASEY: I ask because the gentleman has just dealt with something in which we are interested. The question of lower mark-up of raw materials coming in is an area on which we could spend half an hour, but I am reluctant to do so and spoil his train of thought, and possibly extend the length of the proceedings. I am under the impression that the value of raw materials coming into Canada cannot be calculated or evaluated arbitrarily by the source in the United States, and I would imagine that Canada, through the medium of the customs and excise division of the revenue department would want to evaluate the raw material coming into Canada.

Mr. ENGLISH: My main source for that, I believe, is Mr. Benson's statements on his appearance before this committee. I have not been in a position to verify those remarks.

Mr. MACKASEY: In other words, you are not certain of their authenticity?

Mr. ENGLISH: I would not be in a position to challenge the Minister of National Revenue on this point. The impression I got from those statements was that this might be the case.

Mr. MACKASEY: My last reference to it is that I very much dislike the situation where Canada is being robbed of legitimate excise duties simply because somebody in the United States is under-valuating their material when they are shipping it in to a subsidiary.

Mr. ENGLISH: I did not have reference to what is being done by the firms, but rather the apparent possibility that the mark-up allowance, in arriving at the fair market value, might be less in some cases.

Mr. MACKASEY: The mark-up by whom? Who would mark it up less than it should be marked up?

Mr. ENGLISH: I guess it would be the customs people.

Mr. MACKASEY: Do you mean our customs authorities?

Mr. ENGLISH: The mark-up is not meaningful when the commodity is being imported by firms which are under the same ownership on both sides of the border.

Mr. MACKASEY: I apologize for sticking to this point, but I think it is very relevant, and it was treated at length in the Hall Report. The parent company, say, in Switzerland or the United States, ships raw material—call it basic pharmaceutical chemicals—to a subsidiary here in Canada. Now, somewhere along the line it must cross into Canada and a duty must be placed on it, based on a value. Unless you can tell me otherwise, I would presume that that value is estimated by Canadian Government officials and not by the parent company, otherwise it would be subject to dumping duty.

Mr. ENGLISH: Yes, that is right. It is in the process of determining whether dumping is, in fact, present.

Mr. MACKASEY: How would the Canadian subsidiary receive any financial advantage over, say, an independent company bringing this basic pharmaceutical chemical into Canada?

Mr. ENGLISH: I think the problem of an independent company obtaining it is a problem more closely associated with the patent restraints.

Mr. MACKASEY: I agree that the parent company, or the company in the United States, may be very reluctant to sell this to a competitor of its subsidiary in Canada, but I am more interested in your earlier statement that the subsidiary company in Canada would have an advantage in that it could bring the goods in less expensively than its competitor here.

Mr. ENGLISH: If it were able to get them; it would depend where it was getting them from. If it got them from the United States, presumably it would have to get them from firms that were charging the same price as the parent firm of the subsidiary in Canada, and this would be a price that might be higher than the price arrived at in fair market valuation because of the kind of mark-up employed. This is the point I was referring to earlier.

Mr. MACKASEY: Fine.

Mr. ENGLISH: If, however, the independent in Canada was getting them from a European country, or a source that was not related to the Canadian manufacturing group, they might get them more cheaply.

The CHAIRMAN: Would it be best to let him finish his summary and statement and then go back.

Mr. MACKASEY: I agree; but I wish there were some way we could play back this very revealing testimony and pick these points up. I agree with you, Mr. Chairman, and I will try and pick them up as we go along.

Mr. ENGLISH: I think the other principal point about the tariff, as it relates to the structure of the industry, which we already referred to, is that if we have a 25 per cent tariff on a final dosage form and because we import the basic chemicals in most our production activity in this industry, and if this means that a very relatively low percentage of the value of the final dosage product is produced in Canada, a 25 per cent tariff can give 100 per cent protection. Just

to illustrate, if there is a 25 per cent tariff and only 25 per cent of the value of the product were produced in Canada, this is 100 per cent protection to Canadian production.

Mr. MACKASEY: On a point of information, you are referring now to products brought in in final dosage form?

Mr. ENGLISH: That is right.

Mr. MACKASEY: Thank you.

Mr. ENGLISH: Protection against such imports.

Mr. MACKASEY: That is right.

Mr. ENGLISH: It is the other main point about evaluating or assessing the meaning of a tariff. I think too often it is said that a tariff is not very high if it is 15 or 20 per cent, but it should be judged in terms of what it is protecting in Canada. If it is protecting a relative small percentage of Canadian content then it is a very high rate of protection on that content. This is the other main point about the tariff.

In the case of the trade mark, I believe I made the only point that I would want to make on this already, that it is not now easy for an independent to import a trade marked product because the trade mark law does not make this possible.

In the case of patents, the main dangers lie in two directions. One, of course, is the general one, that whenever a patent exists you can use it for fortifying a monopoly, or causing a monopoly position, and you must therefore ask if the good the patent is doing is worth the monopoly effect it may create. I am not saying that in every case where a patent exists there is a monopoly effect, but one should look at it with that kind of assessment in mind. Patents are, of course, intended to encourage research. If they do, in fact, encourage research on a large scale and we get the benefits of this through Canadian production and Canadian exports, and all the other things one can think of as a result of distinctive Canadian production, that is fine, but if they are only protecting holders from other countries who are getting all the benefits of the patent holding, through royalties and so on, then it is really a question whether the patent system is a benefit to Canada. In this industry it would appear that a great many Canadian patents are held by those outside Canada. That is the general point.

Then there is the specific point that it is very difficult to import pharmaceutical chemicals because of the danger of the patent infringement which I have already mentioned.

There is a further point. Compulsory licensing for imports is not now a convenient process. I am not sure it can be done at all. This is one point on which I would like to get more evidence; but it is very rarely done if it is done at all.

Mr. MACKASEY: You have no observations to make on why it is so rare?

Mr. ENGLISH: No; I believe, from what I have read of the previous discussions you have had, and from other sources, that it is very difficult to get a licence. How it is made difficult, I would like to have more evidence on.

The sales tax has been a source of criticism, of course. It is an obvious way of raising prices. I think that all of us would like to see sales tax on necessities

reduced. I think we also would want to be sure that when we take the sales tax off the effect is to pass the benefit on to the consumer. With the inelastic demand that I referred to earlier there is some doubt about whether this would happen. We feel it would be much more likely to happen if the other measures were adopted as well. Then there would be more competition in the industry and the process of competition would ensure that the benefit of reducing the sales tax would reach the consumer.

I think the over-all conclusion of the main brief relating to the role of government policy in drug prices should be highlighted at this stage, and that is that we recommend that the committee sponsor an independent economic inquiry into the effects of government policy on the price and quality of drugs in Canada and the requirements for efficiency and competitiveness in the supplying of drugs in Canada. We have evaluated the evidence available to us, but we would be the last to argue that all the evidence is in.

The CHAIRMAN: Thank you, Dr. English.

Gentlemen, before we proceed with the questioning, first of all, is it agreed that we should print today's brief, including all the appendices, as part of today's proceedings?

Some hon. MEMBERS: Agreed.

The CHAIRMAN: The second thing is that, apropos of last week's meeting, I think the chairman should rule that every person who wants to question will have ten minutes. During that ten-minute period there will be no supplementary questions at all from any member, otherwise we become confused about the time. If members have supplementary questions would they please devote their time to them? Accordingly, Mr. Mackasey, you have five of your ten minutes left. You may proceed.

Mr. MACKASEY: I bow to your wishes, Mr. Chairman, as usual. If I have only five minutes I rather would like to ask Dr. English—

The CHAIRMAN: Five minutes of the first round, I should say.

Mr. MACKASEY: Dr. English, I am very pleased with, and intrigued by, the brief, because it does present the opposite point of view on many of the questions we have been asking—research, your evaluation of the patent laws—and I would like to get into that a little later—and sales tax which has been rather close to my heart. I was wondering if the consumers' association would, if they have not already, volunteer to do a little shopping for this Committee. Two weeks ago I had occasion to check three drug stores in the Ottawa area with a prescription prepared by a doctor friend of mine, and I was given prices of $12, $8 and $5 for the same products. I do not want to mention the stores and I do not want to mention the product at the moment but my own quiet investigations—

Mr. O'KEEFE: I did not hear you mention the lowest price.

Mr. MACKASEY: The lowest was $5.

Mr. O'KEEFE: You should mention the store at which you got this low price.

Mr. MACKASEY: Well, there may have been a reason. It might have been a substitute. I would like to find that out.

The important thing is that in checking the P.M.A.C. representative firm that would normally sell this product, according to their invoices the product

was sold to all three drug stores at the same price, which was between the $2 and $2.50 mark. Now, presuming this is accurate, here we have a drug store selling a $2.50 article—if you want to use the word "article"; it was a pre-dosage thing—for $12. Obviously the good ladies have been having a certain effect on supermarkets and the price of meat. I am wondering if you people have, in all seriousness, done any research in this particular area. After all, we want to really investigate the drug section which is 37 per cent of the dollar. I would like to know if you have any comments on that?

Mr. ENGLISH: I understand that one of the C.A.C. groups is going to do a survey.

However, the problem here is always the old problem, the matter of money, and also the co-operation of doctors, because you realize you have to get prescriptions and you have to shop in various ways through three or four different stores, and this type of thing. This could be done, and as a matter of fact just two days ago I drew up a brief list. Unfortunately the list I drew up had to deal with drugs that are relatively cheap for obvious reasons. I think it would be very interesting to find out the variations on some of the more expensive drugs.

Mr. MACKASEY: My point is that there are so many ingredients in the end result. There it is not only the cost to the manufacturer, but there is the wholesaler and then the mark-up in the drug store.

Mr. ENGLISH: I think, in this connection, it would be much less likely that you would have found the situation you describe if this country had not already adopted the prohibition of resale price maintenance, because—and I do not know about this particular case—certainly in retailing generally the probability of finding a lower price on some source of supply could be in part attributed to the fact that manufacturers cannot enforce resale price maintenance.

Mr. MACKASEY: A lot of my questions to you are in the consumer area, and this is logical; you are not manufacturers. Do you not think the average Canadian, therefore, needs to be educated to the fact that he is not really a prisoner of the doctor? I have, in ten years, spent perhaps more than any three people in this room on medicine, and I have found it very advantageous to shop around with a prescription. It seems to me that the average Canadian does not quite appreciate the fact that he or she is entitled to a prescription from a doctor, and that he or she is free to canvass various stores in his or her community and get the best price. The variation is amazing.

Mrs. A. F. W. PLUMPTRE (*Past President of the Consumers' Association of Canada*): Mr. Chairman, may I speak to this. I was president when first we started to collect information on this. As you will recall, we thought the committee was going to meet earlier and that they would be studying this last year, I think. We did do some preliminary work and we had some quite interesting results. This was not by any means an organized survey, but we did ask members to inform us of anything they thought would be helpful in the preparation of this brief.

I can recall very clearly, and we could probably still find the reference in our files, a case in Ottawa of a woman who was given a prescription by a doctor and he warned her—and I think this is the thing we would like to see more doctors do—that there would be various prices for this drug, and to shop around. I

should say she was able to shop around. This was an important point. It was not something that was absolutely vital. It was not for a sick child for whom you wanted to get it as quickly as possible. After all, a consumer's ability to shop around is limited by the seriousness of the illness. If you have a very sick child you are not going to rush around—

Mr. MACKASEY: Nor are you going to be too concerned about the cost.

Mrs. PLUMPTRE: No; you just have to pay for what you can get as quickly as you can. But this was a skin preparation and it was not something that had to be bought within the hour. She started off with her own drug store and the price quoted was $20. She was horrified by this. She went to another store, and the price quoted was $5 at which she bought it. Then she went back to her own drug store and said, "I got this prescription for $5", and of course he wanted to know where she got it. She would not tell him.

Two weeks later she rang me again because she was as intrigued with it as I was. She went to a number of stores and back again to her own drug store, and she found that the price had settled, in all the stores that she went to, at about $6.50.

Mr. MACKASEY: Have you formed any opinion on who is really to blame for this original spread between the $5 and the $20? Could you blame the manufacturer, for instance?

Mrs. PLUMPTRE: Not necessarily; in this particular case, obviously, the doctor must have written the prescription in a generic term; therefore, it is up to the pharmacist to decide which brand he uses. I would suspect that in this particular case the man who was charging $20 chose the most expensive brand.

Mr. MACKASEY: Or the most expensive generic?

Mrs. PLUMPTRE: Well, the most expensive of his supply; let us put it that way—whether it was generic or a brand name. He certainly chose his most expensive product, whereas the store that charged $5 was choosing a less expensive one.

In this particular case the doctor must have been sure the quality control of these drugs of different source on the market was good, otherwise he would not have told his patient to shop around.

Mr. MACKASEY: Do you mind if I direct a few more questions to you? They are really for information.

The CHAIRMAN: You have one more minute, Mr. Mackasey.

Mr. MACKASEY: Theoretically, then, had the doctor prescribed a brand name—

Mrs. PLUMPTRE: Yes.

Mr. MACKASEY: —with a fairly uniform retail price across the area that you had visited by your friend, that brand name—let us say it was Parke-Davis or Bayer—may have had a suggested retail value of $8?

Mrs. PLUMPTRE: It may have.

Mr. MACKASEY: Therefore, your friend's chance of getting it at $8 might have been fairly good, but because it was described in a generic term it gave the druggist quite a bit of leeway.

Mrs. PLUMPTRE: Surely.

Mr. MACKASEY: Obviously the moral responsibility rested on the druggist—

Mrs. PLUMPTRE: Yes.

Mr. MACKASEY: —of selling it to your friend either at the $5 which she eventually got it at, or at the $20 for which the first callous druggist was quite prepared to sell it?

Mrs. PLUMPTRE: Yes; I think in this particular case the moral responsibility did lie with the pharmacist. On the other hand, I would like to see more doctors become aware of the economic conditions both regarding the price of the drug and the economic position of the patient.

Mr. MACKASEY: The only reason I am sticking to this point is that throughout our hearings we have heard very logical reasons why, everything being equal, generic drugs can be less expensive. You have opened a new avenue in my thinking, that there is a little danger here that prescribing under generic terms gives the druggist such a leeway that we are placing in the hands of unscrupulous druggists—and there are bound to be some—

Mrs. PLUMPTRE: Very few, surely.

Mr. MACKASEY: Just as very few politicians are unscrupulous—but there are some, and obviously the $20 one that this lady who went to must have been very unscrupulous, but I am wondering if he would have dared taken a brand name, say, the $8 item, and sold it at $20.

Mrs. PLUMPTRE: That I would not know. After all, every consumer is subject to cheating. We all are.

Mr. MACKASEY: I am sure my minute is up, Mr. Chairman.

Mr. O'KEEFE: Miss Pearce, may I commend and congratulate you on an excellent brief.

Unfortunately all the questions I had so carefully written down have been asked by Mr. Mackasey. This usually happens.

If I have any criticism of this brief it is that apparently it did not go into the drugstores as such. It has many suggested retail prices, but are you sure those are the actual prices charged?

Mr. PERNAROWSKI: No; I would say that these are the manufacturers' list prices. There was no shopping involved in any of these.

Mr. O'KEEFE: It is reasonably possible that they could be very much lower?

Mr. PERNAROWSKI: Yes; I think there is a distinct possibility that it could go one way or the other, as has already been discussed. But there is an economic problem here in shopping for these, to set up a proper study.

Mr. O'KEEFE: On page 5 you say, "...the consumer realizes that he can often buy the same drug in two different pharmacies at drastically different prices..." "Surely you must have some instances of this, or some examples—at least one? Perhaps I should ask Mrs. Plumptre.

Mrs. PLUMPTRE: I might say that earlier we did have a number of our branches across the country try to get this. You see, when you ask them to go and find out about this you have, first of all, to have the co-operation of a doctor

who will give you four copies of the prescription, and this is not always easy to get. In fact, some doctors refuse to give it. We did try to do this on rather cheap drugs, and, quite frankly, in some cities we did not find any difference at all.

I do not have the figures with me because this was a year or so ago. We did find some differences. However, I think you are right, that the consumers can probably shop around; there may be some differences. But you have to realize, as I have already said, that sometimes the consumer just does not have time to shop around. An ethical drug is something you usually want in a hurry, and you have a druggist who has been serving your family and you rely on him. Of course, if you happen to be elderly it is not easy to go rushing around, which is an important point in this consideration.

We have had instances quoted to us, but I cannot give you any actual substantiated evidence on this, where a person will go in with a prescription and say: "What is the price of this?" The druggist does not like this very much, and he does not want to give the price unless he thinks he is going to get the order. He does not like this shopping-around business.

Mr. O'KEEFE: There are other necessary drugs, Mrs. Plumptre, other than prescription drugs.

Mrs. PLUMPTRE: Oh, yes.

Mr. O'KEEFE: I had a case the other day of a lady who brought me in a bottle of 100 aspirins for which the normal price is about 63 cents. This was marked $2. The aspirins were chocolate-coated. A good doctor friend of mine said that the chocolate was the most expensive part of that bottle.

Mrs. PLUMPTRE: Yes; I am quite sure of that. This is one drug about which we do know a little because our association did do some tests. We were trying to point up to the consumer that it did not always pay to buy the higher-priced drug.

Mr. O'KEEFE: Would you not agree that those were pretty expensive chocolates?

Mrs. PLUMPTRE: They were.

Mr. PERNAROWSKI: If you are referring to an antero-coated aspirin tablet, there are very good medical reasons for putting on an antero-coating. This, of course, is entirely different from the type of survey the C.A.C. did several years ago, which dealt solely with the compressed tablet. I do not think you can mix the two because in certain medical cases you have to administer a tablet which does not dissolve in the stomach but dissolves in the small intestine. I cannot give you an exact price on them but I would say that that price is a reasonable one. Two dollars would be just about right for those antero-coated tablets.

Mr. O'KEEFE: I have a question for the economist. I always find it difficult to understand—and we are told it so often—that if we take off the 11 per cent sales tax the consumer will get about 10 per cent. It seems to me that when 11 per cent is added to the price of a product the profit is based on the cost plus 11 per cent. Is that so?

Mr. ENGLISH: Yes, that is about right.

Mr. O'KEEFE: Then surely if the 11 per cent is taken off, the profit on the 11 per cent is also taken off?

Mr. ENGLISH: This is perhaps true in some cases, but it is more likely to be true in the instance of drugs than in many other commodities. The reason why it may not be 11 per cent that is passed on to the consumer is the kind of demand conditions you have. If, when you are selling without a sales tax, the cost per unit were a little more than when you are selling, with the—you see, when you put a sales tax on most products it reduces somewhat the amount which is purchased. Right?

Mr. O'KEEFE: No, I do not agree with that. Why should it?

Mr. ENGLISH: Any time you raise the price of something some people will stop buying.

Mr. O'KEEFE: Not in Canada; things are going up all the time.

Mr. ENGLISH: If you, today, raised the price of any commodity, say, an automobile by 10 per cent, someone who would otherwise have bought one is not going to buy. There will be somebody, somewhere, surely.

Mr. O'KEEFE: Possibly.

Mr. ENGLISH: I think you will find that. In any case, this is the observation that economists have made on markets, that when you raise the price a few people do stop buying. If you buy or sell less of the commodity the cost of producing it may change, one way or the other, and if it does change one way or the other this means that you are adding the 11 per cent to a different cost. That is the reason why it is not always exactly 11 per cent.

Mr. O'KEEFE: I suggest that it should be more than 11 per cent because we are also saving the profit on the 11 per cent.

Mr. ENGLISH: Yes; this may be true. It depends on whether you put the...

Mr. O'KEEFE: I always hesitate to argue with an economist.

Mr. ENGLISH: No, you should not! You cannot generalize in either direction on this. It depends upon the particular market.

Mr. O'KEEFE: We are anxious to have this 11 per cent taken off but we do not want to have the 11 per cent taken off and then find that the consumer gets nothing, or 8 per cent.

Mr. ENGLISH: He may get nothing for a very much more fundamental reason, that it pays the producer to leave the price up where it was before. If the producer has control of the market, by a variety of means we can go into, he does not have to reduce the price when the tax is taken off, unless the government takes additional action to make that necessary.

Mr. O'KEEFE: May I ask the ladies one more question?

Do you think that drug prices in Canada are too high? You have not answered that question in your brief, and neither has anyone else.

Mrs. PLUMPTRE: I dare say this is what we are asking the Committee to find out. We are saying that we do think that this is a problem which needs further investigation and study. We have all these problems up to you. Do you think that there is sufficient evidence available on all these aspects? Whether I can say that I think the price of a drug is too high or not—I do not have the evidence to say, "It is too high."

I recall appearing before the Restrictive Trade Practices Commission some years ago and we were relying on the evidence collected by the Combines Investigation Branch. In that book the director certainly gave some instances where, to me, I would say that the drug was priced too high. I can remember one drug, produced in France, which was about 75 cents a unit and which was selling here in Canada at that time for something like $8.25 a unit. That certainly seemed to me to be rather high.

Mr. O'KEEFE: Only seems to you to be rather high.

Mrs. PLUMPTRE: It was rather high in my view. You cannot say, just because one drug is priced high, that all drugs are too high, but we feel that we should have a very good investigation to make sure that they are not.

Mr. O'KEEFE: That is being done, Mrs. Plumptre, but we find it very difficult—at least I do—to have any witness actually say that drug prices in Canada are too high. I have no qualms. I think they are too high.

Mrs. PLUMPTRE: Yes, I think they are, too; but I can only think it, because I cannot say what I mean by "too high".

Mr. O'KEEFE: Thank you very much, Mrs. Plumptre, I will leave the rest of the questions to the experts.

Mr. HOWE (*Hamilton South*): Mr. Chairman, in order to limit myself to ten minutes, I have written down quite a few questions. If I am going to get them all in it will depend on the brevity of the answers I get, more than anything.

The CHAIRMAN: Yes or no?

Mr. HOWE (*Hamilton South*): I will just leave that statement, and hope that the message is there.

Do you think the brand name houses are over-protected by the government in the form of patents and anti-dumping duties?

Mr. ENGLISH: I think the answer to that is yes.

Mr. HOWE (*Hamilton South*): Do you favour, then, easing both or either of these, or removing them? I will carry on with that. The Restrictive Trade Practices Commission recommended the removal of patents, and the Hall Commission Report recommended that compulsory licences be broadened to permit the issuing of licences on the importation of drugs, which, as you said in your statement, are not available now.

Mr. ENGLISH: I think there are a variety of measures which can be taken. I believe you can make a good argument for the suspension of patents on a trial basis, or permanently, but if we wish to experiment with something which does not go that far, first, the compulsory licensing of imports would be a place to start.

Mr. HOWE (*Hamilton South*): In the anti-dumping duty which prevents or discourages anything of a class or kind made—with a question mark—in Canada, do you think that removing the word "class" would open this up a little wider and possibly effectively lower the price of drugs? In other words, "class" has a very broad sense, whereas "kind" limits it to one specific chemical or drug.

Mr. ENGLISH: If we are interpreting this correctly, I think this is one way of proceeding, to start by adopting a narrower definition of "kind".

Mr. HOWE (*Hamilton South*): There is one question which I have asked two of the drug companies. I am going to ask you if you happen to have any information on this. I have been unable to get it so far. The question deals with the f.o.b. prices of drugs leaving the factory, which are going to different countries. This could include Canadian manufacturers exporting or American manufacturers exporting. I mean an f.o.b. price at the factory going to different countries. Do you have any information?

Mr. ENGLISH: No, I am sorry; I do not.

Mr. HOWE (*Hamilton South*): I am having a lot of trouble finding this. I have reason to believe that there are differences in prices as drugs leave one company to go to different countries. That is what prompted the question.

Would you think that drugs imported from countries such as Yugoslavia and Italy, which are countries that have no patent laws, could be safely possible if the authority of the Food and Drug Administration were to be extended to these countries of origin to ensure adequate quality control?

Mr. PERNAROWSKI: The question is whether they could get this power extended to the country in question? I think it would have to be whether they could do anything at the point of entry.

This comes back to the statement on drug specifications. Often it is very difficult to evaluate a drug on the basis of current specifications and you need much more than just straight laboratory testing. You need authority to go back and look at a process. I think there might be instances where the companies might not want to allow Food and Drug inspectors in. However, the Food and Drug Directorate would then have the authority simply to say: If you do not let us in, you do not bring the drug into the country.

The CHAIRMAN: Can I make a point here?

Mr. HOWE (*Hamilton South*): On your time!

The CHAIRMAN: Yes. The Food and Drug Directorate do have the authority now, at the ports of entry of the drug, as long as that port is in Canada, to go anywhere and make spot checks of a drug which is imported. They also have this authority to go into the country of origin for drugs which are injectible, but it is only for those special drugs.

Mr. HOWE (*Hamilton South*): Yes, but I meant the extension of their allowed ability to go into the other countries and inspect quality control in those countries. If we were able to effect this, do you think this would help in any way?

Mr. PERNAROWSKI: We have this power now, in effect, in the sense that if someone wants to bring something into this country they have to meet certain standards and the Food and Drug Directorate can lay these down. One of these standards is simply an inspection of the plant.

Mr. ENGLISH: May I just add one point to that? It seems to me that the only way you can get a really general test of quality is by this means. In other words, if this is not successful, what can be?

Mr. HOWE (*Hamilton South*): In your brief you stated that promotional costs are far too high. The Hall Commission Report recommended 15 per cent. Do you think that this could be done effectively and safely and have the effect of lowering drug prices in Canada?

Mr. ENGLISH: I think it is one of those measures which would be much more certain of success if the other measures were taken at the same time. It would be hard to predict the effect of any one taken by itself.

Mr. HOWE (*Hamilton South*): It is the combination of all these things which you mention.

In our present society government agencies such as the Food and Drug Administration act merely as a buffer between the industry and the consumers. This is true today, is it not? Do you agree that this or some other body could be set up to inform the people of the findings of such a body for the public's protection, both financially as well as with regard to the safety of drugs, as well as possibly for the doctors'? Would this, properly used, help reduce the promotional costs of drug manufacturers?

Mr. PERNAROWSKI: I think, in effect, this is implied all the way through; that is, we ask for a national formulary committee which would provide a flow of information in terms of a book. We ask for what we call, the P.I.L.—a professional information letter—and, at the same time, support for the continuing education of departments in medical schools which would then function with the medical profession to provide information, provided, of course, that this is earmarked for drug information and not for other reasons.

Mr. HOWE (*Hamilton South*): Therefore, it could lower the promotional cost by having—?

Mr. PERNAROWSKI: I would hope so, in the sense that the doctor would not have to rely on much of the other information and getting this from other sources.

Mr. ENGLISH: Can I add a point to that one, too? I think, again, it is a question of what you combine with that kind of measure, because you can have a general circulation of information, but if competition is absent in the industry you cannot be sure that this will be accompanied by lower drug prices. Therefore that promotional margin relates to the amount of financial leeway available to the industry, with which to promote or with which to do research or with which to do anything they want to that proves to be profitable and sells more drugs. But we want to have more emphasis on price competition, and this is the reason for the package of measures proposed.

Mr. HOWE (*Hamilton South*): How much distrust do you think is genuine in the claim that the generic manufacturers make an inferior product?

Mr. PERNAROWSKI: It is very difficult to say how much of this distrust is genuine. I hear this quite often, that people suspect the generic product; they do not want to use it. I cannot really present figures.

I do not know if the director has anything on surveys of this type of thing. I wish we had this kind of information.

Mr. HOWE (*Hamilton South*): Do you feel it is over-rated?

Mr. PERNAROWSKI: That is a difficult question to answer, sir.

Mr. HOWE (*Hamilton South*): I am not trying to put you on the spot. That is not the purpose of the question.

Mr. PERNAROWSKI: Actually, I really think a lot of the problem is that it comes back to how do you evaluate the products. I think that one of the difficulties that we are up against right now is the methodology which we have to evaluate drugs. I have seen instances where products have met all existing specifications and yet have been therapeutically inactive. However, how many of these are there? Does it represent a tenth of one per cent, or 1 per cent, or 5 per cent? I do not really know. I cannot tell you that.

Mr. HOWE (*Hamilton South*): On page 18 of your brief you state that the number of generic drugs, reliable or otherwise, available are very few in number. What must be done to encourage the manufacture of more of the reliable generic drugs?

Mr. PERNAROWSKI: I think that statement is with respect to the fact that in terms of the over-all drug supply there are few single drug dosage forms. There are many combinations. In other words, what we are trying to say here actually is—that if you take the typical generic company, as we think of it—and by the way I do not like this word "generic," but that is another story—they only market six or eight or ten or twenty products. So this is all the competition which is existing along here. One of the reasons is because many of the manufacturers have what they call their sepcialities. These specialities are a combination of drugs, and there is simply no competition there at all. You have no alternative, and it is promoted on this basis.

I think at that point what we are trying to bring across is that even if you went to a complete prescribing by generic name, I do not know what the total effect on the drug bill would be, but it may not be as great as we think because of these speciality preparations.

Mr. HOWE (*Hamilton South*): In other words, the doctor would have to prescribe the mixture but prescribe different drugs rather than prescribing the mixture.

Mr. PERNAROWSKI: That is right. Then again, we go on further, that we do not think that it is the business of C.A.C. to dictate to the medical profession how they practice medicine; that is, whether they should use these or not. We say this is something best left to the medical profession. There is probably a big school which does not like these combinations, but there are many who do. I think this is which cannot be resolved by an association such as ours. We would be very presumptuous if we made any suggestion. I think this is something that the medical profession itself has to do.

Mr. HOWE (*Hamilton South*): I have just one more question and then a request.

Do you blame the Food and Drug Directorate for their rather closed-mouth attitude, or do you think this is because of other forces that are brought to bear on them?

Mr. PERNAROWSKI: Would you please repeat that?

Mr. HOWE (*Hamilton South*): Do you blame the Food and Drug Directorate for their closed-mouth attitude, or do you think this is because of other forces that are brought to bear on this department?

Mr. PERNAROWSKI: I think perhaps other forces are brought to bear on it.

Mr. HOWE (*Hamilton South*): Now, Mr. Chairman, my last, as I said, is a request. I have here a list of prices of drugs—this was sent to me in the mail—that are made by brand name houses selling to the patient at a range of from 11 per cent to 80 per cent off the recognized price of the original brand name. I was wonderng if we could publish this, in part, or in its entirety, in our minutes to save me reading this list.

The CHAIRMAN: I know what you are referring to. I got the same mail.

Mr. HOWE (*Hamilton South*): It is a list of 10 or 12 drugs. I am not trying to advertise and I am not mentioning the pharmacy who sent it, but the list of drugs and the name of the manufacturer and the price and the comparative savings I think would be revealing enough to have in our Minutes for consideration.

The CHAIRMAN: Would they have to be in the Minutes today? I wonder if we would discuss this in the Steering Committee one day, and decide what we should do with this kind of evidence?

I should point out that the Committee itself is getting comparative figures on certain drugs both in Canada and abroad, and of certain drugs that are being purchased by government tendering, and I suspect that this might be the better place for this to go, as a comparison.

Mr. HOWE (*Hamilton South*): However, I have mentioned this and mentioned rates and that will be on the record. Thank you very much.

Mr. ISABELLE: In my best English, Mr. Chairman, I will direct my questions to anyone. It will be easier that way.

The CHAIRMAN: To anyone who knows the answer.

Mr. ISABELLE: Briefly, what is the aim of the Consumer's Association?

Miss PEARCE: The aim of our association is to inform, speak for, and assist consumers in education. Probably one aspect is the particular point which Dr. Pernarowski mentioned, that he had prepared a brief outline of prescription drugs which we might use as a shopping list. This is part of our educational program by which we hope to come up with something that can be used in our magazine, "*Canadian Consumer*", to help people to realize that perhaps they can shop for drugs.

Mr. ISABELLE: In other words, you must have good statistics on various consumers' prices of products.

Miss PEARCE: Quite definitely.

Mr. ISABELLE: This is not quite related to the question I am going to ask afterwards, but it has something to do with it. Could you tell me, according to your statistics, when a housewife is going into a grocery store, or any store, and she buys cornflakes, does she buy cornflakes because of the brand name of the company who manufactures the cornflakes, or does she go for the gimmicks that are in the box, or does she buy that specific brand of cornflakes because the children have asked her to do so?

Miss PEARCE: I am afraid that is an impossible question to answer because we have no sort of typical consumer.

Mr. ISABELLE: That must be very important to do if it has not been done, because price and quality are automatically out of the question in this particular field. The housewife could buy anything, because there are factors other than those of price and quality in this question.

This is related to the question of drugs. You could buy a brand name drug prescribed by a doctor and there would be a difference of as much as $6 per hundred tablets, but this does not depend on the manufacturer, and it does not depend on quality, because we are sure of good quality if it is manufactured by an important company. But, on the other hand, if you buy some generic drug, you may pay double what you were supposed to pay if you had bought a brand name and have a chance of being poisoned.

I am going to give you not exactly an example, but at least a comment. You made a statement which amazed me very much. You said, regarding substitutions, that it should be left to the pharmacist to decide whether he should tell the patient that he could have this drug cheaper if this dispensed by the pharmacist himself. In other words, if you prescribe librium, or any other drug, then he could give you the generic drug saying that this drug is cheaper. If the pharmacist has to decide, this means that you put the legal onus on the pharmacist? Is that true?

Mr. PERNAROWSKI: Yes. I think, again, that this is a situation where there is no black and white, as was the case in the matter of the therapeutic activity of many drugs. Many pharmacists distrust the generic and, of course, they would not substitute. Whether they have the power to do so or not—now they do not, I think, except in Alberta—they do not have this power and they have to give what the doctor states.

If we could take the question of drug quality out of this, then he would have something to contribute. Right now we are in the dilemma that we do not know enough about quality. There is a great argument among the professions on whether the pharmacist should have the right to substitute. As a matter of fact, I think a lot of pharmacists do not want this power; some do, but many of them do not. They would rather fill the prescription as written and have the doctor specify the brand.

Mr. ISABELLE: Is it because they are afraid of the quality, or that they are not exactly sure of the quality?

Mr. PERNAROWSKI: This quality business needs looking into, I think. This has been building up over the years. As I said before, our facts and figures on this are really very slim and very bad. There are all sorts of isolated cases which we can pick up out of the literature, and perhaps somehow we should attempt to gather these together. Perhaps this is a criticism of the profession of pharmacy, and that this is really what they should be doing—that they should accumulate this information and attempt to bring it before a committee such as this.

Again I have to come back to this basic problem: How do you evaluate a drug? It is not as easy as it sounds. Very often you hear, "Well we simply look in the British Pharmacopoeia and that tells us everything." I think this is completely erroneous. There are many reasons for it. The methodology is bad. There are dozens of reasons. It is much more than just what you see in a basic book on specifications such as the pharmacopoeia, and this is the complicating factor here. This is the factor, I think, that must be taken out when you are talking about

substitution and quality. It is very difficult to answer the question. I think, again, as Mrs. Plumptre said, we would hope, or, at least we think, that pharmacists as a whole are ethical enough that they would not hand out anything but the best quality drug, and, in fact, the profession of pharmacy has been always geared to this historically. This was drilled into you—care, quality, care, quality. Anyone who is using a cheap drug is simply not fulfilling his professional responsibility.

Mr. ISABELLE: I have another question here related to the brief on page 11, line 15. I should say at the outset that Report of the Royal Commission on Health Services was a very good document, but it is not the Bible. You have said at line 15 that you are "...not prepared to accept the excessive costs associated with drug promotion not only because these add to the cost..." etc. but "...because some companies spend more to mis-inform than to inform the physician". I do not think this is correct, because the companies' material is always based on statements approved by the Food and Drug Directorate.

Mr. PERNAROWSKI: I do not think this is quite accurate. In the original new drug submission this material is always used, but it is the advertising after that which caused us to put into the brief somewhere that the Food and Drug Directorate should look into this business of advertising in medical journals. You realize why they do not do this now? Everyone always hopes that somehow the professions will do the job themselves and that the drug industry will do the job themselves, without having to be told. This is what we would like to see, but if this does not happen obviously you are going to require regulation. In anything a voluntary basis is better than a new law or a new regulation, but if this does not come about then we have no alternative but to ask that there be closer screening of information.

Mr. ISABELLE: But even the copier—he is not obliged to—but, in the long run, if he is caught by the Food and Drug Directorate he has to submit the literature he is writing on a certain drug, even if it is an old drug; but most of the time it is a copy; so that is why.

The CHAIRMAN: I think the Food and Drug Directorate are only responsible for the advertising carried in the news media, the radio and television. They are not responsible for journal advertising or advertising that comes into the doctor's office. That is not cleared through Food and Drug. It is just put out by the company.

Mr. ISABELLE: Do you think, as representatives of the consumers' association, that the standard of living in Canada is too high? Recently there have been some figures released that out of 30 newly-wed couples 24 were in debt up to their necks before they were married. Do you think, on that philosophy, that the standard of living in Canada is too high today? I know that we have a high standard, but is it too high?

Mrs. PLUMPTRE: Mr. Chairman, if I might take a shot at that—and perhaps Mr. English will want to speak on it, too—I think you are verging on a matter which is under consideration by another parliamentary committee. You say that these young couples are in debt, and they are in debt because they do not know how much this debt is costing them. I think credit is sometimes too easily available. What we are waiting for, of course, is some legislation so that they will know more about the cost of credit.

Mr. ISABELLE: I was just asking the question as a consumer, because—

Mr. ENGLISH: The right approach to that question, in my opinion, is this, that I do not think that anybody would like to defend the proposition that Canadians get too high a per capita income—at least, I am not going to try to defend that. I would have my own personal opinion whether we all spend it as well as we should. I think that setting a high ideal for expenditure is the pre-occupation of individuals and of society as a whole. If our government gives us leadership in giving more external aid instead of consuming ourselves, I would be for that. If our government gives us leadership, or anyone else gives us leadership, in spending more money on worthy cultural objectives instead of more and more on certain kinds of material goods and drinks, then I would be in favour of that. But that is my personal opinion, and I think that to say our standard of living is too high is really a very different thing from saying that our consumption pattern may leave something to be desired.

Mr. ISABELLE: You say that because you are not sure whether it is too high or not.

Mr. ENGLISH: I beg your pardon.

Mr. ISABELLE: You say it is difficult because you are not sure whether it is too high.

Mr. ENGLISH: I am quite sure that our income is not too high. Our per capita income is not too high, because there are so many things that we can do in this country and in the world with a higher and higher per capita income. I am quite confident about that.

Mr. ISABELLE: I am just pointing that out to you because I know that one afternoon someone without a cent in his pocket went shopping on a main street in a nearby city and he bought $19,000 worth of goods without having anything with which to reimburse the stores.

Mr. ENGLISH: That is not the standard of living that you are referring to now.

Mr. ISABELLE: No, it is not. He was setting too high a standard.

The CHAIRMAN: We assume, since we are discussing drugs, that this was mostly drugs!

Mr. FORRESTALL: Mr. Chairman, I have one or two general questions and then one or two specific ones.

First of all—and perhaps one of the ladies could answer this: I have read your brief with interest and commend you, as others have, for the amount of work which you have put into it, but I would ask this: Why did you not go further in your brief? Why did you stop at those things obviously pertaining to matters under direct government control? Why did you not look more deeply, as has been suggested from across the way, into other areas where possibly savings in the cost of drugs might be brought about?

Miss PEARCE: Well, not having had anything specific to do with the preparation of the brief, I might conveniently answer by simply saying that the Consumers' Association of Canada is a voluntary organization, and the three people whom I have as witnesses representing the Consumers' Association today have

done this on a voluntary basis. I am sure they have decided that the specific angle that they have taken was the one they thought most important, with the amount of time that they had at this particular time.

Mr. FORRESTALL: I further commend them for that. I did not realize that it was strictly voluntary.

Mr. ENGLISH: I think, also, it is not strictly right to say that we talked only about government aspects. I did stress this in Appendix "C," but the main brief itself goes over many of these issues—the role of the manufacturer, the role of the pharmacist, and the role of the doctor which Dr. Pernarowski has referred to. Perhaps it is more difficult to get information about some of these subjects.

Mr. PERNAROWSKI: This is a matter of resources. This is a voluntary organization. We simply ask—

Mr. FORRESTALL: I accept that fully. I did not realize it was a totally voluntary organization. I knew, of course, that the officers of it were volunteers and that most of those employed in it were.

I will go on then to some specifics. You make some general assumptions in your conclusion and summary portions on patents. You say, in part, that monopolies inevitably lead to prices of products higher than those produced under competitive conditions. Will you admit this is a broad assumption?

Mr. ENGLISH: It is not an assumption. It is a conclusion from the evidence so far surveyed. I would not say that we have all the evidence that would be necessary to get that—

Mr. FORRESTALL: You would qualify it at least to that extent.

Mr. ENGLISH: You can always qualify it.

Mr. FORRESTALL: What I am concerned about is that the impression I have from your section dealing with patents is that you would favour some change there, and I fear that unless protection is held out—and perhaps you would care to comment on this—unless methods of protection are permitted and they are satisfactory to the demand, we are going to have a fall off in research and people will tend not to go on and develop if they do not have some form of protection.

Mr. ENGLISH: Well, there are two aspects of the patent. There is the aspect of the patent as a promotion to research, and the aspect of the patent as a supposed protection of quality. I think that at the very least one can raise the observation, some of which I have raised already, that, in the first place, most patents are not held by Canada and have not promoted research in Canada. Therefore the patent system has not produced great results for Canadian research.

Secondly, it is possible to provide an incentive to research in Canada even if there were no patent system. The government is now experimenting with encouragements to research by other methods, and possibly these methods would be more productive and involve less cost in the direction of raising prices—with less price-raising effect. If a government gives a direct grant to research, as it does in many fields, it may be focussing more specifically on the point at which real results can be obtained than if it gives the general privilege that can be used to encourage research, or can be used simply to create a monopoly. I think the patent system should not be regarded as the only alternative available for the encouragement of research; and in quality, it is not the only alternative there

either, because the Food and Drug Directorate is much the best guarantee of quality that we have. Many drugs are not patented at all and, therefore, in effect, the patent is no guarantee of quality.

Mr. FORRESTALL: I have one final question. Mr. Mackasey and Mr. Howe got into the area I wanted to touch on, and I do not want to go back over that. You have summarized them, but I had to go through both the appendices and the brief and there are six areas which I found. Could you tell us in what order of priority you would put the conclusions that you hope this Committee might arrive at with regard to the best means of doing what we are bent on doing?

Mr. ENGLISH: That is a very big undertaking. The whole emphasis in the brief is that we want to open up areas of discussion and inquiry rather than to preclude the further discussion and inquiry that you are undertaking. I think there is implicit in what we say some feeling of what we think are the most important issues to be examined and some direction from which we think evidence could be obtained, but I think it would be a little presumptuous at this stage for us to say exactly what order of priority is vital.

I do think one point could be reiterated, and that is that it would appear that a package of policy actions would be more effective than a single action in one or two fields.

Mr. FORRESTALL: This is, then, a package that would embody certain recommendations in regard to areas of government control, as well as those directly concerned with the manufacturing, import duties and so on and so forth?

Mr. ENGLISH: I think, if anything, perhaps, it is a net release of control that we are looking for—a little more competition—and at least removal of some of those government policies which, in their effect, restrict competition.

Mr. FORRESTALL: Thank you very much. Keep up your good work. You have been most useful and helpful to us.

The CHAIRMAN: Mr. Laidlaw, would you like to make a comment on the question of imports and compulsory licences?

Mr. A. W. LAIDLAW (*Legal Counsel for the Committee*): There are several comments I would like to make, and two or three questions which I would like to direct to Dr. English particularly.

In appendix C to the brief, there are several references to foreign sources, such as the U.S. Senate Committee on the Judiciary and the Kefauver report and so on. Are you assuming that the conditions in the United States, to which these references were made, are parallel to the situation in Canada?

Mr. ENGLISH: I think this is a question that would require more time to answer fully, but because of the fact that the references are to the practices of companies who have subsidiaries in Canada, one might expect that to be the case. There would be a similar corporate policy in the two countries—on the product, at any rate.

Mr. LAIDLAW: Might I ask a further question along similar lines, because this has been mentioned before: The green book upon which the Restrictive Trade Practices Commission made its valuation is now about five to six years old. Do you think, or are you assuming, that conditions in the last five or six years have changed at all to make that green book now not sufficiently accurate?

Mr. ENGLISH: I am sure some conditions have changed, but I would expect that in a matter of this kind, at least, the green book opens up questions which we would like to have the answers for as of 1966-67. You cannot be sure, of course, unless you examine it in detail, whether the conditions are exactly the same as they were five years ago.

Mr. LAIDLAW: Generally speaking, do you think the Committee could rely on the evidence as being much more significant?

Mr. ENGLISH: I would say that other evidence I have seen corroborates the evidence of the green book as being still relatively up to date. There may be certain practices that have changed, but these would be specific ones.

Mr. LAIDLAW: Dr. English, in fairness to the drug companies who have appeared before us, one of your recommendations is that the patent system, as it pertains to drugs, could be abolished. It has been maintained by the drug companies that if such an action were taken by the government the international patent system would be so disturbed that retaliation by other countries might be invited which would be harmful to Canada. I think, in fairness, if you have done any work on this subject, that it would be interesting for the Committee to hear about it.

Mr. ENGLISH: Now, you are asking me to predict what would happen in a matter which might be very difficult to predict. The thing that would seem to me to be our best protection—if you want to use protection in this sense—is the fact that the same companies are operating in Canada as in other countries.

We are not implying by what we say that we want to eliminate, disturb, or embarrass, those companies. What we are saying is that we think that there is very good reason why those companies should be more competitive in Canada, and that, at the very least, they should be able to offer us drugs at the same price as those in the United States, and perhaps in both countries there is some action that needs to be taken to reduce the price of drugs, because both countries have higher prices than some of the other countries of the world.

Therefore, it does not seem likely to me that you would get a great deal of disturbance from action on patents in this country. However, I would like to give more consideration to that and know something more about it before I would be fully confident.

Mr. LAIDLAW: Dr. English, turning to another recommendation that appears on page 6 of your brief, recommending that this Committee sponsor an independent economic inquiry, and so on, I am sure you are aware that an inquiry has been conducted before the Restrictive Trade Practices Commission, which was followed by the Ilsley Commission and also the inquiry by the Hall Commission. Does this not appear to you as a self-defeating recommendation, because if this was followed it would be another two or three years before the Committee could come to any conclusion?

Mr. ENGLISH: I think that the nature of the inquiry that I have in mind, in support of that statement, is one that would involve making use of data that may be readily available within the public service, from the combines commission and other bodies within the public service, because I am sure that a great deal of evidence has been accumulated when you consider how many public policies are involved here, and that this inquiry could focus more on the subject matter at

which this Committee is charged to look than the inquiries that have taken place to date. I do not know that a great deal of additional basic data would be required, but I think bringing together the significance of the available data in the published reports would be useful.

One of the difficulties about some of these reports is that they are written for another purpose and they deal with a lot of other things besides those with which you are primarily concerned—the basic price and quality of drugs; and one of the difficulties of a single department of government's responsibility is that they find it very difficult to go beyond their own area of activity. Combines for example, do not find it easy to get into the examination of the consequences of tariffs, because other departments are responsible for that.

Mr. MACKASEY: Or is it the area of safety?

Mr. ENGLISH: Yes.

Mr. LAIDLAW: Speaking as an economist, then, would you, for example, like to see the effect on the economics of the country—and I am talking particularly about the production of drugs in Canada—of an economic study of the patent system? This has never been done. I should say here that at the Ilsley Commission some 126 economists were asked to participate and write a report on the effect of the patent system as a whole on the economics of this country, and nobody stepped forward—none was available. It is a very difficult thing, I understand, to get a government to make studies of this nature.

Mr. ENGLISH: There is, of course, a reference to the Economic Council on this question and on others, and one would hope that this might be the basis for such a study under the Council's auspices. The government's reference includes a specific item on the patent system.

Mr. LAIDLAW: I have one last comment, Mr. Chairman. Dr. English said in his preliminary remarks that he had not all the available evidence, but he stated that it was apparently hard to get a compulsory licence. The evidence to date produced by the drug manufacturers indicates that they are really quite afraid that compulsory licensing permitted by Section 41(3) of the Patent Act, if allowed to stay, might continue to have a very drastic effect on the industry in Canada.

I believe that 14 compulsory licences have been issued to date. I cannot remember how many are pending at the moment, but these are apparently growing in number, as has been pointed out by the drug manufacturers. When you are looking into this evidence further, I wonder whether you could make further comments on this? I am sure that a letter on this point to the Chairman would be appreciated.

Mr. ENGLISH: We will be happy to try to find additional evidence on this. I certainly would like to know, for one thing, how many compulsory licences, if any, have been issued respecting imports.

Mr. LAIDLAW: Imports are not allowed into Canada under Section 41(3). They are allowed under the United Kingdom statutes, but not in Canada at this moment.

Mr. ENGLISH: That was my impression, but I was not sure until you said that.

Mr. LAIDLAW: That is all, Mr. Chairman.

Mr. MACKASEY: Mr. Chairman, on page 2 of the main brief, there is something that I appreciate very much. It say, and I quote briefly, "The Food and Drug Directorate does check the industry"—we are talking about safety now —"but the results of such checks are not public knowledge. Similarly, manufacturers are inspected on the basis of the standards laid down by the Canadian Government Specification Board (74-GP-1a) but the results of such inspections are not made known to the consumer. The Consumers' Association of Canada feels that the public has a right to this type of knowledge and that steps should be taken to publish this information in a suitable form".

I wholeheartedly agree with this. I do not know of any drug company, either generic or brand, that should be protected from public scrutiny. I think the greatest weapon this Committee has is the force of the public as represented by groups such as this association. If there are firms in Canada, generic or otherwise—and that includes those in the P.M.A.C.—who do not meet the standards of quality that the government specifies when they are selling goods to the government, why should they be protected by silence when, in the United States, this is public knowledge?

I went to the library last night on the strength of your report—or the day before yesterday, rather—and I got the F.D.A. report, and I was astounded to find that in many instances the people who are not living up to the safety standards are not generic firms but, in many cases, brand name firms.

They do not have a preferred position in Canada, and they should not assume one. I know this is a statement more than a question, but I point out that I think your brief is refreshing in that it does offer certain suggestions, and the suggestion that appears on page 2 is very pertinent. This is not my question, but—

The CHAIRMAN: I was going to say that the food and drug committee that sat on the safety of drugs made the same recommendation to the government two years ago.

Mr. MACKASEY: Our government seems awfully slow in moving in this area. We have also recommended compulsory registration. We have also recommended, I presume, the abolition of sales tax.

The CHAIRMAN: No, we have not.

Mr. MACKASEY: Well, we should have. I keep saying that.

The CHAIRMAN: You keep saying it, and I keep denying it, and I am right.

Mr. MACKASEY: It is about time that the department started doing something, otherwise what is the use of our meetings?

The CHAIRMAN: I was just pointing out to you that the committee did make that recommendation several years ago, and it has not been complied with.

Mr. MACKASEY: On page seven of the report—and I am going to move fast because my ten minutes is nearly up—there is a figure which I would like explained because it does not jibe with my research. It reads: "In general, the drug manufacturer receives 60 per cent of the Canadian prices shown in the Appendix." In the P.M.A.C. reports, and in most of the reports of individual

companies such as Hoffman-La Roche and Ayerst, they show approximately 35, 36, 37 per cent. Where do you get 60 per cent?

Mr. PERNAROWSKI: This is always the trouble with figures. What we are trying to say is that if the list price is a dollar the pharmacist pays 60 cents, or 60 per cent of the list price. This is not necessarily true, as it goes on to explain further, in that there could be other prices to the pharmacist.

Mr. MACKASEY: In all fairness to the manufacturer, there could be intermediate steps in getting to the druggist, such as wholesalers.

Mr. PERNAROWSKI: In many instances the manufacturer publishes a catalogue and in this catalogue there will be a price for 100 tablets. If the price for 100 tablets is, say, two dollars, the pharmacist would pay roughtly 60 per cent of that.

Mr. MACKASEY: I will leave our boy Friday, here, to refute the argument or justify the difference between 60 and 37 cents.

Mr. PERNAROWSKI: I think it depends on which end you start working from.

Mr. MACKASEY: We can come back later to the sales tax.

Now, on the same page you make an excellent point pertaining to the drug prednisone. You mention—and I think that it has been proven by many reports—that Schering, despite the publicity given to this particular product, still maintains its price, for which I do not blame them, but you also mention that there are five reputable manufacturers in Canada who will provide the identical product for anywhere from $3.50 to $7.50. I am not condemning Schering, but I am wondering, if this is the fact, why doctors do not prescribe the other five products. Why blame the manufacturer? Why blame Schering if the doctor will not assume his responsibility to society and recommend, through his prescription, one of the five products that are available between $3.50 and $7.50?

Mr. PERNAROWSKI: I would think that more and more, for this particular drug, that, say, the Parke, Davis product or the Frosst product is, in fact, being used. I doubt very much whether any doctor who has seriously thought about it would write a prescription for Schering's meticorten.

Mr. MACKASEY: Would it not have been fairer to the medical profession to say in the brief that more and more lower prices are being prescribed? If you were to pick this brief up, you would be left with the impression that the doctor inevitably recommends the Schering product.

Mr. PERNAROWSKI: I do not think this is implied anywhere. There are doctors who will be very careful about what they prescribe, and I think it has already been stated that in many cases the doctors do not know the price. This is another problem. We ask more and more of our medical people. We ask them to be price-conscious, but timewise—

Mr. MACKASEY: I am not a doctor, but if he is trying to cure a patient, surely a doctor in 1966 realizes the emotional problem, this worry and this fear, and the high cost of drugs can do a lot to set the patient back. Would you not agree with me that if enough doctors boycott the Schering product strictly on the question of price, realizing Schering, that they have a product equally safe, would have to drop the price?

Mr. PERNAROWSKI: Yes, I would.

Mr. MACKASEY: Therefore, would you not say that the fault is not Schering's but rather the doctor's in this case?

Mr. PERNAROWSKI: I cannot speak for the doctors.

Mr. MACKASEY: No, but you are an intelligent man. I am sure you can come to a conclusion.

The CHAIRMAN: I think you are asking him to come to an unwarranted conclusion.

Mr. MACKASEY: No, I am not.

The CHAIRMAN: What you do not know here, as he pointed out, is the volume of the market. Perhaps no more doctors prescribe it at that price. He has no way of knowing.

Mr. MACKASEY: Mr. Chairman, you are a doctor. Perhaps you will answer the question. What would justify Schering selling the product at $22.70 for a hundred tablets if the bulk of the sales are not coming from doctors' prescriptions?

The CHAIRMAN: I cannot justify their price, but as a practising physician I would know what my patients would pay for certain drugs.

Mr. MACKASEY: Schering is justified in charging $22.70 if they think that is what the Schering product is worth. But let us get back to the responsibility of the doctor. He has a responsibility to provide his patients with the safest possible drug, but presuming the statement that there are at least five people who product a product as safe as Schering's is accurate, and it is available to the patient at between $3.50 and $7.50, on whose shoulders would you think the responsibility lies to prescribe a safe drug between $3.50 and $7.50? Certainly the doctor's. Now, if all doctors did this, who would buy the Schering product?

The CHAIRMAN: This is my point. Perhaps no one does.

Mr. MACKASEY: Then why do they sell it at this price? Why do they keep manufacturing it?

The CHAIRMAN: You would have to get them before you and ask them for the volume of the market. Perhaps they do not any more.

Mr. MACKASEY: I am only going by the brief. I start with the premise that all briefs are accurate.

Mr. PERNAROWSKI: This is their list. This is the published price.

The CHAIRMAN: This is their list price, but—

Mr. MACKASEY: You do not know anybody buying it, in other words?

Mr. PERNAROWSKI: There are many other examples of the same type of situation.

Mr. MACKASEY: But this is the example that you have put in the brief, and I see tomorrow's headlines, as we often see, "Schering Sells Product at $22.70 that is Available at $3.50." But the papers, because of brevity, do not explain the patient is not getting the $3.50 product simply because the doctor has not prescribed it. It does not fall to the manufacturer in this particular instance but it is on the conscience of the doctor.

Mr. ISABELLE: On a question of privilege, you are speaking about physicians in general?

Mr. MACKASEY: Yes, in general.

Mr. ISABELLE: I want to tell you something—

Mr. MACKASEY: This is not in my time, Mr. Chairman.

Mr. ISABELLE: No, no, this is on borrowed time. Sometimes we try to protect the people and we try to prescribe the cheapest brand name and because they do not pay enough they think you are a cheap doctor. Do not forget that. That is another side of the question that we have not investigated, but it is true.

Mr. MACKASEY: That is psychology.

Mr. ISABELLE: I know; but it is a fact just the same.

Mr. MACKASEY: I cannot, Dr. Isabelle, no matter how much respect I have for the best-dressed man in Parliament, justify the high cost of drugs because it makes a patient feel better to pay $20 instead of $3 for something that is going to cure him. Most patients I know are pathetically eager to get something into their system that is going to cure them. Their resentment at the price comes after they are well, unfortunately.

Mr. ENGLISH: I think there is a parallel, is there not, between this example and the one that Mr. Mackasey quoted at the beginning: Why is there a difference between prices at any time? The answer must be that the information has not got around, and therefore one of the two kinds of proposals that should be made is that we should increase the flow of information. This is in the brief, and it comes in in other ways. There is another type of thing which will help, too, and that is to improve the competitiveness of the market. Increasing the flow of information helps to improve it, but it is not the only method of improving it.

Mr. MACKASEY: You have interspersed your brief with some excellent recommendations. On page 17 you have another one which I would recommend highly, Mr. Chairman, and I will read it for the benefit of those who have not got a brief before them.

> This Association recommends that the labelling regulations to the Food and Drug Act be changed and that each prescription label carry either the brand name or the generic name (and its manufacturer) of the prescribed drug.

In other words, we are back to your suggestion that we inform the doctor. You have just admitted that the doctor does not always have enough knowledge, and, at the same time, you are recommending that one source of knowledge he relies on be curtailed, namely, the literature coming from the pharmaceutical houses. I am not, at the moment, getting into the argument about quality, but certainly, as a source of reference, a doctor does depend very heavily on what we call promotional material.

Mr. PERNAROWSKI: I do not follow your argument with respect to this.

Mr. MACKASEY: I recommend this, and I accept it because basically it gives more information to the doctor, does it not?

Mr. PERNAROWSKI: No, this is for the patient.

Mr. MACKASEY: How many patients could even pronounce the generic name?

Mr. PERNAROWSKI: Our feeling is that actually it is partially a help to the medical profession when a patient returns with a prescription and partially to the consumer who wishes to shop for a particular prescription, so that they know what they previously got. You mentioned the example of the drugs that you would shop for. All right; let us say the prescription had been written for prednisone and you had purchased it. Let us assume it was a generic product. It would be labelled prednisone, and show the company name. On the other hand if you got Meticortin from Schering it would be so labelled. Therefore, the next time you go back if you got something different you could immediately tell.

Mr. MACKASEY: Provided the druggist has not coded his little label to indicate that you paid $22 last time, therefore he will not charge you $23, but we will not give it to you for $21. That goes on, too, I think.

Mr. PERNAROWSKI: On a label?

Mr. MACKASEY: Yes.

Mr. PERNAROWSKI: Oh no; just the prescription number goes on.

Mr. MACKASEY: There is also a code on most of them, indicating what you paid last time.

Mr. PERNAROWSKI: On the original prescription, you mean?

Mr. MACKASEY: No, no, from the druggist. On the bottle the unethical ones include a code telling him what you paid last time. Therefore, if you run down the street to somebody else he knows you are willing to pay $4. You have been educated to pay $4 for this bottle of tablets.

Mr. PERNAROWSKI: Speaking in terms of the usual procedure, the prescription comes into a store; it is numbered; this is for identification purposes; and on that prescription the pharmacist places a price for his own information. But he does not put anything on the label of the prescription. However, if you ask for a copy of that prescription, there has been a practice in the past of coding what you have paid for it.

Mr. MACKASEY: For what purpose?

Mr. PERNAROWSKI: I do not know; but this code is a general code.

Mr. MACKASEY: You do not know, but why do you think it is done?

Mr. PERNAROWSKI: The reason, I think, is so that the next pharmacist who gets it knows what you have paid for that prescription.

Mr. MACKASEY: Why would he want that information?

Mr. PERNAROWSKI: To charge you the same, or less, or more, as he sees fit.

Mr. MACKASEY: If we make it easier for him to sell generic instead of brand do you think the temptation would not be there then to substitute the generic for the brand but to maintain the price you originally paid?

Mr. PERNAROWSKI: Oh yes, the temptation is always there to maintain price. In other words, what you are saying, essentially, is that going from meticortin to prednisone he will maintain his price of $22.

Mr. MACKASEY: That is right.

Mr. PERNAROWSKI: And he would be buying the Parke-Davis product at $3 a hundred and charging you $22?

Mr. MACKASEY: That is right.

Mr. PERNAROWSKI: Certainly there is always this danger.

Mr. MACKASEY: As a representative of the consumers' association do you feel it would help the consumer if we made it illegal to so code this information for future reference by the pharmacist?

Mr. PERNAROWSKI: Well, the only time coding occurs is when you ask for a copy of the prescription.

Mr. MACKASEY: Or when you want to repeat the prescription.

Mr. PERNAROWSKI: You are going to find out this price, in any case; you know what you paid for it.

Mr. MACKASEY: I do not mean the consumer; I mean the druggist who is filling the prescription the second time around, for instance.

Mr. PERNAROWSKI: Well, usually if it goes back to the one store you are going to pay the same price.

Mr. MACKASEY: Yes; but how would he know what you paid the first time?

Mr. PERNAROWSKI: He would know because it is on the original prescription. For his own information he puts it there.

Mr. MACKASEY: You do not want to go back to him—you do not want to be his captive—and you go down the street six blocks. You are taking down to the other pharmacist the information on what you paid the first one.

The CHAIRMAN: If you take a copy of the prescription.

Mr. MACKASEY: Yes; you have to go down with something.

Mr. PERNAROWSKI: If you get a new prescription the other fellow does not know what you paid. He prices it in whatever way he wants to price it.

Mr. MACKASEY: If you get this copy and you go to the other druggist the information about what you paid the first time is on the copy. If this druggist happened to be a little more reasonable in his pricing the temptation would be there for him to get that extra dollar which you had already paid once.

Mr. PERNAROWSKI: Yes; I agree with you. I have never really thought the problem through. There is really no reason to code that prescription. I cannot even tell you how often it is done. It is done usually as a courtesy, let us put it this way.

Mr. MACKASEY: You would say that there is no reason to code it other than to divulge the price?

Mr. PERNAROWSKI: Yes.

Mr. MACKASEY: Therefore if we made it illegal we would not be harming the pharmaceutical industry and we would not be harming the druggist?

Mr. PERNAROWSKI: No.

Mr. MACKASEY: I am speaking of his—

Mr. PERNAROWSKI: As a matter of fact, it is a sort of retail price maintenance, in a sense—

Mr. MACKASEY: Now it is.

Mr. PERNAROWSKI:—when you stop and think about it. I am sorry; I really have not thought it through.

Mr. MACKASEY: I have, and for that particular reason.
I know that everybody is becoming restless—

The CHAIRMAN: You have one more question.

Mr. MACKASEY: I drove 125 miles just to sit in on this brief, because it impressed me. I am not in a hurry to get away from it. I would not even mind if we had another session tonight. There is enough information in it to warrant that.

The CHAIRMAN: I have no objection to that. Mr. Blakely might have a few questions, though.

Mr. MACKASEY: Yes. On page 2 of Appendix C, dealing with sales tax, you have set up two tables, for the United States and Canada. What you have done, quite effectively, is to show us the ingredients that go into the cost of the drugs to the drug store. After you have taken the selling price, the premium on imports and the duty, and so forth, you have put on sales tax of 11 per cent; and then you show gross profit. I am sure our accountant will want to know whose gross profit, or where the 3.1 comes in, but that is not important to me. You then come along to the mark-up by Canadian retailers of 66-2/3, although most of our briefs show that the mark-up is 100 per cent; but, significantly, you have also marked-up the sales tax 66-2/3.

Mr. ENGLISH: Any margin that is added at an earlier stage by law or custom is increased by this.

Mr. MACKASEY: Well, 2/3 of 11 is a little under 8 per cent. If it was 12 it would be precisely 8 per cent. I come back to my point that the 11 per cent sales tax that the government is collecting is now costing the poor soul who goes in to get his prescription filled, 19 per cent.

Mr. ENGLISH: This is not necessarily the case. You cannot be sure. It may be in this instance, although I think the evidence presented by the Minister of National Revenue indicates that there are other considerations that must be taken into account. There is a further calculation, I believe, in a letter that—

Mr. MACKASEY: There have been as many calculations as we have received letters.

Mr. ENGLISH: The point is, I think, that the full effect of the sales tax, when other elements are taken into account, is certainly likely to be more than the initial effect, but—

Mr. MACKASEY: It is not likely to be less.

Mr. ENGLISH: It is not likely to be less, except in so far as you may reduce the amount sold. If you reduce the amount sold you may reduce the unit cost.

Mr. MACKASEY: Mr. Chairman, there is no use my getting into another line of questioning. I will pass.

Mr. W. J. BLAKELY, C.A., (*Accountant for the Committee*): First of all, Mr. Chairman, I have a comment on what Mr. Mackasey was saying on sales tax. The percentage that he is bringing out, of something like 17-odd per cent, is related to cost, not to selling price, and the other percentages that are being circulated are related to the retail price, and naturally you are going to have quite a wide variance.

I have a couple of questions, Mr. Chairman, for Dr. English.

In appendix D we have several examples of where the retail price of the same brand name drug is very significantly different and very significantly less in other countries than it is Canada. Would you be in a position to offer any explanation of why this should occur? For example, we can look at table V and deal again with prednisone, and we notice that Schering's price for that in Canada is $22.70 whereas in Sweden and Australia it is $8.60 and $7.70 respectively—the same brand name drug.

Mr. PERNAROWSKI: I do not want to be quoted on this, because I may be wrong, but I think in both cases the price is dictated by the government, because in both cases they have a medicare scheme of some type or another. If I am correct, I believe I drew these out of the price list issued by the government.

Mr. BLAKELY: Is this the same situation with the other tables?

Mr. PERNAROWSKI: Yes; I think, as a matter of fact, in the text it says something to the effect that Canadian prices are list prices and other prices are those under medical schemes in those particular countries.

Mr. BLAKELY: Are you suggesting, then, that these prices of the same drug in other countries are not on a comparable base?

Mr. PERNAROWSKI: These are just the prices that are paid for these drugs in that economy.

Mr. MACKASEY: May I ask a question here? Is it possible that the Meticortin on page 5, which is listed at $22.70, could be in the average individual dosage form in a drug store, and that the $7.70 in Australia may be the price on bulk purchasing by the government for distribution?

Mr. PERNAROWSKI: This is through retail pharmacies. In the case of Australia, it is the catalogue that is issued by the government, and this dictates the payment for that particular product. Actually, if anything, the Canadian price is undervalued, because, as I stated earlier, these are list prices. They may not necessarily be the prices that you actually pay.

Mr. MACKASEY: They could be higher or lower?

Mr. PERNAROWSKI: Yes; they could be higher or lower. I stand to be corrected on this, but I think in the case of, say, Sweden or Australia these are set and that is it.

Mr. BLAKELY: At page 15 there is a statement on which I would appreciate clarification, in the first sentence of the second paragraph. I presume Dr. English might care to comment on that. It says that the "... association cannot discuss the costs involved in drug store operations but, if the over-all cost of drugs were reduced, there would be no saving to the consumer if the third system of pricing is used...." The third system of pricing is cost-plus professional fees.

Mr. PERNAROWSKI: With regard to the "cannot discuss", let us say that we do not have the facilities to discuss; as I stated earlier, this is a voluntary organization, and this is one thing that it is very difficult for us to go into and to try to figure out the operation of a pharmacy.

All we are trying to say here is, again, that if you do some mathematics on this, and you have a drug that is $20 on the manufacturer's list, it would cost the pharmacist $12. Let us say he charges a professional fee of $2. The consumer would pay $14 for that product—correct? —as against the $20 he is paying... This is all relative, but this is the assumption. Let us assume that the over-all price tumbled down. I think it probably works out mathematically to around $3. Taking an item that is $3, the pharmacist's costs would be $1.80, and if he still is charging a standard fee that would be actually a price of $3.80, which would be more than the $3, on a fee system. In other words, this last system is, in effect, averaging out their profits over a great number of prescriptions.

Mr. BLAKELY: Well, the last system is simply taking a profit on labour at a fixed rate.

Mr. PERNAROWSKI: That is right.

Mr. BLAKELY: If it is $2, or whatever it happens to be; but the statement still does not clarify it for me. It seems to me that if the over-all cost of drugs is reduced there will be a saving to the consumer. It may be that the specific method of pricing which is applied may result in a different saving, or a different amount of saving.

Mr. PERNAROWSKI: I am sorry; I am speaking of percentages. Sure, I agree with you wholeheartedly. In other words, the consumer over the total run is going to pay far less for his drugs. He may a little more for the cheaper drugs but he is still getting a bargain.

Mr. MACKASEY: Where will the druggist make up his over-all profit. According to their brief they do not make too much. Will they sell more chocolates and soft drinks and a few more silk stockings?

Mr. PERNAROWSKI: Again, I am sorry, but I—

Mr. MACKASEY: The point I am getting at is that if the system which the druggists are now talking about introducing—because they have not introduced it to any great extent—in certain areas brings down the cost of drugs to the consumer, it is also going to bring down their volume?

Mr. PERNAROWSKI: Their volume?

Mr. MACKASEY: Their volume is made up, we presume, of the dollars that are paid on prescriptions. If we pay less their volume is less?

Mr. PERNAROWSKI: I am getting into an area here on which I am afraid I am not qualified to speak.

Mr. MACKASEY: The point is that I would like to see—but I guess we cannot see it in Canada—the type of system that exists, say, in Denmark where the number of drug outlets are controlled by the government to, say, one for every

30,000 people, and in this way the price can be controlled and labour can be evaluated.

Mr. PERNAROWSKI: May I suggest this, that, I think, if I am correct, that the B.C. Pharmaceutical Association hired an outside firm of accountants, or consultants, to investigate this whole question, and I am sure they must have the details of this worked out. The committee might like to see this.

Mr. MACKASEY: I have their brief.

The CHAIRMAN: I think the evidence before the committee previously showed that their gross income in a year was exactly the same, relatively speaking, no matter which system they used. It just made the cheaper prescriptions more expensive and the more expensive ones cheaper, but their average was the same.

Are there any other questions of the consumer association other than from Mr. Mackasey would like to spend the hours between 8 and 10 with you?

Mr. MACKASEY: Yes, I would make a motion to that effect, Mr. Chairman. I know there are only Liberals left and we do not know what the other parties think, but I am glad our party is interested in this particular problem.

Mr. ENGLISH: May I make a comment, Mr. Chairman? I would request permission from the committee to submit any other evidence, arising out of the discussion today, as it comes to our attention as a result of our further studies.

Mr. MACKASEY: What I would have liked to discuss further—because I think they are areas that have to be discussed and not shoved under the table—are the questions of imports, discriminatory or otherwise, the question of patents, the question of trade marks and the question of tariffs. I think we have probably left out the most important areas, other than that the consumers' association is educating the public to shop a little more discriminately. I think, unfortunately, that we have not been able but to scratch the surface of this very important area.

Mr. ENGLISH: On the issues that we raise in appendix C particularly, relating to public policies, I would welcome the opportunity, on the invitation of Mr. Laidlaw and others, to give additional information as we can find the time to get it; and I would also welcome the opportunity to submit a further commentary on other briefs on which we feel, as consumers, we have something to comment.

The CHAIRMAN: I should explain that Dr. English is from Carleton University, and he is relatively available, whereas some of the other witnesses are not quite as available. Mr. Pernarowski comes from British Columbia.

Mr. MACKASEY: I may say that your brief, prepared, as it is, by voluntary help, is much more expert than some of the professional briefs that we have been getting.

The CHAIRMAN: We would like to thank the Consumers' Association of Canada for coming before us with such an excellent brief.

Miss PEARSE: Thank you very much, Mr. Chairman.

The CHAIRMAN: At our meeting next week we will have two witnesses again, one in the morning and one in the afternoon. The witness in the morning is a Dr. Davidson from the Addiction Research Foundation, but his brief is not about addiction research; it is a personal brief about the cost of drugs. In the afternoon we will have Mr. Wilson, Manager of *The Medical Post* which is a medical publication.

The committee is adjourned.

APPENDIX I

BRIEF TO THE HOUSE OF COMMONS

SPECIAL COMMITTEE
on
DRUG COSTS AND PRICES

Submitted by
THE CONSUMERS' ASSOCIATION OF CANADA

Representatives of the Consumers' Association of Canada are pleased to have the opportunity to appear before this Committee and to present the views of our membership on drug prices in this country. Responsible organizations realize that there is no easy solution to the problem of drug costs but, at the same time, hope that through inquiry some progress can be made to lighten the cost load on the consumers' shoulders.

Drug Marketing in Canada

Eighty-five per cent of all the prescription drugs sold in Canada are produced by a group of manufacturers who form the Pharmaceutical Manufacturers Association of Canada. The remainder of our drugs come from either outside Canada or, more important, are produced by small, independent manufacturers who may market only in certain regions of the country. The Canadian drug industry produces few of the basic drugs utilized in this country. Most of these drugs are purchased in the United States or in Europe and converted into tablets, liquids, and other dosage forms by the company concerned or by custom pharmaceutical manufacturers producing drugs for a number of suppliers.

Drug promotion is heavy and is aimed mostly at the physician. In the final analysis, it is he who will decide if a product succeeds or fails in the market place. The pharmacist's role is to act as a supplier of drugs to the consumer and it is doubtful if he exerts much influence, at present, in drug selection. The consumer is the captive in this chain of events.

Drug Quality

The consumer knows little about the quality of drugs on the Canadian market. The Pharmaceutical Manufacturers Association of Canada attacks many of the independent manufacturers and claims that the drugs made or distributed by these firms are of inferior quality. The independent manufacturer replies to this criticism by pointing out that his drugs do meet existing specifications and that, in many cases, these very drugs are purchased by the federal government for use in military and veterans' hospitals. The Food and Drug Directorate remains silent or, at best, tends to generalize and thus confuse further an already confused situation.

The Food and Drug Directorate does check the industry but the results of such checks are not public knowledge. Similarly, manufacturers are inspected on the basis of the standards laid down by the Canadian Government Specification

Board (74-GP-1a) but the results of such inspections are not made known to the consumer.

> The Consumers' Association of Canada feels that the public has a right to this type of knowledge and that steps should be taken to publish this information in a suitable form.

The Food and Drug Administration in the United States does make information available to the consumer. As an example of the information to be found in the "FDA Report on Enforcement and Compliance," the May, 1966, issue lists a number of drug seizures, one of which is a rauwolfia serpentina tablet which failed to disintegrate. The product was manufactured by Nusco Laboratories, Inc., Long Island City, N.Y., a company which does distribute drugs into Canada. This type of information is unavailable in this country.

This Association is aware of the reports in the scientific literature on the therapeutic inactivity of some of the drugs marketed under their generic names. We know too that mislabelled drugs have appeared on the Canadian market. A recent survey by the Food and Drug Administration in the United States indicated that 7.6 per cent of the drugs tested failed potency tests[1]. The table on the following page gives the therapeutic categories and the per cent violations in each category.

[1] Drug News Weekly, June 13, 1966.

PER CENT DEFECTIVE DRUGS ON THE AMERICAN MARKET[1]

Therapeutic Category	No. of Samples Examined	Violations OD	Violations ND	Total Violations	% Violations
Digitalis and cardiac glycosides	193	18	9	27	13.9
Corticosteroids	160	10	1	11	6.9
Anabolic steroids	13	0	0	0	0.0
Sex steroids	672	33	25	58	8.6
Other Hormones	492	23	5	28	5.7
Anticoagulants	90	4	0	4	4.4
Antihypertensives	417	49	9	58	13.9
Ergot preparations	21	3	0	3	14.9
Hypoglycemics	9	1	0	1	20.0
Menadione and derivates	20	0	0	0	0.0
Antihistamines	342	17	21	38	11.1
Anti-arrhythmic cardiac Drugs	99	6	1	7	7.1
Diuretics	179	3	8	11	6.1
Nitrites	264	0	24	24	9.1
Anticonvulsants	75	4	0	4	5.3
Central nervous system depressants	366	8	15	23	6.3
Stimulants	158	2	1	3	1.9
Antimalarials	65	2	0	2	3.1
Chemotherapeutics	518	16	6	22	4.2
Antithyroid drugs	32	1	0	1	3.1
Total	4,181	200	117	317	7.6

[1] Drugs tested since March 24, 1966. Potency limits are those found in the United States Pharmacopoeia or the National Formulary (OD) or are 90% to 110% of that delcared on the label (ND).

SOURCE: Drug News Weekly, June 13, 1966.

In addition to the data in this table, this Association has been able to obtain the results of one survey carried out under the supervision of a Vice-President of this Association[1]. Twenty-three brands of phenylbutazone tablets were tested for potency, content uniformity, disintegration and dissolution characteristics. Five, or 21.7 per cent, failed to met existing specification. Thre others were classified by the researcher as unsatisfactory. One was faulty enough (the product delivered little phenylbutazone to the blood) to constitute an absolute hazard to health.

The Consumers' Association of Canada recommends that the Committee fully explore the question of drug quality and the adequacy of standards employed to assure this quality.

> The Committee should question senior officials of the Food and Drug Directorate and determine how budget and staff increases have affected the operation of this agency. If these officials are dissatisfied with the quality of the drug supply, the Committee should suggest ways and means to better enforce existing regulations. If existing standards are inadequate, the Government should encourage the type of research that would produce the methodology to better evaluate pharmaceuticals.

Without an assurance of quality, the professions of medicine and pharmacy will always be under pressure to use the more expensive drugs because of the feeling that the cheaper drugs are of inferior quality.

Drug Prices

The consumer does not understand the subleties of drug quality and drug prices. He does know, however, that drugs are expensive and are a commodity which must be purchased out of necessity rather than choice. While this might not be too important to the person who has good health, it is particularly important to those unfortunate consumers who must use drugs over long periods of time. At the same time, the consumer realizes that he can often buy the same drug in two different pharmacies at drastically different prices or that he can save considerable money by buying a different brand of the same drug. He wants to know whether such differences in prices are the consequence of real differences in the quality, or whether they are merely the consequence of the success of some suppliers in persuading consumers that there is a difference.

Appended to this brief are the prices of a number of drugs sold in Canada and in other countries with relatively advanced economies. The Canadian prices shown therein are the suggested retail prices. Other prices shown in these tables are either list prices or the price paid to the pharmacist by a governmental agency (in those cases where drugs are a part of the medicare program). These prices have been gathered during the past six to twelve months and represent a sampling of the inquiries made in various parts of the world and Canada. Conversions to Canadian currency are on the basis of current rates of exchange but no attempt has been made to balance out economic differences.

No one group is responsible for the final price of a particular drug. It is the intent of this brief, therefore, to examine the various factors that might affect drug costs.

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[1] Information based on research carried out by Dr. M. Pernarowski, Associate Professor, Faculty of Pharmacy, University of British Columbia, Vancouver, B.C.

I *The Effect of Government Policy on Drug Prices*

The government affects the pricing and quality of drugs in several ways:

(1) the tariff on drugs and related customs practices including anti-dumping duties and valuation practices;

(2) some of the provisions of patent and trademark legislation;

(3) the eleven per cent sales tax which is applied to drugs;

(4) the Food and Drug Act and its administration.

It is clear that the combined purpose of public action in the area should be to encourage low and competitive drug prices, the quality required to achieve effective medication through the use of drug products, and such encouragement to the development and production of new products in Canada as would be consistent with efficient use of Canadian resources and production facilities. The submissions of pharmaceutical manufacturers have argued that price levels are reasonable, and that the maintenance of drug quality and the survival of the Canadian industry require the maintenance of the present pattern of government protection and encouragement.

The Consumers'Association of Canada contends that the submissions of the manufacturers do not provide adequate support for this position and recommends that the committee sponsor an independent economic enquiry into the effects of government policy on the price and quality of drugs in Canada, and the requirements for efficiency and competitiveness of the supplying of drugs in Canada.

The CAC offers as Appendices to this brief two papers raising questions which it believes deserve the attention of members of the Committee. Appendix B deals with some of the argument contained in the drug manufacturers' brief. Appendix C deals with possible explanations of the present high prices and other conditions of drug supply in Canada, relating particularly to the importance of government policies affecting the production and sale of pharmaceutical products. Recommendations concerning government policies affecting drugs will be incorporated in this Appendix.

II *Drug Prices and the Pharmaceutical Manufacturer*

In general, the drug manufacturer receives 60 per cent of the Canadian prices shown in the Appendix to this brief. There is, however, no fixed wholesale price. Governments buy drugs by tender and usually receive substantial discounts. Hospitals pay less for drugs than do most pharmacists. This is partly due to the 11 per cent sales tax and partly to the policy of certain manufacturers to promote drugs through hospitals and thus "acquaint" the physician with a particular product. Even the pharmacist can buy drugs at less than that implied in the Appendix. Larger pharmacies buy drugs in larger quantities and thus obtain slightly better discounts.

Even though there are problems in determining a true wholesale price, it is the drug manufacturer who determines what this will be. It is the contention of this Association that the prices of too many pharmaceuticals are too high. In order to illustrate this and to show certain inconsistencies in drug pricing, two examples have been chosen.

The drug PREDNISONE has been discussed by almost every inquiry into drug prices. Throughout all these inquiries, the major producer (Schering) has not lowered the price of the drug to a reasonable and competitive level. There is no justification for a list price of $22.70 per 100 tablets when five reputable manufacturers in this country publish list prices ranging from $3.50 to $7.50. (See Table V, Appendix A). Strong Cobb Arner of Canada, Ltd., a custom pharmaceutical manufacturer, will sell this drug to distributors for approximately $0.60 per 100 tablets when these are purchased in relatively large quantity.

Similar comments can be made about tetracycline HCl. Here, however, all major supplies keep their prices high. Tetracycline is produced in Canada by Cyanamid of Canada Limited (Lederle). This then represents one of the few drugs that are made, purified, and converted into dosage forms in this country. Moreover, this company did the original research on the drug and holds certain patents protecting the product. For the moment, we will justify the Lederle price. The Frosst and Horner prices for this drug are essentially the same. These companies do not make the drug in Canada but buy it in the foreign market place. They have no research costs with respect to the drug and one of the companies has been involved in patent litigation with Lederle. What do they do that is so different from that being done by the supplier who sells these drugs under their generic name? (Strong Cobb Arner will manufacture this product for a supplier for approximately $1.70 per 1,000 capsules, the supplier furnishing the empty capsules and the baisc drug.) Quality control? Promotion? If so, these are indeed luxury items. Assuming that these costs are basic to all companies, either Lederle is getting no return on its original investment or the two companies named are taking an excessive profit.

It is situations such as this that make the consumer wonder about drug prices. Certain factors must contribute to the over-all cost of the drug and this Association would like to discuss each briefly.

(1) *Production*

Basic production costs are probably quite low. It has been previously pointed out that one company will manufacture tetracycline HCl capsules for $1.70 per 1,000 capsules. This kind of information has come to this Association in an indirect manner and the Committee may wish to contact this company (Strong Cobb Arner of Canada, Ltd., Fort Erie, Ontario) for additional price and cost information.

(2) *Quality Control*

It is doubtful if quality control costs are significant with respect to over-all costs. Dr. Karl Bambach, Senior Vice-President of the Pharmaceutical Manufacturers Association (an American association), said that to exercise proper quality control experts in reputable firms estimate a cost of $600 per batch of drug produced[1].

(3) *Research*

Some of the major drug manufacturers have established research laboratories in Canada but basically little drug research is carried out in this country by the industry as a whole. If research costs are incurred, these are incurred

[1] "Bambach on Cost of Quality," P.M.A. Bulletin, No. 66-7, April 7, 1966, p. 6.

elsewhere and the Canadian economy is being asked to support various investigations carried out by parent corporations. No responsible organization wants something for nothing but are we being asked to pay more than our share because of our proximity to the American market place?

(4) *Promotion*

> ".....these are all symptoms of a disease.....that disease is irresponsibility."[1]

The costs associated with the selling of drugs are high. The sales pitch costs money. Dr. James L. Goddard, Commissioner of the Food and Drug Administration in the United States, had this to say about the cost of drug promotion[2].

> "...referring to the "tremendous total effort by the drug industry to influence doctors and patients," he said that FDA figures that the total promotional effort by the prescription and OTC drug industry "runs as high as $800 million a year."
>
> "Depending on your source of data—and a number of sources are available to our agency—income from between 25 and 32 per cent of gross sales for human drugs is directed to advertising and promotion that stimulates those very sales."

The above quotations need no further comment. And even in the midst of such slashing attacks, Drug News Weekly, in the May 23, 1966 issue, points out that a new monthly magazine containing product information and coupons by which doctors can request samples is being launched in Canada and the United States. The cost for a 4 by 6 inch wide page is a mere $6,000.

Some ads distort the therapeutic value of a drug or fail to include necessary data on side effects. The physician either accepts the ad or is forced into a tedious search of the literature in order to determine the true nature of the drug. Dr. Goddard had this to say about false and misleading advertising[3].

> "If the ad does not conform to law or regulation, it is—in effect—misinforming the physician. It is a manacle on his ability to prescribe intelligently for his patient. It can be construed, therefore, to be a clear and present danger to the patient—the human life toward which all this promotional and protective effort is ultimately directed."

Turning again to officials in the American government, Assistant Attorney General Donald F. Turner told a Federal Bar Association seminar that a recent study of consumer goods industries found a significant correlation between the proportion of industry sales devoted to advertising and average profit rates earned[4].

Mr. Turner had this to say about the drug industry.

> "This is an industry that earns very high rates of return, in many years approximately double the average profit rate in all manufacturing."

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[1] Quotations from an address by Dr. James L. Goddard delivered to the Pharmaceutical Manufacturers Association, May 6, 1966. (See National Merchandiser, p. 22, May, 1966).
[2] "Goddard Speaks to Bar on Federal Ad Controls," Drug News Weekly, June 6, 1966.
[3] "FDA Report on Enforcement and Compliance," May, 1966, p. 5.
[4] "Suggests U.S. Subsidize Consumer Research," Drug News Weekly, June 6, 1966.

During his speech, he suggested that the Government operate or subsidize consumer research projects. The over-all goal would be to limit the growth of monopoly abetted by advertising. In particular, he cited *Consumer Reports* and *Medical Letter* and said that these publications keep both the consumer and doctor informed but added that there are drawbacks to these methods.

> "In both of these areas, a major difficulty is that these publications are produced by a non-profit organization and that they frequently face difficulties in obtaining funds required for adequate testing and evaluation."

Further quotations on this subject would be superfluous. This Association is prepared to accept production, quality control and research costs. It is not prepared to accept the excessive costs associated with drug promotion not only because these add to the cost of the commodity but also because some companies spend more to mis-inform than to inform the physician.

The Royal Commission on Health Services said that "a good deal of promotional effort in the drug industry is wasteful." The Commission went on to suggest that in the application of the provisions of the Corporation Income Tax Act consideration should be given to establishing a maximum of 15 per cent of total sales as the allowable deductible expense for advertising, sales promotion, detail men and other similar items.

The Consumers' Association of Canada believes that the most effective means of limiting wasteful and misleading advertising are (a) through the encouragement of independent consumer research and the distribution of accurate information about the quality and value of commodities, and (b) through the effective anti-combines laws to encourage low prices and high quality as a consequence of the competitive process. If these measures cannot be made to work effectively, the Association would support the consideration of a limit on advertising expenditures.

It is evident from the quotation below that medical journals do not carefully screen advertisements. Testifying before the House Inter-Governmental Relations Sub-Committee on Drug Advertising, Dr. Robert S. McCleery, the FDA drug ad expert, said that the New England Journal of Medicine screened drug said ads before publication and according to "Quite high standards"[1]. He continued:

> "The only other journal which pretends to screen ads is the Journal of the American Medical Association and they not only widely publicize but advertise their principle. Now I don't want to judge the quality of their principles, but I can judge the quality of advertising that appears in there and I must say we have found ads subject to much question frequently appearing in JAMA."

On the basis of this and other evidence, the Consumers' Association of Canada would like to make the following recommendations:

> The editors of medical journals should scrutinize advertising copy more carefully and, at the same time, the Food and Drug Directorate should evaluate such content and, where necessary, introduce regulations governing truth-in-advertising in medical journals.

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[1] "Questions Ad Quality in JAMA," Drug New Weekly, June 6, 1966.

III—*Drug Prices and the Physician*

The physician writes a prescription and thus, indirectly, influences the cost of the medication to the consumer. If he prescribes by brand name, the cost of the medication will tend to be higher. If he uses an expensive drug when an inexpensive alternative is available, he is doing the consumer an injustice. The physician is an individualist and insists on the right to practise medicine in a way that, according to him, is in the best interests of the patient. No group will seriously quarrel with this right provided his judgments are based on the best information available about a particular drug.

The physician is bombarded daily with propaganda from the pharmaceutical houses and visited periodically by detail men. Because he is busy, he is unable to study in depth the information that might be available in the literature about the drugs he uses. In addition to this, library resources are not always available and the result is that drug houses have a powerful influence on the way in which he will practice medicine.

This Association feels that alternative sources of information about drugs should be made available to physicians. The responsibility for this lies within the various professional organizations and within the government.

> The government should immediately appoint a panel of experts to create a National Formulary. This has already been recommended by the Royal Commission on Health Services.

This Association does not have the technical competence to discuss the contents of such a formulary but it should be of such calibre that physicians and pharmacists can rely on it as a useful source of information on drugs. In order to achieve this goal, the physicians and pharmacists making up this panel must have an independence of mind and should be removed from the vested interests in the health care field.

> In addition to the above, the Food and Drug Directorate should create a P.I.L. (Professional Information Letter) that would provide up-to-date information to the professions as it becomes available.

Our Association endorses the continuing education activities of all professions and hopes that these would be expanded.

> If necessary, Government grants should be made available for this important aspect of professional education.

The physician should be aware of what he is prescribing in terms of price as well as quality. He cannot blame others for the cost of drugs if he himself is writing prescriptions for costly drugs. Information from sources other than the manufacturers about the relative prices of equivalent drug products should be made available to doctors.

IV—*Drug Prices and the Pharmacist*

There is no one retail price for a particular drug. However, there are several approaches to the pricing of prescriptions.

The first is based on the manufacturer's list price. To this is added a 'breakage' or 'dispensing' fee. The second is based on a percentage of the manufacturer's list price. To this is added a 'professional fee'. The third system is

based on the cost plus system. The pharmacist computes his cost of filling a prescription and simply adds his 'professional fee'. This professional fee appears to range from $1.50 to $2.00 per prescription.

The last system appears to be the more attractive. However, no pharmacist can afford to take a loss on any transaction. The effect of this system is to decrease the cost of the expensive drugs but to increase the price of the cheaper drugs. The same gross profit is merely being averaged out over all the prescriptions received by a particular pharmacy.

This Association cannot discuss the costs involved in drug-store operations but, if the over-all cost of drugs were reduced, there would be no saving to the consumer if the third system of pricing is used. For example, on the basis of the list system, the retail price for 100 Tolbutamide tablets (Bell Craig) would be $3.75 (list plus a $0.50 dispensing fee) but, on the cost plus system, the retail price would be $3.95 (cost plus a $2.00 professional fee). In general, however, this Association would favor the cost plus system. It would be much easier for the consumer to find out the professional fee being charged by a particular pharmacy than it is to find out the retail price for each and every drug. Moreover, it is doubtful if this fee would vary much from store to store and would thus make shopping easier.

In view of the increased importance of sale of drugs by discount stores in some centres, this Association recommends that the Committee seek to determine whether the pharmaceutical products sold by these stores are equivalent in quality, and whether the savings in cost are therefore real.

This Association does advocate more prescribing by generic name. At the present time, there is no impetus for the pharmacist to use such drugs. The pharmacist must always supply what the physician has ordered. If the doctor asks for Mobenol, he must supply Mobenol. However, even if a doctor writes a prescription for Tolbutamide, there is still a tendency to supply the more expensive Mobenol. One reason for this is the higher return (if the list price system is being used to price prescriptions) and the second is the pharmacist's distrust of the generic product. Some of this distrust is real and some is propagated by some of the larger manufacturers. Our position in this regard was stated in a previous section. In addition to the comments therein, it is known that many of the suppliers of drugs udner their generic name do not manufacture but buy their drugs from a variety of sources. The average pharmacist has no way of knowing this because the definition of the word 'manufacturer' in the regulations to the Food and Drug Act is such that a distributor is classed as a manufacturer. While this is administratively less taxing for the Food and Drug Directorate, it does nothing to educate and, in fact, it misinforms the pharmacist about the source of the drug.

This Association recommends that, as an aid to the pharmacist, and the consumer, the definition of the word 'manufacturer' inthe regulations to the Food and Drug Act be brought into line with the accepted dictionary definition.

Drug labels would read as follows:

Made for
ABC Generic Products
Toronto, Ontario
by
Custom Pharmaceuticals Ltd.
Montreal, Que.

The responsibility for the quality of the drug would still be on the seller's shoulders but the pharmacist would now know the actual drug source.

The question then arises about the rights of the pharmacist to substitute one brand for another. The industry and some physicians say that he has no such right. This Association feels that a pharmacist has an obligation to inform the consumer about possible savings. As a professional, he must have some responsibility other than merely supplying a drug and one such responsibility might be that of choosing a particular brand of drug.

Lastly, the consumer has a right to know the nature of the drug being prescribed. The pharmacist now says that the physician can so inform the patient but he (the pharmacist) is unable to do so. In other words, he will not label a prescription with the drug name unless so advised by the physician. It is the feeling of this Association that the interests of the consumer are of prime importance. A drug name on a prescription is a much needed safety factor in this day of complex pharmaceuticals. At the same time, the economic interests of the consumer come into play. Knowing the product, the consumer will know if he is getting the best buy for his money. The ingenuity of the professions can cope with those cases where it is not advisable for the patient to know the nature of the medication.

This Association recommends that the labelling regulations to the Food and Drug Act be changed and that each prescription label carry either the brand name or the generic name (and its manufacturer) of the prescribed drug.

Conclusion

The prices shown in the Appendix indicate that it is possible to buy drugs cheaper in other countries than it is in Canada if the prescribed Canadian drug is the 'branded' product. At the same time, drugs can be bought at a much lower price in Canada (lower, insome cases, than in other countries) if the product is prescribed by its generic name. It is only fair, therefore, that the consumer receive these possible savings in price. The government and the professions should make every effort to introduce specific measures that, in the end, will benefit the consumer and hence the economy of this country.

This Association realizes that the mere prescribing of drugs by their proper name will not lower our drug bills to the extent that is usually assumed. Not too many drugs are available in this particular category. Many of the products prescribed fall into the specialty category and these are usually made by only one company. Such combinations of two or more drugs are popular but according to some physicians and pharmacologists, are not always therapeutically sound.

The arguments for or against such prescribing are best left to the professionals but if these professionals have access to the best possible information about such products, there may be a tendency to stop using them. Again, this Association stresses that the pound practice in the medical profession need not mean that the Canadian consumer should continue to pay higher prices for drugs than consumers in other parts of the world.

Is it not time for us to set aside the interests of vested organizations and take into consideration the interests of the primary group—the Consumers of Canada?

APPENDIX A
(to Brief)

PRICES OF DRUGS IN CANADA
and in
COUNTRIES WITH RELATIVELY ADVANCED ECONOMIES

TABLE I

PRICES FOR 100 CHLORPROMAZINE HCl TABLETS (25mg.)

Product	Canada	Sweden	Japan	Switzerland	Australia
Largactil (Poulenc[1])	8.90			2.85	
Chlor-Promanyl (Maney[2])	4.20				
Chlorpromazine HCl (Bell Craig[2])	2.10				
Chlorpromazine HCl (Leo)		3.90			
Chlorpromazine HCl (Dumex)		3.90			
Chlorpromazine HCl (May and Baker)		3.90			2.35
Wintamin (Shionogi)			5.35		
Contomin (Takeda)			5.50		

[1]Canadian manufacturer belonging to the Pharmaceutical Manufacturers Association of Canada.
[2]Independent Canadian manufacturer complying with 74-GP-1a.

TABLE II

PRICES FOR 110 TETRACYCLINE HCl CAPSULES (250 mg.)

Product	Canada	Sweden	Japan	Switzerland
Achromycin (Lederle[1])	29.50	25.50		37.40
Cefracycline (Frosst[1])	29.00			
Tetrasol (Horner[1])	29.00			
Tetracycline HCl (Lepetit)		23.95		
Achromycin (Takeda)			28.50	

[1]Canadian manufacturer belonging to the Pharmaceutical Manufacturers Association of Canada.

TABLE III

PRICES FOR 100 TOLBUTAMIDE TABLETS (500 mg.)

Product	Canada	Sweden	Japan	Australia
Orinase (Hoechst[1])	12.50	5.25		4.50
Mobenol (Horner[1])	12.50			
Tolbutamide (Bell Craig[2])	3.25			
Tolbutamide (Maney[2])	3.60			
Tolbutamide (Boehringer)		5.25		
Siaben (Chugai)			11.70	

[1]Canadian manufacturer belonging to the Pharmaceutical Manufacturers Association of Canada.
[2]Independent Canadian manufacturer complying with 74-GP-1a.

TABLE IV

PRICES FOR 100 RESERPINE TABLETS (0.25 mg.)

Product	Canada	Sweden	Japan	Switzerland	Australia
Serpasil (Ciba[1])	4.55	1.20		2.15	1.20
Reserpine (I and B[1])	1.15				
Reserpine (Maney[2])	1.25				
Reserpine (Intra[1])	1.00				
Reserpine (Aco)		0.95			
Reserpine (Pharmacia)		1.20			
Reserpine (Shionogi)			3.00		

[1]Canadian manufacturer belonging to the Pharmaceutical Manufacturers Association of Canada.
[2]Independent Canadian manufacturer complying with 74-GP-1a.

TABLE V

PRICES FOR 100 PREDNISONE TABLETS (5 mg.)

Product	Canada	Sweden	Japan	Australia
Meticortin (Schering[1])	22.70	8.60		7.70
Prednisone (BDH[1])	7.50			
Colison (Frosst[1])	4.20			
Prednisone (Intra[1])	4.20			
Paracort (Parke Davis[1])	4.20			
Prednisone (Bell Craig[2])	3.50			
Prednisone (Lepetit)		5.25		
Prednisone (Pharmacia)		4.30		
Prednisone (Fredriksberg)		2.45		
Presoron (Chugai)			25.50	

[1]Canadian manufacturer belonging to the Pharmaceutical Manufacturers Association of Canada.
[2]Independent Canadian manufacturer complying with 74-GP-1a.

APPENDIX B
(to Brief)

Comments on the Brief of the Pharmaceutical Manufacturers Association of Canada

1. The terms of reference of the Committee on Drug Costs and Prices imply that ethical drug prices *are* high and that some means of reducing them should be sought. In light of this objective, it is surprising to find the PMAC arguing that the costs of drugs in Canada are lower than in most other developed countries. This claim is based on a simply averaging of a selected group of drug prices in terms of labour hours. This approach may be criticized on several grounds. In the first place, it violates the central tenets of index number theory by taking as an index an *unweighted* average of drug prices. Little justification is offered for the selection of the seventeen drugs whose prices formed the index; a different selection undoubtedly would have changed the resulting *simple* average. But, more important, the use of labour hours as a basis for comparison defies all logic. In applying this yardstick the PMAC appears to be harking back to a theory that has been central to Marxian economics, i.e., that income or wealth should be measured in labour units[1]. In our opinion, this line of reasoning is, to say the least, obsolete. The end result of the arithmetic manipulation undertaken in Section 4 of the PMAC brief is to rank a number of developed countries by their standard of living or the average capital intensity of their industries[2]. These same results can be obtained by applying similarly misguided arithmetic to many internationally sold commodities. Because Canadian prices of many other products are not so far above foreign prices as are our prices of drugs, if the sort of calculation used by the PMAC were worked out for other products, it would, not surprisingly, demonstrate that Canadians could more easily buy these other products. The fact that Canadians rank among the highest in terms of productivity is completely irrelevant to the pricing of drugs. Surely the only interesting and relevant comparisons are between the actual prices of similar quantities of drugs in different countries? The Consumers' Association of Canada maintains that these comparisons show Canadian drug prices to be surprisingly high. Evidence of this is given in Appendix F of the PMAC brief, and a most comprehensive comparison between Canadian drug prices and those in other countries appears in the 'Greenbook', pp. 203-217, issued by the Combines Investigation Branch of the Department of Justice in connection with its drug enquiry. These comparisons, which in many cases show that Canadian drug prices are higher than those of our trading partners, provide compelling evidence of the need for investigation and, where appropriate, government action to reduce the cost of drugs to Canadians.

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[1] This theory is set forth in K. Marx, "Capital," Vol. I, Chap. I, et. seq.

[2] The phrase "capital intensive" is applied to industries, or the industries of countries, whose production is marked by a high ratio of capital to labour inputs.

2. The statements of the PMAC brief concerning profits and selling and research expenditures seem bound to create confusion. The PMAC brief quotes the profit rate for pharmaceutical preparations at 11.4 per cent, presumably as a percentage of sales, compared with a general rate for all manufacturing of 7.6 per cent. As with the cost or price comparison discussed above, the basis of stating profits has very little meaning. A profit rate has an economic meaning only when it is related to the investment, since profits are the return to invested capital and can be judged adequate or excessive only if they are calculated in relation to capital. Two industries which have equal sales may have very different capital invested. For example, for every dollar of sales, a railway or steel company has very much more invested capital than a pharmaceutical manufacturer or a grocery chain. Hence, if a drug company were to make the same return per dollar of sales as a steel company, this would indicate a very much higher rate of return on capital invested in the drug company. Furthermore, the profit rate on sales may give a mistaken impression of the importance of profits to the extent that sales figures include promotion and selling expenditures directed to maintaining the competitive position of the company's share of the market. The various briefs of the industry and the Restrictive Trade Practices Commission Report on Drugs indicate that selling and promotion expenditures may be more than necessary to acquaint the medical profession and the public with the merits of available pharmaceutical products. This phenomenon is characteristic of a situation in which prices tend to be high and relatively stable, and the rivalry of competitors takes on the form of promotional gimmicks and selling campaigns and minor product variations.

Any policy which encourages more price competition tends to reduce the stress on the most wasteful forms of selling activity. Among the essential features of the economics of drug manufacturing which the government should find it worthwhile to examine are the relevant profit rate and selling costs of the industry and the extent to which they may be uneconomic as a result of the forces which make for rigidity in the pricing of the industry's products.

APPENDIX C
(to Brief)

Public Policy and the Price and Quality of Drugs

The Consumers' Association in its main brief has called for a full and independent economic enquiry into the effects of public policy on drug prices and quality. Following a preliminary examination of the available documents concerning this question the Association wishes to draw the Committee's attention to the following observations and interpretations.

It is our opinion that the combined effects of the sales tax and of the present tariff, patent and trademark arrangements, which protect Canadian pharmaceutical manufacturers are in large part responsible for the high price levels of ethical drugs in Canada. We believe the legislation relevant to these areas should be amended so as to cut drug costs to the Canadian consumer.

ASPECTS OF THE DEMAND FOR ETHICAL DRUGS

The unusual features of the demand for ethical drugs make it particularly likely that incidence of tariffs and taxes levied on pharmaceutical products are passed on to the consumer in the form of higher prices.

These features arise from the necessary arrangements by which the medical profession determines the final demand for drugs by way of prescription. Very often prescriptions are given with no reference to the cost of drugs involved. Apart from the suggestion in the main brief that physicians be better informed about the alternative forms and prices at which a given drug is available, the Consumers' Association does not question this arrangement.

Clearly the physician must be free to treat his patient. Yet it must be recognized that as a result of prescription the consumer is not able to vary his demand for drugs in response to different levels of price. In other words, demand for drugs is perfectly inelastic with respect to price. It is well known that in these circumstances all tariff and tax levies on drugs fall entirely on the final purchaser.

An instance of the precise way in which this occurs is given by some data uncovered in a recent examination of United States-Canadian drug price differentials.[1] A drug company explained the disparities in the following way:

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[1] Report of the Director of Investigation and Research, Combines Investigation Act; Year ending March 31st, 1964, p. 31.

United States		Canada		
Selling price to U.S. wholesalers	$1.10 U.S.	Selling price (U.S. funds) to Canadian subsidiary	$1.10	U.S.
		Premium on U.S. dollar 8%	0.088	
		Selling price (Can. funds) to Canadian subsidiary	1.188	Can.
		Duty 22½%	0.2673	
			$1.4553	Can.
		Sales Tax 11%	0.1601	
			$1.6154	Can.
		Gross profit 3.1%	0.0506	
		Net selling price to Canadian wholesalers	1.666	Can.
		Add cash discount 2%	0.034	
		Gross selling price to Canadian wholesalers	$1.70	Can.
Markup by U.S. wholesalers 20%	0.22	Markup by Canadian wholesalers 20%	0.34	
Selling price to U.S. retailers	$1.32 U.S.	Selling price to Canadian retailers	$2.04	Can.
Markup by U.S. retailers 66⅔%	0.88	Markup by Canadian retailers 66⅔%	$1.36	Can.
List price in U.S.	$2.20	List price in Canada	$3.40	Can.

From this illustration it is evident that tariff duty and sales tax contribute substantially to the final price in Canada, and account for some portion of the international price disparities.

THE TARIFF

The anti-dumping tariff seeks to protect Canadian industry from predatory competition by external producers. Behind this protective wall Canadian industry has been encouraged to grow to serve the needs of our domestic market and, in time, perhaps to seek export outlets. In the case of the ethical drug industry there has never been a substantial group of manufacturers turning out a wholly Canadian product. Rather, the industry has been one which imported the majority of its product in partly—or nearly-finished form, so that the Canadian drug producers often have been involved in manufacturing at the level of tabletting, bottling, labelling, etc.

Under the present operation of the anti-dumping tariff, "classes or kinds" of products similar to those produced in Canada are subject to duty on their "fair market value". This value is also used as the basis for levying the 15-25 per cent regular customs duty. Several difficulties are involved in these procedures;

(1) If the terms "classes" or "kinds" are interpreted very broadly, e.g. anti-biotics might be a "kind" of drug, then the likelihood of application of an anti-dumping tariff to any drug import is greatly increased. The few indigenous producers of small quantities but numerous "kinds" of drug are protected by widespread application of the tariff. We will argue that this protection is of little comfort to Canadian producers if they do not also have access to the production processes of a large number of drug preparations.

A narrowing of the interpretation of "kind" or "class" with respect to pharmaceutical imports could ease the tariff cost burden on consumers without impairing the relevant protection afforded Canadian drug producers.

(2) In a similar vein, we feel there are strong grounds for a review of the methods of arriving at fair market value. This valuation is the base upon which anti-dumping and customs duties are assessed.

This is not the place to give a detailed review of the valuation procedures but it is worth citing two examples in support of our suggestion of a review of "fair market value" calculation.

When a Canadian subsidiary buys pharmaceutical chemicals or finished drugs requiring further manufacture from a parent company, these goods are valued at the estimated cost of production plus an allowance for profit equal to 50 per cent of the exporters manufacturing cost. If the drug imports were in form which needed only labelling and outer packaging then value for tariff purposes is arrived at by doubling the manufacturers estimated costs.

Extremely high advances over cost in the process of valuation are apparently justified by the National Revenue department on the grounds of high gross profit margins in the drug industry. In contrast, National Revenue sets a gross profit allowance of 5 per cent for imported car parts of a class or kind not made in Canada. Downward price adjustments could occur if the allowances for drug profit margins were drastically reduced.

In those instances where the "fair market value" is taken as the wholesale price in the country of export (see our example) there is again an inflation in value for tariff assessment. Since all the large drug manufacturers in Canada are now subsidiaries of foreign parents, imports of raw materials are often intrafirm rather than inter-firm transactions. Under these conditions, it seems likely that domestic wholesale prices overstate the value of intra-firm purchases and where this measure of value is used it results in unnecessary cost increases to the final consumer.

A way out of these difficulties would be to value drug imports for tariff purposes at manufacturers cost plus a margin of 6-12 per cent to cover industry profit margins.[1]

(3) When a substantial proportion of Canada's consumption of ethical drugs involves imported raw materials and small scale "assembly" units in Canada, regular customs duty rates in the range of 15-25 per cent could appear to be too high. As noted above, these charges can be entirely passed on to the consumer whether or not cost conditions warrant it; and further inflate the price increases effected by sales taxes and mark-ups. We, therefore, suggest that these rates could be lowered without damage to Canadian industry and with great gain to the drug buying public.

It is not our intention that changes should be made in the tariff law so as to undermine Canadian pharmaceutical producers. Instead our suggestions are intended to strengthen international competition by reducing "fair market" values and, cutting duty rates, so that the Canadian consumer may benefit.

The long term position of the Canadian industry would appear to be served by those kinds of changes in tariff and other policies which would afford Canadian drug producers access to foreign markets. Under this circumstance there should be a better opportunity of research and development in Canada,

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[1] The PMAC brief argues that gross profit margins in the pharmaceutical industry are 10.8% on sales before taxes, (p. 3.5). This type of estimate is appropriate for judging over cost in valuation for duty purposes.

since the costs of such activity could be spread over sales in a wider world market. Eflective inducements to research and to the expansion of the Canadian industry should go hand in hand with a low or zero tariff, rather than the present high tariff policy, which supports almost no production of pharmaceutical chemicals, but typically only small scale production in "capsule-filling" plants, high prices and promotion costs, and payments for research performed in other countries.

TRADE MARKS

An amendment to the Trade Marks Act to make clear that no infringement can be claimed where imported drugs are manufactured by a company related to the Canadian trademark holder was proposed by the Royal Commission on Health Services. The recommendation was designed to allow Canadian drug distributors as well as subsidiary trade mark holders, to import and sell trademarked products. An amendment of this nature would increase competition and have the effect of reducing profit mark ups by holders of Canadian trade-marks.

We endorse this suggestion and recommend it to this committee. Changes of this kind could eliminate cases of European-based companies charging far less in their home markets than their subsidiaries do in Canada, even after allowance for tariffs and taxes.

Furthermore unless this change is made, the benefits of tariff reduction would not be fully attained.

PATENTS

The tariff laws were designed to protect Canadian industry, and in doing so allow domestic producers to be more competitive in the home market. This goal may be achieved in some industries, but its achievement is doubtful in the production and sale of Canadian pharmaceuticals. This is because competition in pharmaceuticals is seriously hampered by the granting of patents on chemical processes. A holder of a patent can reap monopolistic returns from the sale of his product.

Arguments advanced in favour of the patent system as it is applied to ethical drug manufacturing usually revolve around the guaranteeing of returns to innovators. It has been argued that the majority of research is done by large corporations, and that these firms depend on patent protection to regain their drug development costs.[1] The inference is that without patent rights research in an important area of health care would be diminished.

Evidence on the relationship between company size and innovation manifested by patent application in United States does not confirm the notion that large companies are the most productive of patents. In fact smaller corporations appear to be the most important source of industrial inspiration.[2]

Other evidence suggests that the relationship between patenting and pharmaceutical research is far from obvious. The Kefauver Report pointed out that significant discoveries had been made by European pharmaceutical industries in countries which do not offer patent protection, and that at time these advances had outstripped the rate of innovation in the patent-protected United States

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[1] See PMAC Brief, pp. 11.4-11.8.

[2] F. M. Sherer, "Firm Size and Patented Inventions", American Economic Review, December 1965, pp. 1104-5 especially.

drug industry.[1] It would seem then that patents do not guarantee discoveries nor does the existence of patent laws in Canada necessarily lead companies to undertake research here. Of twenty-seven Canadian drug manufacturers surveyed in 1960, twelve spent nothing on research, nine spent between 1-5% of net sales on research and only one company spent 6% on research.[2] The other impression that emerges very strongly from this survey is that those companies which spend a great deal on promotion often spend the smallest amounts on research. This impression is re-inforced by results of a rank correlation test which reveals signs of an inverse relation between percentage expenditures on advertising and expenditure on research by the firm.

We would argue, with the Restrictive Trade Practices Commission that patent legislation should be suspended at least on a trial basis. It is our belief that this action would greatly increase competition in the ethical drug industry, thus improving Canada's international competitive stance in pharmaceuticals while also serving the best interests of the Canadian consumer. Suspension of the patent privilege would go hand-in-hand with a widening of the powers of the Food and Drug Directorate in the policing of drug quality and potency, and perhaps also with appropriate short-term inducement by government and its agencies to industrial research.

The present system of compulsory licensing is a second-best solution to the suspension of patent protection. If improvement of the licensing system is the best we can hope for, we urge that Canadian pharmaceutical manufacturers be encouraged to apply for licences under Section 41(3) of the Canadian Patent Act.

Price competition is more likely if manufacturers are producing under the terms of truly compulsory rather than voluntary licencing agreements. In any case, the recommendations of the Hilliard Committee Report should be implemented so as to assure that the public may be prescribed high quality drugs at competitive prices.

Furthermore, compulsory licensing should be extended to permit authorization of drug imports covered by Canadian patents. A step of this kind would also tend to increase the competitiveness of the pharmaceutical industry. Extension of FDD powers to include checking of imports under licence and inspection of plants producing final dosage forms would insure the quality of drugs imported under these licences.

We may summarize this section on Patents as follows:

(a) Patents grant a temporary monopoly to the holder. Monopolies lead inevitably to prices of products higher than those produced under competitive conditions.

(b) Interaction of tariff and patent protection tends severely to limit competition in the Canadian pharmaceutical industry.

(c) A relationship between protective patent legislation and a high rate of research expenditure or technical progress cannot be adduced from the present evidence on Canadian drug production.

(d) Encouragement of compulsory licensing for domestic production and importation would, with increased FDD surveillance, improve competition in the market for ethical drugs, while maintaining quality.

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[1] Report of the U.S. Senate Committee on the Judiciary, sub-committee on Anti-Trust and Monopoly, Washington, 1961, pp. 105-6 (The "Kefauver" Report)

[2] "Greenbook", pp. 106-110 is the source of this data.

SALES TAX

There can be little doubt that the incidence of the sales tax is passed on to the consumer, given the continuing arrangements that make for a highly inelastic demand for ethical drugs. Thus one element in the price of drugs could be eliminated if the sales tax on drugs was abolished. The extent of the reduction possible from repealing the sales tax is of the order of about 10% of present prices.[1]

These are the possible savings to the consumer, but their being passed on to him hinges on the effectiveness of competition in the ethical drug industry. There is evidence that previous tariff concessions have not always been passed on in the form of price reductions.[2] The only insurance that the public will benefit from tax and tariff reductions is a simultaneous easing of the trade mark and patent legislation (along the lines we have suggested, perhaps) so as to bring the clean breeze of competition to the Canadian drug industry. We can see little merit in lowering sales taxes on drug products unless this is done in conjunction with an overall package to improve the competitive climate, but we urge that the tax be eliminated in conjunction with action affecting tariffs, patents and trade marks.

In summary, given the nature of demand and the fact that for most particular drugs there are only a few Canadian Suppliers (not more than five or six in most instances), the Canadian producers have every encouragement to set their prices on the basis of the foreign price plus the Canadian tariff. Since economies of scale are not important for the kind of processing typically done in Canada, the high Canadian price level provides scope for high promotion expenditures, which in the Canadian setting would appear to be a more popular and perhaps more effective means of stabilizing market shares among producers than competition in research and development activity.

The working of the anti-dumping laws and the patent and trade mark systems appear to provide further protection against import competition. Since they cannot be readily defended on grounds of their contribution to new product development in Canada, they are supported as means of assuring quality of product though this can obviously be much more effectively assured by the Food and Drug Directorate which is assigned the responsibility for consumer protection respecting all drugs and not only those that are patented.

In view of the role of these various government policies and interventions affecting the pricing and quality of drugs, the Consumers' Association of Canada recommends urgent consideration of the changes in government policy suggested in this Appendix.

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[1] The letter from the Accountant to this Committee, October 7, 1966, estimates the impact of Sales Tax as being 9.87% increase in prices, on the average, Minutes of Proceedings and Evidence, No. 9, p. 576.

[2] When tariff rates were lowered on the imports of the firm cited as an example on p. 3 of this Appendix there was no similar reduction in price. See Combines Investigation Act, Report 1964, p.32.

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OF

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LÉON-J. RAYMOND,

The Clerk of the House.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 18

TUESDAY, NOVEMBER 15, 1966

WITNESSES:

Dr. Alan S. Davidson, M.D. of Toronto. *For The Medical Post:* Mr. Charles E. Wilson, Publication Manager; Mr. R. W. Robertson, Executive Officer, both of Toronto. Mr. M. G. Allmark, Assistant Director Drugs, Food and Drug Directorate, Department of National Health and Welfare.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1966

25166—1

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

MINUTES OF PROCEEDINGS

TUESDAY, November 15, 1966.
(26)

The Special Committee on Drug Costs and Prices met this day at 10.05 a.m. The Chairman, Mr. Harry C. Harley, presided.

Members present: Mrs. Rideout and Messrs. Asselin (*Richmond-Wolfe*), Harley, Howe (*Hamilton South*), Isabelle, Mackasey, O'Keefe.

In attendance: Dr. Alan S. Davidson, M.D., of Toronto.

Also in attendance: Mr. A. M. Laidlaw, Q.C. of Ottawa, Legal Counsel for the Committee.

The Chairman introduced Dr. Davidson.

The Committee proceeded to consider the brief on "Ethics and the Prescription Drug Industry with Reference to Consumer Costs".

Dr. Davidson made an introductory statement and requested the protection of the House. The Chairman referred to Beauchesne's Fourth Edition, 1948 and read into the record Citations 309 and 314.

The witness asked and the Committee agreed that corrections be made to his brief, particularly to section 4.2.

Agreed,—That the brief be printed as part of today's proceedings. (*See Appendix "A"*)

Dr. Davidson was examined by the Members.

Mr. Laidlaw also asked questions of the witness.

On behalf of the Committee, the Chairman thanked Dr. Davidson for his presentation.

At 12.30 p.m. the Committee adjourned to 3.30 p.m. this day.

AFTERNOON SITTING
(27)

The Special Committee on Drug Costs and Prices reconvened at 4.00 p.m., the Chairman, Mr. Harry C. Harley, presiding.

Members present: Mrs. Rideout and Messrs. Forrestall, Harley, Hymmen, Isabelle, O'Keefe.

In attendance: *For The Medical Post*: Mr. Charles E. Wilson, Publication Manager; Mr. R. W. Robertson, Executive Officer, both of Toronto; Mr. M. G. Allmark, Assistant Director Drugs, Food and Drug Directorate, Department of National Health and Welfare.

25166—1½

Also in attendance: Mr. A. M. Laidlaw, Q.C. of Ottawa, Legal Counsel to the Committee.

The Chairman introduced Messrs. Wilson and Robertson.

The Committee proceeded to the consideration of the submission of *The Medical Post,* copies of which had already been distributed.

Mr. Wilson made a short statement. Both he and Mr. Robertson supplied information, particularly with reference to advertising by the pharmaceutical industry.

A copy of *The Medical Post* for November 8, 1966 was distributed.

Mr. Allmark supplied information with regard to regulations concerning the advertising of drugs.

Mr. Laidlaw asked further questions of the witnesses.

Agreed,—That the submission by *The Medical Post* be printed as part of today's proceedings. (*See Appendix "B"*)

The Chairman thanked Messrs. Wilson and Robertson, on behalf of the Committee, for their appearance and for having given their views on the matter of advertising and costs of drugs.

At 5.20 p.m. the Committee adjourned to 9.30 a.m. Thursday, November 17.

Gabrielle Savard,
Clerk of the Committee.

EVIDENCE

(Recorded by Electronic Apparatus)

TUESDAY, November 15, 1963.

The CHAIRMAN: Ladies and gentlemen, we will proceed with the meeting. There is quite a bit of correspondence but I think we had better have it cleared through the steering committee, rather than just bring it before the meeting. I would like to introduce Dr. Alan Davidson M.D., from the Addiction Research Foundation of Toronto. Dr. Davidson has already passed around a sheet outlining his background to all the members of the Committee.

Dr. ALAN S. DAVIDSON: Thank you, Mr. Chairman. I would like to make a very brief introductory statement, and I assure you it will be brief. However, I have been reviewing my written statement with others and have been told that it is sometimes hard to determine my theme in the main points that I am trying to make. So, I thought I should cover a few areas and leave the remaining time for discussion. I would like to emphasize that this is my own private statement. Although I am employed by the Alcoholism and Drug Addiction Research Foundation of Ontario and although I am a member of the Editorial Board of Applied Therapeutics, I am not representing any organization here. I would like to make this very clear, particularly to the press here today as I do not want anything I have said relayed as an official announcement of these organizations.

Now, my lawyers have advised me to request the protection of the House, Mr. Chairman, because I have made some statements that are possibly controversial. Some of them reflect on the ethics of drug manufacturers; I believe that I can back them and I have researched them very carefully, but I do not want to be involved with any litigation or libel suits, so, I am requesting the protection of the House and that would apply to any copies of this brief that have been distributed to the press or anyone else.

The CHAIRMAN: That is fine. Dr. Davidson has written to me about this very point and I have spoken to the law officer of the House of Commons, Dr. Ollivier, who referred me to Beauchesne's Fourth Edition of 1958. I think at this point it might be well to put these paragraphs on record for any witnesses who do want to come before the Committee. I will read at page 246 of Beauchesne paragraphs 309 and 314. Paragraph 309 states as follows:

> The privilege of freedom from arrest and molestation is attached to all witnesses summoned to attend before either House or Parliament, or before parliamentary Committess, and to others in personal attendance upon the business of Parliament, in coming, staying and returning.
>
> Every witness attending before the House or any committee thereof may claim the protection of the House in respect of the evidence he is called upon to give and also ask leave to be assisted by counsel.

Paragraph 314 reads:

> Statements made to Parliament in the course of its proceedings are not actionable by law. While the House punishes misconduct with severity, it is careful to protect witnesses from the consequences of their evidence given by order of the House; and on extraordinary occasions, where further protection has been deemed necessary to elicit full disclosures, Acts have been passed to indemnify witnesses from all the penal consequences of their testimony.

I think I quote Dr. Ollivier correctly in saying that these passages apply to Dr. Davidson's appearance before the Committee and certainly give him immunity for any statement he makes before the Committee. I should say, however, if any action were intended by anyone and if Dr. Davidson repeated anything he said in the House outside of the House, then that would be strictly his own responsibility.

Mr. O'KEEFE: I presume, Mr. Chairman, the Committee has the same protection.

The CHAIRMAN: Members of parliament and Committee have the same protection.

Dr. DAVIDSON: There are some typographical errors and there are a few corrections which I will note as I proceed through the brief. I think I should mention one right now though, which is quite unfair with regard to the publication *Canadian Doctor*. I would like to note that because certainly what I said was partly unfair.

I note in Section 4.2 that in November of 1960 this magazine published anonymously a factual essay on the contribution of the drug industry to medical progress. I mentioned that it took a little time to identify the author as a representative of the industry. However, it was not actually that hard, I had lost that article and I did find that his name was mentioned; but, his affiliation with the industry was not noted and, furthermore, I believe I am correct in saying, that actually the article was a summary of the industry's brief to the Ontario select committee on drugs. So, although his name was mentioned, I still feel it was misrepresented as a factual essay; it was a brief. It was in a magazine that is distributed free of charge to physicians and for which the entire revenue is obtained from drug company advertising, or at least almost the entire revenue.

There are other corrections—that was the big one—of minor importance which I will note as I proceed. You might wonder why I quote Morton Mintz' book "The Therapeutic Nightmare" so much, and also Senator Kefauver's book "In a Few Hands, Monopoly Power In America". Now, I quoted those because both reviewed the same material that I reviewed in my own presentation. Both reviewed it and I could not help but agree with their conclusions in most cases. Also I thought by quoting these two authors, you would have ready sources of information. The same views they mention in their publications are, of course, found in the various hearings and proceedings. I am willing to submit an additional document, a statement by Dr. Harold Cowant of the Alcoholism Foundation. His is really the only negative statement that I have obtained on my brief and, I think out of fairness, I will try to cover his criticisms as I go along.

Now, when we talk about costs, I think that we have to consider the cost of drugs in a very broad sense. If we have a lot of products that are very similar in their effect, where one product would suffice, I think there is a cost involved. If these products are harmful, there is a further cost to society because we may be using products that are damaging when we could get along with something much simpler. As I drove through Algonquin Park coming here yesterday, I heard an interesting radio program in which an American sociologist talked about the decline of the Roman empire. And he tied it in with the use of lead. Lead was used apparently in the cooking implements. The Romans had found that copper was very caustic; they knew that lead was caustic also, but they were not aware of its prime causticity, according to this man. He stated, the Romans ran into great difficulty with two things: sterility and mental illness. Lead, can, apparently, produce both. So, he thinks, the Romans went out of popularity, you might say, on the basis of their usage of lead. Now, I sometimes wonder, in this 20th century, if our western society is going to disappear on a wave of multi-coloured pills. We are inundated now and I really wonder how long we will survive unless something is done to arrest the flood.

Mr. HOWE (*Hamilton South*): Maybe it is because we are being—led.

Dr. DAVIDSON: It could be, Dr. Howe. Now, that view is not original. Many people have stated concern about the number of products on the market. I think there are far too many drugs of poor quality. By quality, I mean effectiveness and novelty. I think that these products cost far too much. Because of price maintenance, through patent control, I think quite often a drug will stay on the market at its original price for years and years when the manufacturer must have recovered his initial investment long before.

I feel that advertising, promotion and marketing costs are exorbitant. In that I include detailing; the so-called professional sales representatives. To me it is just phenomenal that 30 per cent of the manufacturer's dollar is involved in promotion; it must be much more for the consumer. I feel that industry has gained control of postgraduate medical education. This discouraging development has been noted by many medical authorities in the United States.

For some time now the drug industry has been under control of three basic agencies: government, the manufacturer himself and the physician. If the manufacturer and the physician are not doing an adequate job, then it would seem logical that government should show a greater interest. I am not opposed to free enterprise. I am not opposed to democracy. I do feel, however, that government has to take a stand and has to do something if the industry and the medical profession are not protecting the consumer. We cannot wait forever for effective control. Many people have expressed concern about this. One doctor said that the industry translates exploitation into noble purpose. Another has said that good drugs do not need promotion. To me, this makes sense.

If you look at vitamin B-12, which is a remarkable product—a tiny dose will protect a patient from pernicious anaemia, a disease that used to be fatal—I would be very surprised to find any advertising done on this excellent drug. If you take a look at any medical journal you will find many products being advertised in a very flashy way. I feel that this is done because many of these products are not very good.

Well, that is all I wish to say right now, Mr. Chairman.

The CHAIRMAN: Fine Dr. Davidson, thank you. First of all, is it agreed that we print today's brief as an appendix to today's proceedings?

Some hon. MEMBERS: Agreed.

The CHAIRMAN: The meeting is open for questions.

Mr. HOWE (*Hamilton South*): Mr. Chairman, I am sorry I did not get the brief. I do not know what happened, perhaps it was a postal mistake. From what I have heard and from what I have been able to scan now, however, I certainly cannot help agreeing with you 100 per cent. I would like to follow this up because I had some questions written out before I came today about continuing education, shall we say, being, actually to all intents and purposes, dependent on the drug companies. You agree with this, of course, since you have just made the statement. Do you not agree that this is a wrong method for doctors to be acquiring their education?

Dr. DAVIDSON: I could not help but agree, Dr. Howe. No matter how honourable and ethical a manufacturer tries to be, he has a very definite vested interest. He has his profits to consider, his shareholders and for this reason, the information provided cannot be objective. I would admit that the industry, if asked, will provide detailed documentation, both negative and positive, on its products. They will send reprints to you. Actually, from this brief, some of the material that is critical of the industry was actually provided by industry sources. They will do this if asked; but the regular promotional and educational material is heavily biased and I think this a most unfortunate change. There are very few conventions and professional meetings that do not receive some kind of support from industry. I do not want to go too far on that because I am not exactly sure how much the industry will contribute to a convention. I am willing to bet, however, that without industry support the Canadian Medical Convention might have to be held at a university.

I have here, as an example, the sort of thing we would get in a mailing, on parnate and stelazine. As you probably know, these two drugs were contained in a combination product called parstelin. It was removed from distribution in Canada several years ago because of toxicity. Now, the manufacturer is pushing the combined use again. They are recommending that we use them together. They cannot sell them together in one pill, but they are certainly pushing it. The article, by a Montreal physician, appears in the publication *Medical Services Journal of Canada.* This man I know, does not believe in double blind controlled studies on psychiatric conditions. He stated that in a previous article almost identical to this one. Anyone in the field of psychiatry who has a scientific understanding of the problems of testing drugs in depression, knows that the double blind method is essential. He is quoted in a reprint sent out—and it is this kind of thing that we are trying to combat, that I am trying to combat. If I could just carry this a little bit further; just before I came here I was phoned by a general practitioner in Toronto. Now, six weeks before he had sent me a woman who was depressed—the typical depression of old age. I suggested that she be placed on tofranil, one of the antidepressants, for three months. Six weeks later he came to me and said, "she is all better; it is just wonderful; she is all better". I said that I was very pleased. He said "I think I will switch her to triavil". Now, triavil contains trilafon a tranquillizer marketed by Schering, and elavil, another antidepressant very similar to tofranil. He did not know that it contained tofranil;

he did not know that it is unwise to swich from one antidepressant to another without a waiting period. The thing that really bothers me is that here he was switching the products after the patient had got better. So, I think that it is really out of control.

Mr. HOWE (*Hamilton South*): You obviously agree that this is costly. I would like to quote a paragraph, if I may, from C. D. May and J. D. Rising who record in some detail the cost and extent of the drug trade's aggressive continuing education of physicians in the United States.

> The figures stagger the imagination; $750 million for promotion a year; four times the operating budget of all medical schools; $5,000 spent annually per doctor; a deluge of 4,000 pieces of promotional gloss per doctor per year; and for every fifteen physicians a "detail man teacher" promoting polypharmacy.

The CHAIRMAN: May I ask where this report comes from?

Mr. HOWE (*Hamilton South*): I gave that quote, Mr. Chairman. It is by C. D. May and is called "Selling Drugs by Educating Physicians" and J. D. Rising's "The Practising Physician's Approach to the Evaluation of New Drugs."

The CHAIRMAN: Thank you.

Mr. HOWE (*Hamilton South*): What I feel is wrong about this is that this costly bill is borne by the ultimate consumer; that is, the patient, who is not really responsible for the education of the doctor, because the patient is paying for the education of the doctor when he pays the doctor's fee. Then, in a sense, he is paying for his continuing education again by the exorbitant costs that are involved in the prescription that the patient has to go out and buy. Do you agree that this is what is wrong with drug companies educating physicians? It is one of the aspects in which it is wrong, I should say.

Dr. DAVIDSON: Yes, Dr. Howe, it is a tremendous investment and it eclipses the investment in research. This really bothers me. The manufacturers talk about their detailmen and praise them, but many of them are uninformed and I find it very surprising that salesmen going to a professional man could be so uninformed.

I can remember, as one example, a man from a Montreal firm who was pushing Miltown at me. Now, Miltown is a tranquillizer that I do not think is any good, and when I say "I", many other people do not think it is any good. It is mentioned here in the brief. He said: "Doctor, we have a new form. We have a sustained action form. It just has to be taken twice a day and costs half as much." I said: "That is fine, let us figure out what the cost will be on a bottle of 100". It turned out that there was half as much drug for twice as much money, and to add to the insult, as far as I was concerned, I had just finished writing an article mentioning Miltown and to add insult to injury, here he was pushing this drug and he was not aware of negative opinion about its effectiveness. Ten years after it was marketed it is withdrawn from the American pharmacopoeia, the U.S.P.—I may be wrong there but, anyway from "drugs of choice" listing. According to Kefauver it was one of the most profitable tranquillizers ever sold.

The cost of advertising is phenomenal. I worked as a detailman for one year, and they have to pay their detailmen a reasonably good salary. You would be

amazed how long these men sit in a doctor's waiting room each day. I am sure this is one reason for the cost. I am sure that the doctors on the Committee are aware that they keep detailmen waiting.

Mr. HOWE (*Hamilton South*): Intentionally or otherwise. I would like to have this on the record, and I am just going to say that this article from which I am quoting was a speech given by a professor. He suggests that there are two different ways that the education is proceeded with, and one is by the "food garbage disposal"—items which he feels should be marked "refused"—which means that they would be sent back to the manufacturers at their expense. As it is not first class mail presumably it would be returned and they would have to pay for it. He suggests, also, closing the door on the detailmen because he feels very strongly, as you do, that this is not the source from which a doctor should get his education. C. D. May reveals, in his article called "Selling Drugs by Educating Physicians", the gargantuan promotion of the drug trades' continuing education program. He exposes in considerable detail the path or genesis of the promotional techniques, under such revealing headings as "Semantic Smog"; "Manufactured Complexity"; "Smart and Sly"; "Payola"; "Tricks of the Trade"; "Learning made Difficult"; "The Enticing Web" and "The Menace of Entanglement".

It is not a pretty picture for public scrutiny. How well are we doing in disentangling ourselves, an honoured and learned profession, from this dishonourable situation?

I think that is an excellent paragraph explaining that doctors are more and more subject to this educational process of the drug companies, and avoiding the proper type of education. As you say, a good drug does not need promotion; it sells itself because it is efficient and does what it is supposed to do, and certainly does not require the education by the drug companies.

You name B-12, and one could name insulin and many others that automatically sell themselves. The only way in which they have to be sold is, perhaps, in combinations such as penicillin is, because I am sure penicillin *per se* does not need salesmanship, but rather the different forms in which it is put out is one of the great costs of drugs. So really this was not a question, but simply a statement of complete agreement with you along this line; but if there are any comments you would like to make I would be very glad to hear them.

Dr. DAVIDSON: I think for the moment I would like to leave that, except for one thing. We do not really know the breakdown of costs of advertising, promotion and marketing. In my recommendations I talk about restricting detailmen by insisting that they have a university degree. I talk about restricting advertising outlets to reputable, official medical journals, so that manufacturers cannot print their own journals or magazines. I make that recommendation at the very end. I am assuming actually, that all those magazines cost a great deal, but I do not know. I get copies for which the subscription price is $2 an issue, and I am sorry I meant to bring them; I forgot to bring my exhibits.

They are very fancy; they are beautiful magazines and my patients who enjoy art like to get them, but should the consumer be paying for that? I do not know.

Mr. HOWE (*Hamilton South*): Do these $2 journals contain advertising as well?

Dr. DAVIDSON: Yes, they certainly do.

Mr. HOWE (*Hamilton South*): So the $2 does not represent the entire cost, then?

Dr. DAVIDSON: Well, we get them free. We get most of our journals and magazines free, but that does not mean that they are free. The consumer is paying I do not know what proportion of the total budget these things represent I do know from my work at the foundation that in running a clinical treatment unit the greater part of our costs is salary. Ninety per cent of the cost is the people we pay. I would think that salaries of the detailmen would be very high—not high, but the total cost would be very high. But I do not know. I think this is something that should be explored.

The other thing about the detailman, Dr. Howe, is that his selling methods are almost impossible to control. Kefauver mentions that in his book. You do not know what goes on in the doctor's office unless you tape it. You can control advertising if you want to, by law, or by some method, but it is very hard to control the detailmen. My feeling is that if you are going to control them you are going to have people that are really trained in some basic science, or pharmacy, or pharmacology.

Mr. HOWE (*Hamilton South*): Do you feel that the average detailman is sufficiently knowledgeable to be able to educate a doctor?

Dr. DAVIDSON: No, far from it. There are some good detailmen, I will admit. I think I now see the good ones; the other ones do not come near me. But some of them are pretty ignorant, and the gimmicks that are used are ridiculous. A couple of twins visited the foundation a few months ago. We were supposed to guess which twin represented the company. This sort of thing is just fantastic.

A couple of weeks ago we had a detailman come into one of our divisions and say: "We have a scientific project we want you to do on our product," and he brought out a nice psychological test form, a check list by which you could figure out how much depression the patient had. The psychologists demolished him right there. They said: "This is a terrible test". I happen to know that this kind of pseudo research project is what the industry calls "seeding". What they are trying to do is to get their product used and identified by physicians in an organization so that they will prescribe it. It is not really scientific. Were it really a research project, the medical director would have gone there, not a detailman. Anyway, he left, a very sad and dejected man. He did not even realize what he was heading for when he went in there.

Mr. ISABELLE: There are so many questions to ask that I do not know where to begin. Nevertheless, Doctor, it seems to me that you are more a poet than a psychiatrist. You tell me you were a general practitioner in Brampton from 1958 to 1959. Am I correct.

Dr. DAVIDSON: Yes, that is right.

Mr. ISABELLE: Why did you abandon this practice.

Mr. DAVIDSON: This glorious practice? I thought I would die. I enjoyed it but I found it extremely hard work, extremely fatiguing, and I was attracted to

psychiatry long before I went into general practice. I happened to get my best marks in psychiatry in medical school, and our professor felt that we should all have experience in general practice, if possible, before we went into specialty training.

Mr. ISABELLE: It was not because it was easier than the general practice?

Dr. DAVIDSON: There are easier working hours in psychiatry, but I do not think it is one bit easier. It is fatiguing work.

Mr. ISABELLE: Science is more obscure, I imagine, in psychiatry.

Dr. DAVIDSON: It is more obscure from a scientific viewpoint, yes.

Mr. ISABELLE: That is why I say you are a poet, because there are some shocking words in this brief, especially in item No. 5.0, where you say: "In this case, the manufacturer sponsored a 'symposium' on 'Mixed Anxiety and Depression' held at Ste. Adèle." You say this is a phony symposium. Do you mean that the Canadian Psychiatric Association is a kind of phony organization?

Dr. DAVIDSON: No. I think they cooperated with this quite unconsciously unwittingly. I am sure they regret that now. The theme was "mixed anxiety and depression", but it was quite obvious that the products of the manufacturer were the real theme and on which there were papers. This happens to be parnate, the very thing I talked about earlier as being withdrawn because it was not proven effective, for one thing, and because it had very serious and sometimes fatal side effects.

I do not think the Canadian Psychiatric Association or McGill University realized that in supporting the Geigy symposium on Tofranil that they were assisting the manufacturer. You see, in both cases a special supplement of a journal was published on the product. It contained articles covering a broad field, so the Canadian Psychiatric Association published a supplement on "Mixed Anxiety and Depression" in which they reported the proceedings. I cannot remember who published the one on "Depression" but it was published as a special supplement. You will find I am mentioning Monase, a product that was withdrawn eventually. When they marketed monase the only article they had to back it came from a symposium. I do not know whether this symposium was legitimate or sponsored by the manufacturer. At these symposia, the speakers, the participants and the audience are all entertained by the manufacturer. They are transported great distances, treated lavishly, and I do not see how objectivity can prevail when you know that the manufacturer is paying the bill.

Mr. MACKASEY: Do they pay the transportation bill as well?

Dr. DAVIDSON: Yes, as far as I know.

Mr. MACKASEY: But you are not sure?

Dr. DAVIDSON: I am not certain, Mr. Mackasey. That is my understanding but I cannot prove it. With respect to this Ste. Adèle conference, I am quoting a colleague of mine from Toronto who noted that a very reputable psychiatrist had actually got equivocal or indefinite results from his study. Yet, he felt compelled to praise the product. The man I am quoting is a very respected person in Toronto, and he was angry when he returned from there.

I would not object if the industry said: "Look, we will devote $1 million a year to symposia on therapeutics". That would not bother me at all if the industry did this collectively, but to the individual manufacturer according to Walter Modell, whom I quote elsewhere, it is one of the cheapest forms of advertising.

Mr. ISABELLE: But do you not think it is more rational to be entertained by Parke, Davis or Smith, Kline and French at a cocktail party than by General Motors or Ford Motors, or to be entertained at such a symposium by different companies?

Dr. DAVIDSON: Did you use the word "rational"?

Mr. ISABELLE: Yes, rational.

Dr. DAVIDSON: It is obvious that they have a closer interest but I cannot see that it is rational; I think it is foolish.

Mr. ISABELLE: I mean that they are closer to us than General Motors or Ford Motors.

Dr. DAVIDSON: I an afraid that they are all too close, sir. I think we are far too close to them for comfort.

Mr. ISABELLE: I have the symposium here, and I have the Canadian Psychiatric Journal which mentions what has been done in this symposium, and I do not think this is a "phony" symposium. I think it is one of the best documents that the Canadian Psychiatric Association has ever produced.

Dr. DAVIDSON: You are entitled to your opinion, Dr. Isabelle but, first of all consider parnate. Parnate was marketed without good evidence of effectiveness. It was immediately combined with stelazine in Canada—but not in the United States—to make parstelin. Parstelin was a very, very successful drug. There was still no good evidence that it was effective, and its effect was to boost the blood pressure, as you know. If a person eats old cheese or takes cold remedies his blood pressure might go way up, and a few people died here in Canada and in England, I believe, when their blood pressure went way up because of this unexpected reaction.

Parnate and parstelin were marketed by Smith, Kline and French. In the United States the Food and Drug Administration decided to hold a public hearing, and this is the first time they were going to hold a hearing on efficacy and safety. They wanted the manufacturer to prove that his product was effective and safe, and at the last minute the meeting was cancelled. At that time there were only four controlled studies on the product and the results were far from convincing. Admittedly, many psychiatrists did think the drugs were useful, but the results were far from convincing, and I have an idea that if the hearing had been held this particular product would not be on the market now.

Mr. HOWE (*Hamilton South*): What do you mean by a successful drug, financially successful?

Dr. DAVIDSON: Yes, in terms of volume sales and return of profits. Smith, Kline and French really have had high profits for a number of years now because they marketed chlorpromazine in the United States which was the forerunner, first big drug in the treatment of mental illness. So when I talk about successful

drugs—there is a section in my brief—I researched this matter of the successful drug, once before, and a drug does not have to be any good to be successful.

Mr. HOWE (*Hamilton South*): You do not mean therapeutically successful?

Dr. DAVIDSON: No, far from it. I mean sales.

Mr. HOWE (*Hamilton South*): I did not want any ambiguity on it.

Dr. DAVIDSON: No, I do not think that sales success and therapeutic effectiveness are necessarily the same at all.

Mr. ISABELLE: You mentioned to us before the questioning that most of the drugs were of poor quality. What exactly do you mean by that? Was there a lack of control?

Dr. DAVIDSON: No. I mean that there are far too many in each of these categories. There are far too many and many are very similar. If you want me to translate it simply, I would say it is pure junk. There is no doubt that the medication is pure; there is no doubt that it meets the standards in terms of content in each pill; there is no doubt that extra irritating or noxious chemicals are removed, but the product itself may be no good, or it may be very closely related to another compound so there is really no practical advantage, so I say it is pure junk. Why do it? Why have five stimulating phenothiazine tranquillizers, the trilifon family? I am using trade names because I cannot remember all the generics, but you have stemetil, trilifon, dartal, stelazine and moditen or permitil. They are all just slight variations in structure.

The trick of structure modification was learned long before in antihistamine research. All you have to do is pick on a chlorine here or a trifloral methyl group or something like that and you increase the potency. The industry maintains that increased potency means less toxicity, but that is not so. It is different toxicity and sometimes greater toxicity. I would not give permitil or moditen to a patient. It is less than a milligram dose, whereas largactil is 100, but the side effects are phenomenal. Parkinsonism; it is like Parkinsons Disease. So when I say they are no good, I mean that we are swamped with many products which are very, very similar.

I do not think the industry has really given us anything very novel for some time. There are two things which I have mentioned which I think meant the same thing. The American industry developed cortisone derivative which is a very valuable drug. They developed the hydrozides, the chlorothiazides family of drugs and certainly chlorothiazide is a very valuable diuretic. But, otherwise, I asked them to prove what else they have really given us that is novel. I do not think they have done very much. There is no doubt they are selling many and they are being licensed by European manufacturers who are originating some novel products, but the American manufacturers really are not producing much in the way of novelty and the Canadian manufacturers are their subsidiaries.

Mr. ISABELLE: How do you explain the phenomena of psychiatry which is very popular today? You are aware of the fact that many people are consulting psychiatrists today. I do not know if it is the world not rolling the proper way but it seems that everything seems to be unbalanced today. Could you explain to me this phenomena of people going more and more to psychiatrists and coming

out with a prescription which costs from $24 to $35 or $40, and I am not exaggerating. Are you prescribing cheap drugs or are you prescribing expensive drugs? By a cheap drug I mean are you prescribing generic drugs?

Dr. DAVIDSON: The drugs used in psychiatry are, unfortunately, predominantly patented drugs and the prices are high. I feel that one of my patients left me a week or two ago when I gave him a prescription. There are not too many of the newer psychiatric drugs available generically, chlorophromizine and phromizine and I believe, now, that librium chlorodiazepoxide is available generically. Unfortunately, as you know, the generic prices are starting to get higher and they are getting closer to the so-called ethical prices. I do agree that many people are getting substantial bills for drugs.

In mental hospitals where you encounter severe depression, the drugs are very valuable but psychiatric outpatients are predominantly neurotic with character disorders and drugs have not proven to be too effective for them, but they are widely used and I deplore this, that so many psychiatrists do prescribe expensive drugs. Not only that, they prescribe many drugs. I know one patient who has a cupboard full of containers of pills all along the shelves. He has a two o'clock pill, a four o'clock pill and a six o'clock pill.

Mr. ISABELLE: They become crazier in the long run.

Dr. DAVIDSON: Actually, we do encounter insanity as a result of toxicity. We do encounter this on occasion. Sometimes the best cure is to take people off all their medicine. I do not approve of the kind of thing you are encountering but, unfortunately, it is too common and this I deplore. This is my point. The industry has us educated now. For instance, I am using a drug now at the Alcoholism Foundation about which I have serious doubts. I doubt that it is effective. This is your librium. You like it.

Mr. ISABELLE: It is very good.

Dr. DAVIDSON: Yes, I know you indicated you liked it when you were speaking earlier at the hearings. Now, Professor Meyers of U.C.L.A. testified at the Kefauver hearings that it has a profile very similar to phenobarb and it would be very hard in experimental animals to tell one from the other. Yes, I know we use it to withdraw alcoholics because it is the thing; librium is a great drug for alcoholics. This has been pushed so well that most physicians are convinced. I am not convinced, at all, that phenobarb would not do just as good a job of withdrawal where you are worrying about an epileptic fit during the withdrawal phase. I am not convinced that phenobarb would not do just as good a job but am I the person who is going to change the pattern at the foundation? No, because they would think there is something wrong with me if I do.

Mr. ISABELLE: There are some psychiatrists around today who think that phenobarbital does just as good a job as librium or chlorodiazepoxide but today we do not prescribe phenobarbital any more because people think we are cheap doctors if we give them that drug.

Dr. DAVIDSON: Exactly.

Mr. ISABELLE: I am glad you said that because as a general practitioner my opinion does not count in this big world of ours.

Maybe I misunderstood you because you said that generic drugs today—let us say we are talking about librium or chlorodiazepoxidates together. Are they selling the generic at approximately the same price as the librium is selling?

Dr. DAVIDSON: It is not as much but I understand the prices are getting closer.

Mr. ISABELLE: They are about the same.

Dr. DAVIDSON: I would not like to be committed to that particular drug in saying that, but I think generic prices are getting higher and the spread is getting less. Are you referring to the subject of equivalency and whether a generic product is equal to brand names?

Mr. ISABELLE: Yes.

Dr. DAVIDSON: Of course, the industry maintains that there is a big difference; that an ethical product is more pure, it meets higher standards in terms of dose and all that sort of thing. They maintain this but I have spoken to people who disagree. Professor George Lucas, a retired professor of pharmacology at the University of Toronto, is now involved in the purchasing of drugs for the Ontario government hospitals and other hospitals and, as you probably know, they have their own quality control and standards set up now so they can measure drugs from both generic and ethical manufacturers. He says that they both meet Ontario government standards. The one thing he cannot be certain of is a term he calls "availability". Does it really get to the blood? Does it get to the target organs, the brain or the liver or whatever organ is being affected. He says he does not know that but certainly they meet specifications. He says you will find generic manufacturers whose products do not meet these specifications but you will also find ethical producers who do not meet the Ontario government's specifications, too. I think this whole subject of equivalency has been misrepresented.

There is a crying need for a good federal government control on drug products, and I think this federal control should be integrated with the provincial drug control laboratories so that we can assure a consumer that a generic product is equally effective and safe. This is not done at the present time. The Food and Drug division cannot possibly test all the compounds. They have admitted that they are under staffed; their salaries are low compared to the United States; they cannot guarantee generic equivalency but in actual practice the big buyers find that quite often the generic products are just as good. The one qualification is availability. Does it really get to the brain? This is a very hard thing to measure in the brain or whatever body organ is concerned. This is a very hard thing to measure. The ethical producers are more inclined to produce evidence of that kind.

Mr. ISABELLE: In other words, you would like to have further research made after the first research has been done?

Dr. DAVIDSON: No; I do not want to fall into that trap. I think that the federal government should impose good standards on the drug manufacturers; not just the manufacturing plant and facilities but they should be doing random testing of batches. They do this but they cannot possibly cope with the thousands of products.

Mr. ISABELLE: I imagine you are trusting the Food and Drug division here.

Dr. DAVIDSON: Do I trust the Food and Drug division here?

Mr. ISABELLE: Yes.

Dr. DAVIDSON: I think they are working very hard but I do not see how they can cope with the problem either here or in the United States. I do not see how they could possibly cope with it. They are underpaid; they are overworked and I think the Minister of National Health and Welfare mentioned to these proceedings that they cannot handle it. You see, if they could, they would never have allowed a product like dartal on the market.

Mr. ISABELLE: Who produces dartal?

Dr. DAVIDSON: G. D. Searle & Company. I have mentioned that in section 4.8 in my brief. I was fascinated to find Frederick Mayers, who is a respected authority from a good American university, stating that dartal breaks down to trilafon and vinegar. I wrote him and asked if this was really true. He replied: "Yes, you can smell the vinegar when you put in water." He said that they could not market it as an injectible because as soon as you add water or a salt solution to it, it becomes trilafon which would not be the same label. They apparently announced that they had a special manufacturing process to keep it from switching to trilafon, a coating or some sort of compounding that prevented it from breaking down in humid conditions.

I cannot understand this. I checked with Dr. Kalant of our Alcoholism Foundation, years ago, if this was true. He said: "Yes, it has to be. If the company says it is not true they cannot defend that unless they tagged the drug radioactively and followed it through the blood. They cannot possibly deny it". I asked our pharmacist at the Alcoholism Foundation and he said, "yes". Now, how could that get by the testing. Apparently that is fundamental chemistry and how could that get by the Food and Drug division here and in the United States? What bothers me is that I mentioned this example to the Food and Drug division a number of years ago at the Canadian Medical Convention. There was great laughter but their company was not asked to withdraw the product.

Mr. MACKASEY: It is not funny to be injected with vinegar.

Dr. DAVIDSON: There are injections with lots worse things Mr. Mackasey, but they could not sell it as an injectible compound. I wonder how this could happen. These companies, Schering and Searle, made a patent agreement of which Professor Meyers has given me the reference. They made a patent agreement but I am not sure if it was a prepatent arrangement or a patent agreement made after Searle received the patent for several drugs, but certainly they made a deal and the company concealed that from me, I feel. I have the letters to prove it and to me they were dividing a lucrative market. As it turns out, dartal never was sold. Searle had the patent; it should have been successful but it never did succeed. Schering had their advertising all printed ahead of time, all ready to go as soon as they were licensed and trilifon was very successful, so that is ironic.

Mr. ISABELLE: To sum up, do you think that if we socialized drugs there would be certain benefits for the Canadian people as far as the price of drugs are concerned?

Dr. DAVIDSON: Sir, you are using the word "socialize", not I. I am recommending greater control of the industry. The industry is already controlled. I am not recommending socialization of the industry; I am recommending greater control. I think there is a difference between regular business and the health business. A higher ethical standard is necessary and if the industry cannot do that, then I think they have to be regulated. In my recommendations for advertising—I do not know if they could be made into a law—all I am asking them to do is to do what any other industry would do in advertising to a professional customer. An engineering journal does not have this fancy killer work and photographs. They do not use motivational research methods to the same extent. They use black and white; they have products of good quality and bad quality and price.

Mr. ISABELLE: You were mentioning engineers but they have been making gifts, for many years, to all the municipalities in Canada and they do not need advertising for that.

Somewhere in your brief you mentioned that health services in Canada are a privilege and not a right. I do not agree with you on that. I think health services are the right of the Canadian people.

Dr. DAVIDSON: That is an opinion of mine. I think the provision of health services, not just in Canada, is really a privilege given to the people by society. You see, I have mentioned, and apparently it is vague, about the surgeon losing his hand if he makes a mistake. This is the old code of Hamurabi. If the surgeon made a mistake, they cut off his hand. Now, we do not want to see this kind of restriction introduced again in Canada but, certainly, for years and years control methods have been employed and you and I have the privilege of practicing medicine. I think it is a privilege and an honour and if we do not practice it ethically our college can restrict us. I realize that you could say: "Why not let the industry have its own professional body"? But I think the profit motive is so much greater in manufacturing that the two cannot be compared.

Mr. ISABELLE: You spoke of the industry but people have the right to be protected by the government against diseases or any sicknesses. That should be natural right. I do not think we are using the word privilege in the same sense.

Dr. DAVIDSON: No, I was talking about those who provide services. I think it is a privilege which is limited. Society has a right to control those who provide health services. That may sound a little socialistic, I agree.

Mr. MACKASEY: Doctor, this is a very intriguing morning. You mentioned three areas: government, manufacturing and physicians. What about the druggist? Our main function here is to concern ourselves with price and safety, of course. I would like to read a letter I received yesterday, dated November 11, and I read it because the gentleman in question, Mr. King, of 8 Kirkland Blvd., Beaconsfield, Quebec, asked me to use it, if I felt free to do so. He mentioned that he takes medication in the form of pills for a fairly serious case of hypertension. He says;

> Recently, finding myself in short supply on a Sunday, and leaving by air the same day, I took my prescription to—

He mentioned the drugstore; there is no need to embarrass the store. I continue:

> Beaconsfield. They asked 28 cents per pill.

He did not buy them and went on to another drugstore in Valois, where the price was 20 cents a pill. He said he bought a supply there because plane departure time was near. He goes on:

> However, at the Hub drugstore on McGill, where I normally have the prescription filled, I pay 13½ cents per pill, and, at my own company clinic, where I used to obtain them until policy changed, I paid 7½ cents per pill—

He mentioned the brand, a Merck Sharp & Dohme product known as alderol. He then goes on to make some references about the industry that I would just as soon not read. The point I am getting at is we have been belabouring the industry at most of our meetings, but if this is the same pill sold in four different outlets, I presume they are the same price certainly to the drugstores—I am not talking about hospitals—perhaps there was some price advantage to the company clinic, because there they may have bought this pill in volume, but the point is that the company could sell the pill at 7½ cents, the drugstore on McGill sold it for 13½ cents, the store in Valois was demanding 20 cents and the store in Beaconsfield was asking 28 cents. Who is to blame for that?

Dr. DAVIDSON: We do have a number of examples of such pricing. I will accept the man's statement that it is the same patented product. He has mentioned the trade name. I do not know the product. I think it would be rather unwise to assume that each druggist got it at the same price. You see he did not mention whether these certain drugstores were part of a chain. If the drugstore is part of a chain, they have volume buying and I suppose that would lead to lower prices. Hospitals get lower prices, and I am sure the company, his employer, got a lower price because of volume buying.

Now, a chain might possibly transmit that price reduction to the consumer and that might explain it. I know that different drug stores have different methods of charging professional fees for dispensing and unless we knew more facts, I really could not explain it. Certain drug stores used to code their prescriptions and if the patient took in the prescription a second time to have it filled, the druggist would know how much had been charged before. I understand that that procedure has stopped. I know you get these examples and they are very dramatic. I read the brief which was submitted by the pharmacists to your hearings, and I thought it made good sense. They contend that their prescription business is supported by the front of the store. I thought they had pretty convincing figures. I did not review it in detail, and I did not include it here, but I felt that they probably did not make much money on their prescription products. They are swamped by the deluge, too. You see they have to stock dartal, for instance. It might not be sold for another two years and if it goes out of fashion, they are stuck with the stock. This happens fairly often.

Mr. MACKASEY: Does the company not take the stock back?

Dr. DAVIDSON: I think the companies will take back some products if they have gone over their dates. I would not be too sure of this though.

Mr. HOWE (*Hamilton South*): Those are only on intact quantities.

Mr. MACKASEY: The point I am getting at is that you have covered all the areas in your very interesting brief, other than the druggist, and it seems to me from the evidence I have been getting, that this is an important factor in the cost

picture. There may be too many druggists and they may be too close together. It seems ironic that a druggist, who is a professional man and who has a better than average education, should let a situation creep in which almost prostitutes his ethics, because he is not getting the recognition that he is entitled to in society, as a result of his professional education.

Dr. DAVIDSON: I think the necessity of counting pills is really pathetic.

Mr. MACKASEY: More pathetic even than selling silk stockings and chocolates to keep the place open. It is unfair.

Dr. DAVIDSON: They are members of a very honourable profession and the apothecary held a very honoured position in the community 50 years ago, but I think now they are in a most unpleasant situation and I think they are the scapegoats. They are in the focus. When you buy an expensive drug, you pay the druggist; he then has to take your hostility. I know they have strange pricing methods, but I do not know. I accept their brief as a fairly valid straightforward one.

Mr. MACKASEY: Have you any right to accept one brief over another. All the briefs are very valid when you read them; it is reading between the lines that is important.

Dr. DAVIDSON: There is not as much published on the pharmacist. I was looking through my files and I noted one reference and I think it was the manufacture, distribution and sales of drugs report to the Minister of Justice in Canada, where they questioned the ethics of having a professional organization not only determine professional ethics, but also marketing policies, and that economics should be separated from the college of pharmacy of the province.

Mr. MACKASEY: The point I am getting at is if these druggists were in an economic position to survive and make the profit that they are entitled to make, through the filling of prescriptions, do you not think they would be more inclined to use generic drugs and things that may have a smaller dollar volume and therefore less profit.

Dr. DAVIDSON: I missed part of your question.

Mr. MACKASEY: In Denmark the number of drug outlets are heavily regulated. I think there is one to every 30,000 population. In other words, that is the only drug outlet in that particular area. Therefore, based on statistics, a druggist can feel reasonably assured of an adequate living.

Dr. DAVIDSON: Now I see your point. I think there is a big difference between Denmark and Canada, as the druggists and the manufacturers have pointed out, that the population spread is a real problem. I would say that in a big city, it is my personal feeling there are far too many drugstores. I live in the Forest Hill section of Toronto, and there are 4 druggists in that one little intersection. To me this is foolish. Each one is competing with the other and I see no reason why the prescription drug end of it could not be automated so that druggist could push a button and get a standardized package distributed, like a cigarette machine. He would have to check it to make sure it was the product prescribed by the doctor; he would have to go through all those procedures, but he would not be counting and all that nonsense.

Mr. MACKASEY: Do you not think then you are defeating your own argument that there are too many products? If they have to carry every size package, they would then have to carry a lot more stock, would they not?

Dr. DAVIDSON: The industry has already moved into this field of standard packaging. They know what doctors commonly prescribe for a given condition and they have already moved into that, and I think it could be extended.

Mr. MACKASEY: Before I leave this line of questioning, if we are going to justify the government's control or intervention in the manufacturing end of it, we can just as easily justify the government's control or intervention in the retail end of the dispensing of the product. In other words, if the government can control the manufacturing, as it should and as you suggest, it should, by the same argument, be entitled to control the number of drug outlets.

Dr. DAVIDSON: Well, that is possible. It is an area perhaps that someone else could comment on more effectively. I would ask you: "What is the percentage of the consumer dollar the druggist charges? What does the druggist get out of the consumer dollar." I do not know that we have these figures anywhere.

Mr. MACKASEY: Well, their brief is very vague and they were supposed to come back with more information on this particular topic. At the time they argued that it was almost impossible to segregate the revenue and the net profit and the gross profit from their dispensing area, and from, shall we say, their soda fountain. But, as I recall it, they were supposed to make that analysis for us.

Dr. DAVIDSON: All right, we cannot get the figure. We have trouble then getting the percentage figure, so until we have it I would not want to go along with your thinking until I knew more. We do have a figure on promotion costs. Thirty per cent of the manufacturer's dollar; it is more obviously to the consumer.

Mr. MACKASEY: Let us get into that area. Let us presume that we followed the Hall Commission. You said 30 per cent to 15 per cent. If it does not hurt the industry this is a sizable savings. It is not too far off the 11 per cent sales tax—it is only 4 per cent off. It is certainly a lot less than the deviations we have seen in this letter on the price of the pill which varied anywhere from 7.5 cents to 20 cents. It is just not one area. I would like to discuss the detailman.

Dr. DAVIDSON: Do you mind if I just ask one thing before we go to that. I think you just endorsed the Hall Commission's recommendations that advertising be restricted.

Mr. MACKASEY: I did not endorse it; I mentioned it. I quoted it.

Dr. DAVIDSON: My feeling about that is that it would be quite unfair to restrict the industry to a percentage of sales. Now, I will give you an example: Chlorpromazine largactil had to be marketed in North America against tremendous medical opposition. The medical profession were rather keen on psychoanalysis and other methods of treatment that did not use drugs. Furthermore, they had a lot of drugs which were heralded as being effective and proven ineffective so there was a lot of prescriber resistance. Now, the industry had to put a lot of money into the introduction of chlorpromazine and this could be possible with a future product. A good product would need a lot of promotional investment to get it going.

Mr. MACKASEY: This is just the opposite to what you said 20 minutes ago.

Dr. DAVIDSON: I realize that. I am saying this as an isolated possibility. I do not expect that it would be very probable but it is possible, so I would rather see advertising expenses restricted by cutting down the number of detailmen and restricting advertising to a very recognized outlet.

Mr. MACKASEY: Well, do not let me get you off the hook on that last statement. You admit, therefore, that there are specific cases or incidental cases or isolated cases where heavy promotion is necessary.

Dr. DAVIDSON: Very isolated. That is the only one I can think of.

Mr. MACKASEY: There could be others? It is one that you are aware of.

Dr. DAVIDSON: There could be others but really, basically speaking, if there is a good drug the medical profession love to have it. They want it right away.

Mr. MACKASEY: How do they know about it? Let us take that particular drug you were talking about which obviously you approve highly of.

Dr. DAVIDSON: Well, medical journals, conventions.

Mr. MACKASEY: You mentioned here in your brief you took a rather jaundiced look at conventions, symposiums and the rest of it.

Dr. DAVIDSON: Well, drug sponsored symposia. I do not oppose medical conventions.

Mr. MACKASEY: Are not the P.M.A.C. boys equally prominent at the conventions?

Dr. DAVIDSON: Well, they have exhibits but they are all there. It is not just S.K. and F. or Geigy; they are all there. I do not know how much these exhibits contribute to the total—

Mr. MACKASEY: Is it any more ethical or valid because they are all there instead of just one?

Dr. DAVIDSON: Well, I think there are questions about ethics in both situations but I think it is more ethical to have all the manufacturers represented than one who pays the full bill for the participants as well.

Mr. MACKASEY: It is a degree, in other words. Let us get back to the one drug which needed to have the promotion which you were talking about. Let us presume that through government regulations heavy promotion was impossible either because of the 15 per cent or maybe because of the form of publicity. Let us say that they came along and said that the advertising or the brochure must be on cheap bond, one colour, and so on. Is there not a grave danger then that that particular product you talked about may not reach the attention of the physicians until years later than normal?

Dr. DAVIDSON: I think it is a possibility but not a probability. We are eager for good methods of treatment.

Mr. MACKASEY: But the point is, how are you going to find out about it. You are talking, perhaps, as a phychiatrist, but let us take doctors in general. How would you find out about these things. Is it strictly at conventions? How many doctors can go to conventions?

Dr. DAVIDSON: I do not know the percentage but a substantial number do. They certainly read journals. Many of us are members of the Canadian Medical Association. We get the *Canadian Medical Journal*, and most, I think, subscribe to a number of journals. This information is available. Where they could really get the information is something like the *medical letter* published in the United States. There is no advertising at all.

Mr. MACKASEY: It is published by whom?

Dr. DAVIDSON: A group of physicians and pharmacologists. It is a non-profit organization which is mentioned in the Kefauver hearing and in Mintz' book. It is entirely financed by subscriptions and it provides very objective articles on new drugs and all drugs. It is an excellent publication. But because it costs money its circulation is limited. The physician has to subscribe.

Mr. MACKASEY: Now, let us get down to the detailman. Your description of the detailman is at such odds with what we have been hearing from the company representatives that I am confused. I did bring out through questioning that with very rare exceptions the detailmen are on a salary rather than on a salary and a bonus or on a commission. Either the witnesses have been lying to us or there is some confusion because they have all emphasized the high degree of integrity of the detailmen and also the basic education. They emphasize they have so many university graduates and—

Dr. DAVIDSON: Well, naturally they have emphasized that. There is no doubt that some are university graduates but many are university dropouts. You will find people coming from chiropractic training, and all sorts of things, ending up as detailmen.

Mr. MACKASEY: I am sorry. Is a university dropout necessarily bad? Before you answer it, I happen to be one.

Dr. DAVIDSON: I was afraid of that. He is not necessarily bad. He may be a very decent person and very intelligent. He may have dropped out for various reasons. I would like to see these people with qualifications in science. If they knew basic pharmacology they would not get caught by a physician when giving their spiel. Some of them are so naive, they memorize their spiel.

Mr. MACKASEY: Yes, I know what you mean because so does just about every other big industry. They memorize it and if you interrupt them they will start all over.

Dr. DAVIDSON: Yes.

Mr. MACKASEY: I have seen this happen. What have you done to acquaint the company when you run across a detailman and you find him flagrant with his statements or certainly a poor representative of a company, what do you do about it. What have you done about it?

Dr. DAVIDSON: I have written on occasion and I have told the detailman, myself, that he did not know very much about the subject and I would rather not see him unless he did a little more studying, unless he gets something really worth while to sell. I have a select group of detailmen who come and visit me now.

Mr. MACKASEY: Do you notify the company?

Dr. DAVIDSON: On occasion, where there is something really flagrant. The Maney's promotion to me was one of the most disgraceful things I have ever seen. The detailman came to me and said: "Look, doc, this is great stuff for psychosomatic disorders." And I said: "Is that so". And he said: "Yes, Professor So-and-so of your university has endorsed it." And I said: "Is that so, I did not know that." Now, this product was marketed with, I think, only four references which were all from one symposium. It happened to be that this doctor they referred to had done a study on Maney's. He had supervised the study done by five clinical research facilities in Toronto. Now, I happen to have the memo; I got a copy of it. In summary it said: "Your product is not much good and it has some unpleasant side effects." They said "it might have application to psychosomatic disorders". Subsequently, the product was marketed as a psychosomatropic agent. I will have to spell that one later. But a psychosomatropic agent and very colourful advertising. It covers four pages. Here is the blood pressure cup, and this is a brochure they sent out, but I think as many as four pages in journals, very impoverished bibliography, and I said, "where is the evidence" I kept on writing them. "Your detailman told me that one of your people endorsed it. Where is the evidence of that?" They never gave me any evidence and then they encountered some blood disorders with it and withdrew but I felt here is a detailman who has been misinformed and he should have gone back and said, "Look, I am not going along with this any more." Nothing happened.

Mr. MACKASEY: I agree with you. Did you contact the Food and Drug Directorate?

Dr. DAVIDSON: No. I did not. I wrote a letter to the Canadian Medical Journal which I never sent. I had to fit my studies into a certain context. I was trying to get my certificate in psychiatry at the time, and the doctor concerned happened to be one of the examiners, and the product was off the market. It satisfied me for the moment.

Mr. MACKASEY: Your brief, if I were to sum it up, is a rather strong condemnation of the medical profession in general and I applaud you for having the courage of your convictions. Not being a doctor I cannot pass judgment on the validity of your argument, but I am rather concerned about, I should not say, cynical approach, but at least your analysis of the ineffectiveness of our Food and Drug Directorate. You did qualify it by saying they were underpaid and that there were not enough of them. I presume pay is one of the reasons there is not enough of them but once they are attracted to the directorate, do you not think they are fulfilling their role? Would you not say those that are now in the employ of the government under the Food and Drug Directorate are fulfilling their function properly?

Dr. DAVIDSON: To the best of their ability. I think perhaps I was unfair in saying that we need people of talent, imagination and administrative ability. I think that was probably unfair. I am sure we have those people. I know we do, but they are overworked and understaffed and underpaid. I have been told by one authority in Toronto that they had a very good scientist here in Ottawa who was getting $10,000 a year. He was given an offer from the American Food and Drug Administration to go for $17,000. He said he would have stayed here for

$13,000. The American Food and Drug are doing a little reading right now apparently because they have had to make a vast increase in their division to meet the requirements of the Kefauver bill.

I have been critical of our Food and Drug perhaps unfairly, because I do feel that they are overworked. I remember Dr. Murphy talking about the examination of a new drug application. A new drug application is about 17 or 19 volumes and I remember he was asked, "What do you do with that, Dr. Murphy when you have got it there before you on your desk?" He replied, "I call my secretary and we both carry it from there over to there." Now everyone laughed, but how can they analyse in detail all this information. With a product like Monase do they ask psychiatrists for an opinion whether or not it should be marketed. I think if they had it would never have been sold here.

Mr. MACKASEY: But reading between the lines you have more or less implied that they could always find a psychiatrist who would approve or disapprove of anything. This has been the basis of your brief, that the medical profession or some of the doctors at least, have prostituted themselves.

Dr. DAVIDSON: Well, I think you can always find people who will approve or disapprove but I was thinking of academic. I think there should be a close relationship between university departments of therapeutics and the Food and Drug administration. There is to a degree already but they should know they can phone somebody in Toronto or Montreal or Winnipeg and send along material and get his opinion right away. They should have people right on their on staff who know all the intricacies of the double blind clinical research method, and they should require that when an application is made.

Mr. MACKASEY: In section 1.4 you say "perhaps the Kefauver hearings were unfair to the industry when abundant evidence of medical irresponsibility or inability was presented." Do you think the Kefauver hearings were unfair to the industry, or not?

Dr. DAVIDSON: Well, they were but I think that you have done the same thing in one way. All the headlines, mark-ups, 2000 per cent, and that sort of thing. If you quote figures on mark-ups from basic costs you can get these figures whether it be a generic manufacturer or an ethical manufacturer.

Mr. MACKASEY: That is right.

Dr. DAVIDSON: You see you did this here last week, I think.

Mr. MACKASEY: I am glad you brought it up. The point I was making is that at least the ethical manufacturer, if we are going to use that term, claims and this is one of the problems of the Committee, at least in its fantastic mark-up that it must reclaim, the money spent on research. This is something the Committee will eventually discuss and decide, but the generic representative who was there admits that he does not even have that excuse in marking his product up. This is the basic difference.

Dr. DAVIDSON: The research comes out to about 6.5 per cent of the consumer dollar according to the figures I have for the ethical manufacturer, 6½ cents. I know this argument is made that research justifies anything, but Senator Kefauver and others have said that it is not good reasoning at all.

The actual cost of the basic materials in the manufacturing can be very cheap. Tolbudamide is a good example. I believe it was basically developed from sulfonamides. Sulfonamides were developed in Germany in the 1930's. The basic techniques must be fairly well known, yet tolbudamide is priced against insulin which is extracted from slaughtered animal pancreas tissue so there must be a great mark-up on it. Phenothiazines are very cheap too, like largactil.

Mr. MACKASEY: Where do all these abnormal costs come from; what are they reflected in? On the stock market if we want to buy shares in Cyanamid or some of these other companies we are all free to do so. I do not see them skyrocketing. They may have at one time when they came across something good. But where does all this money go to? It comes back in taxes, I presume, and the dividend rate is not that high.

Dr. DAVIDSON: Well, in the Kefauver hearings they maintained that the profits were ploughed back into development of expanded facilities, capital development, or whatever you call, it. I am getting into economics here. I am not familiar with this field but, basically they increase their plant with profits and Kefauver said in other industry they would increase their plant by selling more shares, not by charging it to the consumer.

Mr. MACKASEY: That is where it goes but it should show somewhere on the balance sheet. That is the disposition of the profit. The balance sheets we have been getting here have not shown that abnormal profit. They have shown a healthy margin of profit.

Dr. DAVIDSON: Ten per cent, is it not?

Mr. MACKASEY: Yes, but soft drinks show 14 per cent. Which is more important?

Dr. DAVIDSON: You can always find examples higher. They claim 10 per cent on the average but some companies have gone up I think, almost to 50 per cent.

Mr. MACKASEY: Well, that was back in the fifties, according to the Kefauver report.

Dr. DAVIDSON: Well, I know you can make a nice balance sheet that will show anything. I think a lot of their sales go into advertising and other things. I do not know where their profits go but their stocks certainly sell well and it is very interesting. It mentions the contraceptive manufacturers had their stocks go up when the Pope was supposed to make an announcement on the Catholic philosophy of the contraceptive pill.

Mr. MACKASEY: He has not too many shares because his announcement was not the most satisfactory for the stock market. It has driven the prices down.

Dr. DAVIDSON: Yes, it drove the price down, but it was interesting that such a thing could affect the market.

Mr. MACKASEY: At 2.7 you say we are possibly more careful about safety and efficacy. We allow compulsory licensing but our controls are substandard. Controls of what, of the person that gets the compulsory licence or the controls of safety?

Dr. DAVIDSON: I am sorry. Which section?

Mr. MACKASEY: Two seven.

Dr. DAVIDSON: That is introductory.

Mr. MACKASEY: Yes, but it is in there.

Dr. DAVIDSON: Section 2?

Mr. MACKASEY: Section 2.7.

Dr. DAVIDSON: Our controls are substandard. Well, I am referring back to the fact that many questionable ethical products appear to be marketed despite the control systems.

Mr. MACKASEY: Who allows them to be marketed, the Food and Drug Directorate?

Dr. DAVIDSON: The Food and Drug Directorate, and I think the professions.

Mr. MACKASEY: I know Mrs. Rideout wants to ask a few questions, and I have just a few short ones.

On the next page you refer to Mr. Condor the chief apologist. Is this rather a loaded reference or weighted reference to Mr. Condor?

Dr. DAVIDSON: I am obviously not very friendly toward Mr. Condor. He left the P.M.A.C. I think basically his role was that of a propagandist. Two examples are given here, I think he was very foolish, to do this in an inquiring position, because at the particular time, 1957, there was some unrest in the United States and I am sure that the industry and its official body had some better figures than the American Medical Association. They have better sources than that.

Mr. MACKASEY: Your description of a successful drug on page 3.7, is rather intriguing. You have the criteria for a successful drug; "partial or slight efficacy, multiple supposed applications," and so forth. You bring our good friend the placebos, in fact, into it, yet despite all these things they can obtain permission from the Food and Drug Directorate to be marketed and sold in Canada.

Dr. DAVIDSON: Yes. This is quite possible. These references were all researched very carefully. Before anyone criticized me, reference 12 happens to be me. It was my one and only article; but you will find many references in that article I am not criticizing you; indicating—

Mr. MACKASEY: I am just trying to get some information.

Dr. DAVIDSON: I thought I would anticipate it but I quoted many people on this subject in my one article. Yes, drugs can get by that have very little effect. Take meprobamate, Miltown or Equanil. That is a good example. Frank Berger, an American physician researched mephenesin which is a muscle relaxant drug. He researched it in England before he came to America and he thought it might be useful for neurotic conditions so they did a double blind and found it was no good. He got a slight molecular manipulation, meprobamate. He sent it to two physicians who gave what I call testimonial reports indicating that it was great. Then, Dr. Berger, and I am certain this is correct, joined the company, Carter Products, who make Carter's Liver pills. They have a subsidiary called Wallace Laboratories who sell it, but they pushed that thing with the greatest of vigour. I think eventually there must have been 500 articles on it but there are only a few controlled articles in the whole number. That product got through very easily

and then it was combined with vanacdezine in a combination drug that was called deprol, an anti-depressant, and again that was marketed before there was any published reference.

Mr. MACKASEY: I apologize for jumping around but I am just following the brief, page by page, as I outlined it. In 4.1, earlier in your testimony you painted a rather dismal picture of the form of advertisements used by these companies, yet you go on to praise the house organ of Ciba.

Dr. DAVIDSON: I could have mentioned a number of others but Ciba's *Clinical Symposia* has been published for years and they have a very good medical artist, Dr. Frank Nedder, who produces excellent art work on anatomy and surgery.

Mr. MACKASEY: In black and white?

Dr. DAVIDSON: No, in colour.

Mr. MACKASEY: No, but you took a dim view of colour.

Dr. DAVIDSON: I am trying to be fair. Some of these drug houses do produce good material but they have total control of advertising.

Mr. MACKASEY: In other words, it is unfair to generalize, is it not?

Dr. DAVIDSON: Well, you can always find exceptions to the rule.

Mr. MACKASEY: Both ways.

Dr. DAVIDSON: Sure.

Mr. MACKASEY: This is an exception in favour of—

Dr. DAVIDSON: There are a number of others. S.K.F. has got a good one. I meant to bring these. I am sorry.

Mr. MACKASEY: It is all right.

Dr. DAVIDSON: I left them in my room.

Mr. MACKASEY: Now you get on to another one. At the top end of 4.1, you say:

> A perceptive reader can soon identify those publications captive to industry direction. They usually present a biased viewpoint and sometimes ignore authorship.

Well, certainly the Ciba house organ is a captive of Ciba, is it not? And it does not prevent it from doing a good job, but then you go on and talk about the *Canadian Doctor* as a good example, supposedly published independently and with a medical editorial adviser. I think somewhere else in your brief you mentioned it, you do in 4.3. I will wait until I get there.

> One rarely finds criticism in the industry in this dubious publication but medicine and its leaders are rather constantly glorified. In November 1960, this magazine published anonymously a "factual" essay.

This is the one I think you mentioned earlier.

Dr. DAVIDSON: Yes.

Mr. MACKASEY: In other words, you do not approve of *Canadian Doctor*.

Dr. DAVIDSON: No, I certainly do not because here is a magazine that publishes statements on health needs, medical economies, all that sort of

thing, entirely subsidized by advertising revenue. I know that these particular magazines operate on a very low profit margin and, as they say, they are "walking the tight rope". They have to satisfy the doctor to get their issues, and they have to satisfy the advertisers who pay them.

Mr. MACKASEY: What have they got to do to satisfy the doctor?

Dr. DAVIDSON: Well, they put a doctor, in this case, on the cover of just about every issue. When I say "glorify", I mean literally every issue has a photograph or a painting of some Canadian physician who is a member of some important organization, and they have many articles about how hard it is to be a doctor these days. They have other articles on how to set up a practice and how to buy a house.

Mr. MACKASEY: It sounds very innocent. I am more concerned with the control over the quality of the ads. that go into the book. What you are saying is that the medical profession encourages this thing because of the revenue. This is not the house organ of the medical profession or the medical association.

Dr. DAVIDSON: No. It is far from it. The medical profession have no official relation to this publication other than the fact that a doctor is now editor.

Mr. MACKASEY: What you are saying is that naturally the articles are slanted to please the doctor so that he will support the thing by accepting a free copy and putting it in the waiting room.

Dr. DAVIDSON: That is my impression.

Mr. MACKASEY: You have brought up something a little more important in section 4.3 where you mention,

> Others have objected to the "clouded parentage" of publications such as *MD of Canada* and have claimed that this journal channelled $250,000 to a division chief of the American FDD Antibiotics division.

I suppose this is hearsay.

> John Godden contends that *MD* and similar publications are supervised by a "dummy board" of eminent physicians who are never consulted. Clifford Scott, a Montreal psychiatrist, expressed concern about anonymous authorship in a subsequent letter to the CMAJ.

That is the Canadian Medical Association Journal.

Dr. DAVIDSON: That is all taken from an editorial by John Godden who was then head of the east coast medical journal.

Mr. MACKASEY: In Canada?

Dr. DAVIDSON: East coast, Canada, Nova Scotia Medical Bulletin or something. Actually this was in the Kefauver hearings and in this book it referred to the apparent kick-back to the food and drug divisions antibiotics chief. Talking about "clouded parentage", it is alleged in these books that the MacAdams agency of New York owned these MD publications and when they were criticized they unloaded it to Peggasis Press. I am sure if you check the Kefauver minutes you will find that they have quoted their references very carefully and so far as I know they were not sued.

Mr. MACKASEY: Not being a doctor, I am rather appalled at the suggestion here that the medical association does have its own house organ, if you want to call it that, and is so badly in need of revenue. Surely you people are fairly numerous in Canada and certainly you are not exactly suffering from lack of income. It seems to me you can finance your own medical association without dubious practices such as you have suggested here.

Dr. DAVIDSON: Let us be clear about this. The medical associations have nothing to do with MD publications.

Mr. MACKASEY: But I am on another one.

Dr. DAVIDSON: The *Canadian Medical Journal* at section 5.5.

Mr. MACKASEY: That is right.

Dr. DAVIDSON: Yes, we pay as much as $100 a year, I guess. Some physicians pay $100 a year for membership in the Canadian Medical Association and that fee includes the journal, but in actual fact the advertising has pretty well supported the journal for a number of years and now it is, turning a profit. I have serious questions about this because—you know I am not just a disgruntled author; I wrote two articles and one was published but it had to be altered before—

Mr. MACKASEY: Why did it have to be altered?

Dr. DAVIDSON: Because I referred to Carter's liver pills. They thought it was an unpleasant thing to say. It was interesting but unpleasant and they did not like me to mention that Carter's liver pills and Miltown were related, you see? Now this actually was edited out or toned down before it ever got to the Journal. I hardly recognized it. Once it got to the Journal they asked me to take out two references to the industry after they had accepted it.

Mr. MACKASEY: Did you take them out?

Dr. DAVIDSON: Yes, I took them out.

Mr. MACKASEY: Well do you think your code of ethics is any greater than theirs? If I was writing an article I would be damned if anybody would take anything out of it.

Dr. DAVIDSON: Well, I will tell you, you have to be a little practical. This was a work involving considerable effort and it was a good article. I presented it to the Journal Club at the Toronto Psychiatric Hospital and I desperately wanted it published. The readership was fascinating. I got requests from Yugoslavia and Russia and Australia. I wanted this article published so I was willing to make a few alterations because they did not detract from the general theme. But the second article that was refused, contained much of this plus a good review article on tranquillizers and antidepressants. Now they did not argue about the review article part. They said it was good but they said we cannot take another attack on the industry.

Mr. MACKASEY: Well. Mr. Chairman I have still a few more questions, if you do not mind. In your conclusions and recommendations you say "government, medicine and industry have not protected the prescription drug consumer". This is, of course, what we are out to find and I am glad you agree with us.

> Government control has been erratic, impulsive, expedient and inadequately enforced.

When the Food and Drug Directorate people are here we will have to hear their side of this.

3. Legislation and its enforcement must be strengthened to force industry to curtail promotional and marketing excesses.

But, you already said you would not cut back to a percentage figure.

Dr. DAVIDSON: If you follow that through in section 7.5 there is proposed legislation.

Mr. MACKASEY: I am coming up to advertising. I will leave that until I get there.

4. Good pharmaceutical research must be encouraged by the government.

I thought we were because further on you say we spend nearly three times as much as the industry.

Dr. DAVIDSON: On basic medical research, we have spent three times as much as industry, according to this particular report which is dated 1958. I do not know how valid that is now. I am talking about pharmaceutical research, research into drug treatment.

Mr. MACKASEY: We cannot do this research independently.

Dr. DAVIDSON: Well, there is the National Research Council. There is a special medical research division, I believe, and I think more money should be directed there to produce an equivalent of the National Institute of Health in the United States. The kind of work they do down there—for instance, they sponsored a study by Loringer under which he sent out two placebos to a hospital two batches. He said these are new drugs, one is a tranquillizer, one is an antidepressant and here are placebos, so you can do a controlled study. We want you to do uncontrolled and controlled studies on these two new products and report back in a year's time. He said do not treat your most seriously ill patients with them. In the uncontrolled studies they found they had a good tranquillizer and a good antidepressant. In the control study they found they had very little effect beyond the usual initial placebo effect. So, they said that if these products had been named Quietel and Moodex, they might soon constitute welcome additions to our clinical armamentarium, or clinical supply of drugs. This is sponsored by the National Institutes of Health. It is an important article and Mintz quotes it in his book. This is the kind of research we desperately need.

Mr. MACKASEY: In 7.2 you state:

Canada already has laws covering efficacy and safety. I feel that these should be applied more strictly by a vastly improved Food and Drug Division.

Earlier your emphasis was that they were just shorthanded but now you say:

Increase in personnel is not enough if the top men lack the imagination or required scientific and administrative abilities. New drugs should not be passed unless there is substantial proof of novelty and safety.

Now we have our parliamentary secretary here to the Minister of National Health and Welfare, who has taken this in. Are you saying that the top men lack imagination? And that they lack scientific and administrative ability?

Dr. DAVIDSON: I think this could have been so a little while ago. I am saying, how do they let some of these products get through? They have to approve them. Why, when there is so much good evidence that combination drugs are very dubious in utility and safety, do they allow marketing of more of them?

Mr. MACKASEY: You say all combination drugs are dubious.

Dr. DAVIDSON: Yes; you will find most university men interested in therapeutics will deplore the use of combination drugs.

Mr. MACKASEY: Do you know how many there are on the market in Canada, approximately?

Dr. DAVIDSON: Combination drugs, I have no idea but there are a vast number of them. The problem with them is you have two or three constituent ingredients and you cannot tell which one is working. They may inter-react and you cannot adjust the individual dose, so that they are opposed. They cost more to make, too. Yet, they are still coming through. We have Triavil now, Elevil and Trilifon, why?

Mr. MACKASEY: I continue:

> One part of the Kefauver bill compels the manufacturer to print the generic name of the drug directly under the trade name in type one-half the size. Such a measure would help physicians to relearn generic terminology.

This was also recommended by the consumers' association. Are there any other sections of the Kefauver bill you feel should be implemented in Canada that is not.

Dr. DAVIDSON: I should mention before we go to that the P.M.A.C. code includes the mention of the generic name. The Kefauver bill in the United States says you must have a simple generic name. Sometimes manufacturers will give a very complicated name to their product so the doctor could not pronounce or spell it. If they continue to do that, then I take it the Food and Drug Administration will take a simple name. I do not think we have legislation to cover that. In the United States the Kefauver bill recommends proof of efficacy, proof of effectiveness. We have already had this for some time. I think this should be spruced up so that real proof of efficacy is required. The other thing the Kefauver bill did was to recommend proof of effectiveness on old products. There was a great outcry; this is going to kill us; we will not have anything left if we have to prove our old products. According to Mintz this has not actually been implemented yet in the United States.

Mr. MACKASEY: You may feel better to know that the new director of the food and drugs in the United States recognized that it has not been done yet but he sent out a directive about a month ago giving the industry two years to implement this.

Mr. O'KEEFE: Is it being done in Canada?

Mr. MACKASEY: No; I do not know how far back ours go.

Mr. O'KEEFE: Is it being done in Canada?

Mr. MACKASEY: You ask me if it is being done? No, it is not being done that I know of.

Dr. DAVIDSON: I do not think, retrograde proof of effectiveness is done here at all.

Mr. MACKASEY: Now at 7.6 I quote you again:

> I see nothing wrong with compulsory licensing if the product originator gets a fair licence fee for his invention.

Now, they said the same thing, of course, the P.M.A.C. This seems to be the bone of contention, how do you calculate a fair licence fee. Then you go on:

> The Hilliard Committee report seems to penalize the generic manufacturer by requiring him to make an elaborate and costly new drug application when continued proof of efficacy, quality control and safety should be all that is necessary.

Why should not a generic manufacturer—

Dr. DAVIDSON: Actually, in looking that up again, I think the Hilliard Report does not exactly recommend that but the weakness in it that I see, is that all drug manufacturers have to make a new drug application if they have a new process. To the ethical people this is great because to them—I think this is the way they are reasoning—any manufacturing process other than their own is a new process. So if someone wants to make Miltown, even if he buys it from somebody in Montreal—

Mr. MACKASEY: If he buys the raw material?

Dr. DAVIDSON: If he buys the raw material. Now, that is the raw manufactured material, not the contributing chemicals necessary. Even though he buys it, and all he has to do is pound it into a tablet and have quality control to make sure that it does not have any irritants or toxic chemicals, and that it meets certain standards of dosage, even though that is all he has to do, he has to make a new drug application with animal testing and human testing. Well, there will not be a generic manufacturer left in a year if it is interpreted that way.

Mr. MACKASEY: Well I had a generic representative on this—excuse me Mr. Chairman—the Committee had before it a gentleman representing Empire who is unfortunately deceased. We discussed this particular point. He assured me, and it is on record for posterity, that with respect to the end product, the pill, the tablet, the disintegration rate of that particular pill after it is hammered into a pill, as you mentioned, was not important. I then quoted to him case after case after case of people who took tolbutamide or its generic equivalent or insulin, and found that the thing did not disintegrate in the normal period of time, and therefore would pass from the body, and of course the patient went into a coma where acetone set in. He still stuck to his guns that it was not important. Now, surely to goodness you can change the value of a product even in going from the manufactured raw material to the dosage form?

Dr. DAVIDSON: Yes you certainly can. Now, I think he was foolish to argue that point because there was a very good example, tolbutamide. And I believe that actually in the experiment done on it they took the same pills and passed them through the same volunteer three times. Now, it sounds rather revolting but it proved the point that it was not absorbed. The trouble is that that story has been around the profession for years. That is an example. There are such examples of poorly manufactured generic products, but there are also some of poor ethical products, too.

Mr. MACKASEY: I quite agree. The only reason I used this is to emphasize, or, at least state the argument that just because the copiers' product comes from the same raw material, it does not necessarily mean that the drug is going to be identical. It could be a better product by the time it gets to the people.

Dr. DAVIDSON: Well, the way you get around that is by having a good federal-provincial system of control; government quality control. Random batch testing, requiring the manufacturers to prove as much of this as possible, that the drug is actually available in the body.

Mr. MACKASEY: Let us get back to the new drug application which you admit is costly. Certainly, it was costly when the drug was first brought forward. Is there any reason why the copier should not at least absorb some of the cost? He is benefiting by this new drug application.

Dr. DAVIDSON: Well, no, let him absorb the cost, that initial cost, by paying a proper license fee. I know it is hard to figure out what is proper.

Mr. MCKASEY: But the licence fee, as far as I can gather, is not based to take this into consideration. It is based just on the dollar value of the original substance.

Dr. DAVIDSON: Oh, no, I think that you will find in the—oh, one of the Canadian hearings; I cannot quote the exact one—you will find that, actually your own. Did not the P.M.A.C. give an example? One manufacturer explained its problem in being forced to license to another, and how research was computed at a certain level. I think it is in you—

Mr. MACKASEY: Last week, or two weeks ago, again a representative of Empire, the Chairman pointed out that the royalties on a copier's submission to reproduce, I think, Valium or Librax, I forget which, would have been only $18.00 on a kilogram.

The CHAIRMAN: It was calculated at 15 per cent of the cost of the bulk product—

Mr. MACKASEY: The product in this case, I think, was $68.00. Fifteen per cent of that was about $10.00, which would have simply brought the cost to the copier to the ridiculously low figure of $80.00.

Dr. DAVIDSON: Well, I agree that it is hard to estimate the research expenditure—

Mr. MACKASEY: Yes, but your recommendation, and I keep coming back to it, is that the poor generic manufacturer is being penalised by the Hilliard committee report in that he should submit a new drug application.

Dr. DAVIDSON: My feeling is that he should be subjected to the same quality control as the other manufacturers. He has to prove that his product gets into the blood and gets to the target organ, just like the ethical product. I think that is all he should have to prove—well safety, and you know—

Mr. MACKASEY: Does he prove this through a new drug application?

Dr. DAVIDSON: No. All a new drug application shows is that he gave it to a hundred guinea pigs and thirty died, and a hundred humans and so many lost their hair, or whatever it is. A new drug application is an expression of experimentation on animals and humans, and I do not think that this is really necessary—

Mr. MACKASEY: What I really meant was, he is just simply not bringing over a sample of the material which he succeeded in getting legally from the originators. He has got to bring it over in dosage form.

Dr. DAVIDSON: Bring it over—

Mr. MACKASEY: Well he should bring his end product along with his clinical testing.

Dr. DAVIDSON: Oh, yes. Well, in my view these products should be monitored all the time by federal and provincial agencies. In other words, I am saying that governments should guarantee generic equivalency by inspection of plants and by monitoring product quality from time to time.

Mr. MACKASEY: One last question Mr. Chairman.

The CHAIRMAN: Well, before you do that, I think we should make one point of clarification that the testimony of the witness you referred to was before this Committee on its hearings on safety, and is certainly not in the evidence and the minutes. I am sorry. I just wanted to bring that point out.

Mr. MACKASEY: I was intrigued with and appreciative of the bibliography in the back here. Some of it however—and I can well understand why you have not gone into some of a later date—goes back into the fifties, and I am just wondering if it is all relative any more, whether a lot of it has been updated or whether any of these sources of reference are now obsolete, in view of the fact that there have been a lot of changes and a lot of legislation brought in.

Dr. DAVIDSON: Well, I think really I covered that at the beginning. In my view the change is not that apparent. There are certain changes, that have occurred. For instance, there are not as many new drugs. The industry tells us we have not had much luck recently. Well, the reason for that is they have to prove their products are effective, Kefauver bill. So we have benefited there.

The criticisms of advertising. I think that drug advertising now is somewhat more responsible, but you see, in Canada there is no law about advertising, in the United States they have a law now. In Canada, the manufacturers have adopted their own code of honour, and they say "we have a code now as of January 1966" well, that is a matter of opinion. Now they say, "Are we not nice, we have got a code of honour". Well, they had to have a code of honour because they get their advertising, some of it, from the United States, where it has to meet the Kefauver requirements. So all they are doing is giving in to necessity.

Mr. MACKASEY: Do the doctors have a code of honour, too?

Dr. DAVIDSON: Well, we certainly do. It is not actually legal, you know—

Mr. MACKASEY: It is not as effective, obviously.

Dr. DAVIDSON: I do not know when I talk about doctors being—sure there are examples I could quote from the literature about unethical practices. I think a lot of this is quite unwitting and unconscious. Doctors feel sorry for the manufacturer, you know, he has got the government on his tail, and they are worried about him because they feel the same thing, and the kind of argument I hear is that boys will be boys, you know, and this is business. They seem to identify with some of the more rascallious elements in the industry, and get a little kick out of that, but I do not think the great proportion of physicians is unethical. I do not think they know.

Mrs. RIDEOUT: Mr. Mackasey has not covered all the questions I wanted to ask, but I have forgotten the ones I had in mind. I would like to say, Dr. Davidson, that I count myself as one of the consumers of this Committee. I certainly could not even begin to pronounce a lot of the names of the drugs that you have mentioned. Reading your brief, I cannot find you saying anything nice about the drug companies or practitioners or pharmacists and I sort of feel that you must like some of them. I feel that we have to be fair and they have made a contribution and certainly the statistics today show humans are living a lot longer than they did 25 or 30 years ago. I have to think that some of the credit goes to the research and work of drug companies and doctors who prescribe their drugs and pharmacists. My pharmacist is as close to me as my family, I trust him implicitly. But I find a great distrust of these people in your brief.

Dr. DAVIDSON: I admit right from the very beginning that this is biased and loaded. But I think the manufacturers have presented an equally biased and loaded presentation, and I have emphasized here to the point that it appears rather extravagant in places, but I felt this was necessary because this is called an inquiry but in a way it is a trial. There are people who represent one viewpoint and another viewpoint on your own Committee. It ends up in the old adversary system of the courtroom.

Mrs. RIDEOUT: Oh, yes, I appreciate that. I am just amazed that you are here by yourself. Have you not anybody that shares your feelings that would be here with you as moral support if nothing else?

Dr. DAVIDSON: I have one relative in Ottawa but she is a civil servant and she has to deal with Food and Drugs. Although I am staying at her place she said: "Do not take me".

No, in the professional community there are people who agree with me, but they are reluctant to be associated with this kind of hearing because they feel it is unprofessional.

Mrs. RIDEOUT: It is very daring.

Dr. DAVIDSON: Oh, yes, well I am not going to be exactly popular when I leave here today.

Mr. MACKASEY: It does not bother you, though.

Dr. DAVIDSON: Oh, I like to be liked. I think this is very important. I came here on my own, at my own expense, because I felt this was a vital subject and I know it is caustic and I have been criticized for my caustic tone; this would detract from it. But, I felt it was necessary for someone to take the dissenting view.

Mrs. RIDEOUT: You feel that most of the witnesses we have heard previously have taken the other view and so—

Dr. DAVIDSON: The manufacturers, I think, did a wonderful selling job. Dr. Wigle is a great man for the industry. He presents a very convincing argument, I would say. I was quite impressed by the way he dealt with your Committee, but, I think there is a need for another viewpoint, an opposite viewpoint. Look, it took five pages for this Committee to get consumer breakdown and research costs, pages 195 to 200. I think Mr. Mackasey got the answer finally that it was 7 cents out of 37 cents—no, I am not sure. Anyway, they talked about all the

millions spent in the world, and they talked about the millions spent here but, they did not give the percentage breakdown clearly at all and they were most reluctant to provide it. Well, I think someone else has to give the opposite view and maybe go a little overboard in the opposite way to make the point.

Mrs. RIDEOUT: I am not pleased; I am not being critical, I admire the way you researched this. You certainly must have fatigued yourself going into all the details you have. I would like just to mention section 5.4. You said:

> Organized medicine and the individual doctor seem to identify with the Industry in a common fear of government control. Doctors are extremely uncomfortable about the prospect of Medicare and appear to sense that Industry is fighting a similar battle.

I trust that is a personal opinion.

Dr. DAVIDSON: That is a personal opinion, yes. There is great anxiety here and more so south of the border. I have criticized the Canadian Medical Association here today, but I think they are trying to work with government toward a reasonable solution of medical insurance. They are doing a tremendous job here in Canada, I think, but in the United States it is fantastic. The AMA lobby against medicare and the fear, the irrational arguments, and as one Senator said down there: "Gentlemen, these were the medicare recommendations my father made 30 years ago for America." Then he took some scissors and snipped off half of this long strip of paper and said: "Those amendments have already been enacted in law." That is quoted from Richard Carter's "The Doctor Business."

There is a tremendous amount of anxiety expressed about medicare. I have worked for provincial governments and in a very good province. I think Ontario is wonderful. As far as medicine is concerned, we are left alone. But I find it very provoking when I think I am underpaid and I find that Ontario psychiatrists are getting less than just about any other place in North America. That makes me angry. First of all that we have not grouped together as a body and that we have not bargained for something. I do not think it should be necessary. But, that the government has done the study and has not admitted it. This is the kind of thing we encounter that makes us suspicious, that when you start paying the bill we are going to have great difficulty getting the incomes we think we deserve. We are afraid, I am stating a personal view, that you are going to tell us how to practice medicine.

Mrs. RIDEOUT: That is where you are completely wrong. Just in closing, because I know Mr. O'Keefe wants to ask a question, I am wondering if you have ever visited our Food and Drug Directorate laboratories here in Ottawa and seen things in action there. If you ever have the opportunity I wish you would take advantage of it because I think they are doing a wonderful job under the circumstances.

Dr. DAVIDSON: I have not visited it but I have been told they are doing an excellent job and that my remarks were unfair. Would you not agree that they are overburdened?

Mrs. RIDEOUT: Of course, we are all overworked. That is the name of the game today in our society.

Dr. DAVIDSON: Do you not think health—

Mrs. RIDEOUT: You admitted to being overworked yourself.

Dr. DAVIDSON: I work hard but national health is the question, is it not food and drugs? We seem a little more concerned about having proper roads going to and from Toronto and to and from and over Ottawa. This is the impression I get; that there is less concern about food and drugs here than in the United States. In the United States they had them housed in wartime housing temporary buildings until recently.

Mrs. RIDEOUT: I do not think the public generally realize the amount of work done by the Food and Drug Directorate and I think that probably there is a lack of public relations there. But, I would just ask you, if you have a chance, to go out and see them in action and you will be impressed.

Dr. DAVIDSON: I would very much like to do that. I think the kind of thing that bothers me is they have the FDC 123 form, toxicity report form. There is nothing wrong with the form but it should have been made in a mailer, so the physician can just fold it, lick the thing and mail it. There should be someone you can phone, someone that a doctor knows he can call.

Mr. MACKASEY: You want the postage prepaid, the doctors cannot afford that stamp?

Dr. DAVIDSON: Prepaid postage, absolutely, that five cent stamp is a real deterrent; these little things, you know.

The CHAIRMAN: I should say there is a doctor someone can phone in the Food and Drug Directorate, I think it is Dr. Napke, is it not?

Mr. O'KEEFE: Mr. Chairman, I will not take very long but to get back to the cost of market overload at paragraph 4.6. You say:

> It is not easy to quantify (in dollars) the cost of market overloading with drugs of dubious novelty, utility or safety. The cost must be phenomenally high, but there is another cost more evident to the perceptive observer—new diseases caused by drugs.

Would you give the Committee one or two instances and one or two names that we can understand of diseases actually caused by doctors prescribing drugs.

Dr. DAVIDSON: There are many. In general, estimates range from one in ten to one in every 20 hospital admissions. Someone has a sickness that is partly related to the use of chemicals.

Mr. O'KEEFE: Could you name some.

Dr. DAVIDSON: Specifics, yes, parnate blood pressure—if the blood pressure goes high enough and a person has fragile blood vessels in his brain, he will have a stroke and die. This has happened, an excruciating headache, the loss of white cells from the blood. White cells are necessary to combat infection. Many drugs produce this. It is rare; sometimes one in 100,000 patients. Nevertheless it occurs and I have personally seen a patient have this. He recovered only because we caught it in time.

Mr. O'KEEFE: How could you be sure that that particular disease was caused by a particular drug?

Dr. DAVIDSON: That is a good point. It is relatively rare without drugs. But with this incident, it is a good point. It certainly is a belief held by many

physicians agranulocytosis. White cells loss is related to the chemical. This is seen occasionally. Heart attacks: the tranquillizers of the largactil chlorpromazine family, antidepressants of the tofranil family. They are actually very closely related chemically. They drop blood pressure. A person who is starting to fail can have a coronary when his blood pressure drops. The industry talks about the number of people who have recovered in mental hospitals as a result of their drugs. The death rate of the elderly has gone up substantially since the drugs were introduced. There is definite factual evidence that Tolfranil produces a higher chance of coronary attack. Liver disease, skin disease; there are many illnesses that can result from drugs that are in use. Now, a doctor takes these drugs and he has to balance advantage against disadvantage. It is a calculated risk. Sometimes the advantages are not sufficient to take that risk, in my view.

I do not use that many drugs—I do not prescribe that many, but I have run into side effects that had fooled me, and, I think I know something about drugs used in psychiatry. I sent a man to a general hospital because he had had a stroke and they said that there was nothing wrong with him and they sent him back to me at the hospital where I was working. I sent him back again and said: "Look at him carefully, I know what I am talking about." They said: "We cannot find anything wrong with him." I realized, to my horror, that it was a form of dystonia—spasm of the neck muscles due to Trilifon.

Mr. O'KEEFE: Are you sure of that?

Dr. DAVIDSON: Yes, it could not have been anything else. This was the conclusion that they reached as well. I knew Trilifon very well. I even worked with the company that sold it at one time, and here I had missed this. I was afraid this man might die. Now, just in the last year I had a lady on parnate. I warned her about old cheese and cold remedies. She went home and she had an awful headache and I could not figure out what had gone wrong; I had warned her. Then I realized she was an asthmatic and that she took the same adrenalin type compounds for asthma. They interacted and pushed her blood pressure away up. I think I know something about this field yet I have been caught a number of times and I wonder how often this occurs.

The CHAIRMAN: I was going to say that I think in general practice one of the most common allergies would be to penicillin. Anything from a minor skin rash to instant death is caused by penicillin.

Mr. O'KEEFE: Mr. Chairman, you are talking about allergies, but new diseases caused by drugs is a frightening phrase; at least it is to a layman. That is why I wanted to be specific about this particular point. I will not ask any more questions; I will leave it at that.

Dr. DAVIDSON: Moser is a very good authority. He writes a column called "Diseases of Medical Progress." It is a very good journal on clinical pharmacology and therapeutics.

Mr. O'KEEFE: It will not be in the Ottawa *Journal* or the Ottawa *Citizen*?

Dr. DAVIDSON: I am afraid not.

Mr. O'KEEFE: Or even the *Globe and Mail*?

Dr. DAVIDSON: Moser has a regular column pointing out how many diseases are due to drugs. There are some very extreme examples which I have not mentioned here. The Meritran 29 and thalidomide; everybody knows about them. Meritran produced loss of hair and cataracts of the eyes. It produced it in experimental animals and it was not reported to the Food and Drug Administration in the United States. The Merrell Company were sued and last week a victim received more than $1 million. These things happen. I think those are diseases.

Mr. O'KEEFE: Thank you, doctor. I commend you on your courage.

The CHAIRMAN: Do we have any other questions?

Mr. LAIDLAW: I have some comments I would like to make to Dr. Davidson. Dr. Davidson, at the consumers' association hearing the other day Dr. English, their economist, suggested, if I understood him correctly, that if the Committee made only one or two simple recommendations without going into a packaged recommendation he would doubt very much if the prices of drugs would come down. Now, your area here, in so far as prices are concerned, really concerns promotion and over promotion. Dr. English went on to say he felt that prices would not come down unless the drug industry as such became more efficient. Perhaps, the way to make it more efficient was to introduce more competition into the industry. Have you given this any consideration or do you feel that this is outside your brief?

Dr. DAVIDSON: Well, competition—they use the word differently from all other forms of industry. There is very little price competition in the prescription drug business, but there is intense product competition. You will have five products all competing with each other for the same disease. In fact, they have to invent diseases sometimes to use the products, like the psychosomatic thing in Maney's. It would be very nice if you could get the industry to compete, but they are following what Kefauver called the administered pricing concept. The product category leader sets the price and others follow. This is not price fixing according to any combines act because they do not sit down at a table and decide prices but it is basically the same thing, is it not? I am not an economist, but if the leader sets the price and the others follow, it is just a variation of price fixing, in my view. It is true that prices sometimes come down in the time but not too often.

Mr. LAIDLAW: Dr. Davidson, if the laws were changed to permit importation of drugs into Canada under regulation of the Food and Drug Directorate what would your view be on that with respect to the eventual pricing of drugs in Canada?

Dr. DAVIDSON: I am sure the price would come down if advertising were restricted on ethical products. If the industry's—when I am talking about industry, of course, I am talking about ethical manufacturers—if their views about drug economics are challenged and disproven; if the doctor feels that he can trust the generic product imported, then I think prices will come down. You see, the hospitals have been buying generically for a number of years. Some hospitals in the United States have been buying for 50 years.

The American Military Supply Agency has been buying generically, and when they did the ethical producers in the United States matched the price. The

way the patent is set up here, and in the United States, a manufacturer may get patent control and prevent the others from importing; the use of patents for monopoly. I am trying to think of an example. I think chloromycetin, but I am not sure. I think Parke-Davis got exclusive patent control of chloromycetin in the United States and Canada. Then, they went to the American government and said: "Look, we are being underpriced by imitators in foreign countries." I understand, I think it is from Mintz, that the American government made representation through its embassies in foreign countries to force other manufacturers of chloramphenicol to be licensed by Parke-Davis. So not only do they patent their own North American continent, of which we are part, in their empire, but they also have control of other countries. It is fantastic.

Mr. MACKASEY: There is one question I would like to ask, sir. You mentioned that generic prices are going up—the gap is closing. Do you have any reason for this statement other than that it is going up, the gap is closing. Do you have any reason why this is happening?

Dr. DAVIDSON: I do not know. I know that they have had to do more thorough quality control in recent years, but quality control is really a very little part of the total amount. I do not know why their prices are going up but I find this upsetting. In the United States at one time on reserpine, which is a tranquillizer actually discovered in India but marketed by CIBA, the generic price was $2.96 a thousand, I think, and $29 and some cents at CIBA. At one time there was real economy but I am a little alarmed that generic prices seem to be increasing, from what I am told. I think you heard that here. I do not know why; they are not advertising that much more.

Mr. MACKASEY: Will you not have an uncomfortable feeling therefore that generics in a sense are making as much money—in view of the fact that they do not advertise, in view of the fact that they only sell to a limited market, in areas of heavy population and to hospitals, would you not say that generics are making an abnormal profit as well as the—

Dr. DAVIDSON: I do not think you can make that judgment on the selling price. You would have to get their breakdown on the consumer dollar.

Mr. MACKASEY: We had a rather pathetic breakdown. I say this because —you can look at the balance sheet in the one submission they gave us. If you do not have it, I am sure we can get it for you before you leave. They go on to say that they spend nothing on research, and they spend nothing or very little on detailmen, and that their cost of marketing is about half of some of the other firms.

Dr. DAVIDSON: I am sure you are referring to Empire Laboratories.

Mr. MACKASEY: No, this was a brief of a new association; they have incorporated and are setting up their own code of ethics.

Dr. DAVIDSON: Was it not Professor Wright of Toronto who came to speak about a new organization but complained that he had been quizzed about his own company?

Mr. MACKASEY: Let us say he volunteered. He came in conjunction with a Mr. Dan who was president of this association and also a very fine person who was in the generic field. The fact that Mr. Dan has dissociated himself from some

of the statements of Mr. Wright is not the fault of the Committee. They came here representing the generic firms in general.

Dr. DAVIDSON: I have forgotten what the original question was.

Mr. MACKASEY: The original question was: Why do they not advertise as heavily and have so very few detailmen?

Dr. DAVIDSON: Are they making a great profit? I think you would have to take the whole industry and do a cost analysis. They should do that just, as the P.M.C.C. has done. Then you can tell whether they are making exorbitant percentage profits and total profits. I will be very surprised if they are. In the United States, S.K.F. has been really doing well for a number of years on chlorpromazine.

Mr. MACKASEY: I would say in the mid '50's in their formative years, they regained their capital fairly quickly.

The CHAIRMAN: On behalf of the Committee, I would like to thank Dr. Davidson for coming today, as he says as an individual, and giving his views. We have another witness this afternoon from the *Medical Post,* which is one of the publications that comes to the doctors free of charge. It is not mentioned in the brief.

Mr. MACKASEY: Before you leave, Dr. Davidson, could we have some information on the *Medical Post*?

Dr. DAVIDSON: It is another one of the para-medical publications. I believe it is sold by Maclean-Hunter.

The CHAIRMAN: I am not sure that it is sold to the medical profession. It comes in the mail.

Mr. MACKASEY: Do you classify it in the same category as the *Canadian Doctor* or one of the others?

Dr. DAVIDSON: I enjoy reading it. It is free. They asked us if we wanted to pay for it and I said "No", but I am still getting it. It is subsidized by advertising, but I have some questions about this. I really have not noted editorial content that was unfavourable to my views I have not noticed any partiality.

Mr. MACKASEY: You are going to wait until next month's issue of all these magazines?

Dr. DAVIDSON: I have a few other things to do.

The CHAIRMAN: The meeting is adjourned until 3.30.

AFTERNOON SITTING

The CHAIRMAN: We will proceed with the meeting. We have with us this afternoon two gentlemen from the *Medical Post,* which is a medical publication I believe you all have a sample copy of it before you. I introduce Mr. Charles E. Wilson, who is the manager of the *Medical Post,* and Mr. Robertson who is the publisher of the *Medical Post* and other publications, from Maclean-Hunter Publishing Company.

Mr. Wilson, we are not going to ask you to read the brief. You might wish to make a comment on it or to summarize it, and then we will open the meeting for questions. We do not expect you to read it; the members should have read it by now.

Mr. CHARLES E. WILSON (*Manager, The Medical Post*): Thank you, Mr. Chairman. We are particularly concerned with the recommendation or suggestion in the Hall report that the pharmaceutical industry be limited to a maximum of 15 per cent of gross sales on a tax allowance basis for advertising promotion, and the implications this would have on a free press.

Our brief outlines the function of the specialized press in Canada, its contributions to specialized readers in industry and the professions; the role of the Canadian medical press—that is a generic term—and its contributions to medicine in the way of an information service and a partial contribution to the continuing education available to physicians.

We outline the financing of publications and all mass media through advertising investments and then, in our opinion, what would be the probable results of an artificially controlled medical publishing economy to the publishers and to the physicians and health services generally.

Mr. Robertson, as a senior executive of our company will, I think, be able to help you with answers to any questions that you might have, particularly at the corporate policy level at Maclean-Hunter.

There are a couple of points which originated this morning that we would like to go over. We will leave this until later in the hope that these might come out in your questioning. We would be delighted to try to handle any questions you might have.

The CHAIRMAN: Thank you, Mr. Wilson. The meeting is open.

Mrs. RIDEOUT: I did read your brief, but that was last week, so I am trying to familiarize myself with parts of it. Do you have to clear advertising of drugs in your *Medical Post* with any federal agency such as the food and drug directorate?

Mr. WILSON: Yes, that is correct.

Mrs. RIDEOUT: Does advertising appearing on television have to be cleared?

Mr. WILSON: I believe that a proprietary medicine advertising has to be approved by the B.B.G. Is this not correct? I am a little out of my depth here, Mrs. Rideout, but I believe for television and radio it must be approved by the B.B.G.

Mrs. RIDEOUT: But I presume you try to stay within bounds to conform to what you feel is correct. Is there somebody who keeps an eye on you?

Mr. WILSON: I think we have a two-part answer to this question, and I would like Mr. Robertson to give you the corporate policy that governs generally all the advertising that we accept in the Maclean-Hunter business paper media. We have some additional safeguards in connection with the pharmaceutical advertising itself, more of which I believe are coming up and on which I can go into a little bit of detail with you. But I think from the point of view of your question you should know our own corporate policy regarding our responsibility towards the acceptance of advertising in general in our divisional level.

Mr. R. W. ROBERTSON (*Publisher, Maclean-Hunter Publishing Company*): We do have a code relative to the acceptability of advertising in any Maclean-Hunter publication. I am sorry that I did not anticipate this question, so I did not bring the code along with me.

Basically it gives us, as publishers, the right to refuse any advertising that we feel is misleading, untruthful, possibly distasteful, and several other areas in which we, as publishers, exert the right to refuse acceptance of advertising. There are some very specific items in there which affect certain proprietary types of drugs; but we are not really concerned about those in The *Medical Post* because we really do not solicit this type of advertising.

On the *Medical Post* itself, as you know, the P.M.A.C. has its own advertising code and its members, we feel, are following this code to the best of their ability. In that sense we feel that our policing there is not required too much, but for non-members of P.M.A.C. we do look at the advertisements and if we feel that they might be misleading or not in line with the code, we have a medical adviser on our staff, and a medical advisory board from whom we can get an opinion; we use as a guide the code that the Canadian Medical Association has set up for advertising. I think Mr. Wilson might have touched on this. The medical publishers are planning a meeting next week to discuss further what areas of control all medical publishers should exert in the acceptance of advertising. I hope that some additional regulations will come out of that.

Mrs. RIDEOUT: If you have followed any of our Committee hearings in our Health and Welfare Committee you will know that we are studying changes in the Criminal Code in so far as the sale of contraceptives is concerned. You have an advertisement in your paper, so you actually are breaking the law. I am probably being facetious there, but I was just interested in what your responsibility is in so far as your advertising is concerned. I am quite sure that television is—am I correct, Dr. Harley—under federal jurisdiction.

The CHAIRMAN: Perhaps Mr. Allmark would like to comment on that, but I think the advertising by news media has to be cleared through the Food and Drug Directorate.

Mr. M. G. ALLMARK (*Food and Drug Director, Department of National Health and Welfare*): Only the advertising that actually appears on radio and television is scrutinized before it actually goes on the air. The newspaper advertising is scrutinized afterwards, not prior to its publication.

The CHAIRMAN: I used "news media" incorrectly. I should have said "television and radio". Thank you, Mr. Allmark we realize you came as a spectator.

Mr. WILSON: May I just make one point on this code of advertising conduct if you will that the P.M.A.C. has instituted and which is self-policing, in this country. This is in contrast to legislative control, as I understand it, in the United States and in even greater contrast to the situation in England where, as far as we can determine, the pharmaceutical advertising is all persuasive and non-informative to the extent that the Canadian industry has decided themselves to handle.

I think Dr. Davidson was attempting to make the point that the Canadian manufacturers have brought up, or made, this code of advertising conduct

because they were bringing into Canada, American advertising which, is true only to a very small degree. Most of the copy is rewritten. The interesting point here is the same companies have subsidiaries in most cases in England and this is still in an English language area. However, the English industry has really not seen fit to do this self-policing that the Canadian industry has done. I think the industry in Canada should get some type of recognition, if nothing else, for what they are attempting to do. That is my point.

Mr. ISABELLE: Is this sent free to all physicians in Canada?

Mr. ROBERTSON: If you like I will answer that Dr. Isabelle. I am glad you asked the question actually because this is one of the points we wanted to touch on because of what we heard this morning on the matter of free versus so-called paid publications. I hope you will not mind if I take a lengthy way of replying to you. The situation in medical publishing in Canada is that to our knowledge there is no Canadian medical publication which operates on a policy of complete voluntary paid circulation. Really, I am stressing the world "voluntary". There are what are called paid circulation publications but these are association publications and the person who wishes to join the association is charged a subscription fee for the official journal so he really has no choice whether he takes the journal or does not, if he wants to be a member. So in essence there is not too great a difference between this type of circulation or the so-called free circulation. I say so-called free because really this is a bit of a misinterpretation. We operate on what we call controlled circulation and our audits of our circulation are through the controlled circulation audit bureau.

There can be both free and paid circulation in the total mix. Now, in the *Medical Post*, when we entered this field, we were competing for the reading time of the physician with all other medical journals which are distributed free to the doctors. So, initially, we have had to provide this newspaper free of charge. As time develops we are working towards converting the physicians to pay for this publication because we believe it should earn some of the physicians money. We do not expect them to pay for the total cost of producing the paper because it would be way beyond reason in the subscription fee. Currently we have approximately 1,400 paid subscribers on the *Medical Post,* that is after slightly more than a year's operation. We expect this to build pretty rapidly over the next few years. I am sorry I took a long way of answering.

Mr. ISABELLE: Thank you, but there are still many physicians who are receiving this edition free of charge, are there not?

Mr. ROBERTSON: Yes, sir.

Mr. ISABELLE: What is the Maclean-Hunter company? Is it a non-lucrative company, or is it a company—

Mr. WILSON: That is one reputation I think we do not have.

Mr. ROBERTSON: Do you mean a non-profit organization?

Mr. ISABELLE: Yes.

Mr. ROBERTSON: We are pretty low on profits but not that low.

Mr. ISABELLE: In other words you are not losing money on the *Medical Post*?

Mr. ROBERTSON: We are currently, yes. It is as you perhaps know a fairly new publication. It was started in September of 1965 and in our planning of this

newspaper we anticipated that it would be a minimum of three years before we could be in what we call a break-even position. So we are still losing money on the paper.

Mr. ISABELLE: So Maclean-Hunter thinks that maybe it would be a good thing in a few years. It is a kind of a loss leader?

Mr. ROBERTSON: Oh no, this is standard practice in the publishing business. You cannot expect to begin a new publication and make a profit on it within your first year. You would be very fortunate if you were able to do this. Normally it takes three to five years to start a new publication and get it to the position where it is beginning to be profitable. Some take even longer than that.

Mr. ISABELLE: May I ask you what was the aim in founding this *Medical Post*?

Mr. ROBERTSON: Our ultimate aim, of course, is to make a profit from this publication because this is our business. We are professional publishers and we are motivated by profits. So this is our ultimate aim. We do have 60 business and professional publications in Canada which cover quite a broad range of interests, nuclear engineering, controls and instruments, papers for retailers and so on. The medical field is one part that we have not served. We felt there might be a place for a different form of medical communication so we spent a year researching this. We talked to a considerable number of doctors about their reading habits, their information needs and from this we could sense a certain frustration in that the doctor is very pressed for time; he has to be very discriminate in the time he allocates to his reading and to his choice of reading. Yet he needs to be kept up to date on important medical happenings that are taking place and important discoveries and advances in medicine. So, from this year of investigation it came through quite clearly to us that there was a need for a more rapid form of communication, a form that was easy to read and brought to the doctor in succinct style the important new events in the medical field which translated into publishing as a newspaper.

Mr. ISABELLE: Is your editor in chief a doctor?

Mr. ROBERTSON: No, he is not. He is a journalist.

Mr. ISABELLE: He is a journalist?

Mr. ROBERTSON: Yes.

Mr. ISABELLE: So, who checks the articles that go into the *Medical Post*? Have you a medical staff to check on that?

Mr. ROBERTSON: We have a medical adviser who checks all copy before it goes into print. This is a bit of an unusual way to operate a medical journal, I agree.

Mr. ISABELLE: Yes, that's what amazed me but nevertheless you said your aim was good, to make profits so I do not think—

Mr. ROBERTSON: I might explain a little further. In our examination of the previous choice of medical reading material available to the doctor, and being conscious of the time problem he has, we realized that there was a place for a different form of writing that was—I do not wish to be sarcastic—less turgid and a little more comfortable to read yet still is a scientific paper. In our estimation

this indicated the writing should be done by journalists, men who are skilled in communicating, but to be sure of the accuracy all copy must be checked by qualified physicians. We do have a doctor who checks all copy. We have a very active advisory board comprised of 19 doctors, covering all major specialties. If our regular medical adviser feels that he is not competent to judge a piece of copy in a specific field, it goes to a member of our advisory board to double check.

Mr. ISABELLE: I think it would be a wise thing if you could put that on the second page. I was looking for it and I could not find it.

Do you intend to broaden this circulation and sell it at large, or sell the editions to people outside the medical profession?

Mr. ROBERTSON: No, sir. That is not our plan at all. This is strictly a paper for the professional man, not for outsiders. We will accept subscriptions, in certain cases for example, from an administrator of a clinic. He might have an interest in reading this paper, if he is directly connected with the profession, and in that case we would accept the subscription, but it is not available to the general public.

Mr. ISABELLE: I think we should commend you for this publication. It is very easy to read and it is quite informative. We will be able to obtain some very good information from it. I have received it for the past two years, and it is about the only medical publication I read, because at one glance you have a picture of what is going on. I think you should stick to this principle even with profit in mind, which is a very natural aim. If you do not have too much advertising, I think it will remain quite a piece of literature which can be easily read by the medical profession.

The CHAIRMAN: Perhaps we should ask if it is also available in French.

Mr. ISABELLE: The other day I asked for a copy of the Toronto *Star* in French, but I could not find one.

Do you intend to publicize something like that in French, or put in a few French pages?

Mr. ROBERTSON: It is not in our thinking to mix French and English together in the same paper. It is sort of a philosophy that we have not to have the two languages in one paper. We do publish in the French language in other fields. At this point, we do not have any firm plans to publish in French. We have had many, many requests to do so, but our feeling was that we had enough on our hands with the English publication to get it out of red ink before we take on any more. Certainly if there is a demand and once we have it more firmly established in a profitable position, we would well consider printing it in French.

Mr. ISABELLE: Is it your intention to pack the journal with more advertising?

Mr. ROBERTSON: It will have to grow in that area, Dr. Isabelle, for us to make this into a profitable publication. It is a fact of life in publishing that your major income does come through advertising and we do need much more than we are presently carrying to come into this position. However, when this does happen, there will be an increase in the editorial space too in the journal therefore, we will not be squeezing out any editorial material.

The CHAIRMAN: I would like to ask a question for my own information. What is the proper ratio between advertising content, editorial content and story content. Is there a figure you work toward, say 25 per cent of the space of your paper or so many lines of space be advertising?

Mr. ROBERTSON: As an objective we should be up in the area of 55 per cent advertising and about 45 per cent editorial. We are a fair bit away from this at the moment, but that is an objective.

Mr. HYMMEN: I would like to ask about the advisory board. These matters are referred to them on a consultation basis, but does the board meet regularly?

Mr. WILSON: Yes; since we started operation in September, 1965, we have had three formal editorial board meetings. Coincident to this I think some reference was made in the brief this morning to the so-called medical editorial advisory board being—I think the implication here was—nothing more than a window dressing. Because of our operation, with journalists doing the actual writing, we need an active medical advisory board and just last Friday the editor of the paper was obliged to send a polite letter to one of our advisory board members who, for personal reasons, had been unable to attend any of the three editorial board meetings that we had, and consequently we had to replace him, because we need the advice in his particular specialty. The answer is yes that we do meet as a board.

Mr. HYMMEN: With regard to the question a few minutes ago, have you set limits on the advertising you will carry in the paper. I mean physical limits not qualitative.

Mr. ROBERTSON: You mean on the volume?

Mr. HYMMEN: Yes.

Mr. ROBERTSON: We have not as yet, no. It is not a problem at the moment.

Mr. HYMMEN: I know this is not a proper comparison, but some of our daily newspapers, particularly on the week ends have a very high percentage of advertising. While it might be a good way of disseminating the information to the doctors, I think you suggested a guide of 45 to 50 per cent.

Mr. ROBERTSON: This is a rough rule of thumb, that in order to be a profitable publication the ratio should be approximately 55 per cent advertising and 45 per cent editorial. As I mentioned, we are well below that level at the moment of this paper, since it is a fairly new publication, but that is a pretty reasonable level. The concern that this might crowd out the editorial section is not too valid I do not think. If this is worrying you, as I mentioned earlier, as the advertising lineage grows, the editorial space will also grow. The size of issue might become a problem conceivably in years to come. However, we do have options available and at such time we could, for example, go to weekly frequency rather than every two weeks which would overcome this kind of problem.

Mr. FORRESTALL: I have a couple of general questions. You say there are about 25 or 30 publications in Canada servicing the medical field. How many of these are under Macleans?

Mr. ROBERTSON: In the medical field just the *Medical Post.*

Mr. FORRESTALL: Who publishes the others?

Mr. ROBERTSON: A good many of them are association publications. For example, I think the Toronto East Academy of Medicine has its own journal, as does the Toronto Academy, and of course the Canadian Medical Association has its journal. The University of Laval has what I believe is called the *Laval Medicale.*

Mr. FORRESTALL: I was not asking you to name all 25 or 30 publications, I just thought Maclean-Hunter might be involved in some of them.

Mr. ROBERTSON: No, it is universities and associations.

Mr. FORRESTALL: A lot of these then would be periodical papers that are produced from time to time each year on—

Mr. ROBERTSON: Yes—

Mr. WILSON: Well, on a regular frequency, you know, monthly or every other month, or weekly.

Mr. FORRESTALL: Is the advertising content in this a product of our Canadian houses; for example, what proportion of the advertisements in here would your staff have been responsible for, or is it agency work?

Mr. ROBERTSON: It is pretty well all agency created material; there is very little of it that we would be called upon to develop.

Mr. FORRESTALL: Not to delve into the secrets of Maclean-Hunter, but are the majority of the agencies Canadian?

Mr. WILSON: The majority of the business being carried in the paper is being placed by Canadian advertising agencies. There are quite a number of American based agencies that are in the paper, but I think we have to look at the volume of advertising, and the bulk of it is coming out of, I would say, Montreal agencies.

Mr. FORRESTALL: I am thinking of the flow of dollars and cents in the industry, for example, was that ad produced in Canada?

Mr. WILSON: Yes, that was produced in Montreal.

Mr. FORRESTALL: As a generality it can be said that by and large the advertising is Canadian content?

Mr. WILSON: Oh, yes, yes most definitely. I think that even in the cases, and this particular issue is just bringing it back to mind, where the advertising has been contracted for, if you will, through a New York agency, the actual art work has originated in most cases in Canada. It is a matter of payment from a U.S. agency. I would say 95 per cent of the advertising we are carrying is developed in Canada to some degree. In some cases there may be some of the mechanical brought in and it has been revised for Canadian consumption. We really do not have our finger that closely on where some of the original photography might come from. For example, to the best of my knowledge, most of the mechanical is done in Canada.

Mr. FORRESTALL: I recognize of course it is a difficult question for you to answer because you do have a motivation that is other than service. Do you think the Canadian drug companies advertise enough, too much, or too infrequently, or are they too confined? Would you remove yourself, if you could, for a moment or

two from your day to day desires to put this on a paying basis and comment generally, because you must be well qualified or you would not be where you are, sir. Could you lend us the benefit of your experience in relation to this?

Mr. WILSON: I would like to make one comment, if I might, Mr. Forrestall. I think your comment was—you correct me if I am mistaken—that we have a motive other than service.

Mr. FORRESTALL: We want to make money.

Mr. WILSON: Yes, most definitely, but,—

Mr. FORRESTALL: Don't be ashamed of that. I think all of us like to make money.

Mr. WILSON: No, no. The form in which we provide the basis for our income, I think, is service. This is in the context of how we edit our publications, and it is a service primarily for the reader. If we satisfy the reader in the service that we are giving him, then the fruits of the advertising will come to us. This is our primary concern of the reader. This is where our major service is developed. I do not know whether that is what you had in mind with that particular phrase, but this is part of our company philosophy. I really do not think I am qualified to give an opinion on whether the drug industry is advertising too much, or too little, or just right. An interesting thing came out of this mornings session. Dr. Davidson, on the one hand, was, I think, decrying the amount of advertising which this industry directs towards the medical profession, on the other hand, he gave a specific example where he had, I think, forgotten one of the contraindications of a particular pharmaceutical with a particular patient. Why did he forget it? Perhaps there is not a sufficient volume of communication with this particular pharmaceutical to people such as Dr. Davidson. We can, each one of us, say that if you tell a person something once, then he should remember it, particularly if it is dealing with his line of business. This unfortunately, I think, is idealistic. The doctor is a human being like anyone else, and I think he has to be reminded; this advertising that we carry is as much, if not more so informative as persuasive. And how necessary is it to get the information of contraindications, precautions, to the medical profession. I just cannot answer it.

Mr. FORRESTALL: It is a difficult question.

Mr. WILSON: It is. I think as an exercise you might take a look at this advertisement on the back page on Norinyl-1 milligram, notwithstanding that somebody might be breaking the law here. There is a considerable amount of copy in here on contraindications, precautions, side effects, dosage, availability and reference. This is all very informative and very necessary for the medical profession to have. And I suggest to you that the extreme to this type of advertising is sending out an eight and a quarter, eleven and a quarter mimeograph sheet once, and that is it, doctor, you have had it and make sure you hang on to it. I think the doctor needs this type of thing. Conditions change with individual pharmaceuticals. These precautions—I hate to take a specific example,—are normal, they may expand by 10 per cent next month. This information has to get out to the doctors; it has got to get out more than once, too.

A doctor is—and I am sure that Dr. Harley will agree with me—on the horns of a dilemma. He has got in a busy practice maybe 150-200 patients he is

seeing a week, on the one hand, and on the other hand, he has got a flow of valuable information coming in to him. His reading time is not really free time; this could be money time to him. He is on the horns of a dilemma. It may be that a particular physician is not even going to pick up this particular issue of the *Medical Post*. There may be some valuable information in a particular advertisement form that he needs for his practice. Hopefully he will pick it up the next time the advertisement is run. That is a long-winded answer to say I do not know.

Mr. FORRESTALL: Yes, I appreciate that.

Mr. HYMMEN: Mr. Chairman may I ask a question? I ask this because we have had so much evidence about the high cost of advertising and public relations. I am looking at this issue, at the double page by Roerig and the insert by Upjohn. This is obviously something that a doctor is not going to stick on the wall, and it is too large for filing. Could you give us a rough idea of what this insert would cost, including the advertising expense, or the expense by an agency in developing it?

Mr. WILSON: I can tell you Mr. Hymmen what the investment by Upjohn is, in the *Medical Post* for that particular advertisement—roughly $1,600. How much it cost to develop this art work, and the film and the printing, I really do not know. I would estimate that it probably cost them around, perhaps $800 or $900 to print and create the thing. This is a very rough estimate, I could be off here.

Mr. ROBERTSON: The advertising agency creates the art work and the copy. This can vary a great deal from one ad to another, the production costs involved and so on, and we as publishers never really know what money is spent, or the expense incurred in an individual ad.

Mr. HYMMEN: Then it would be much less expensive than direct mailing of the same information, although it may not be readily adaptable. Not being in the medical profession, I do not want to get into an involved area.

Mr. WILSON: Well, I think you are right, sir. This is an economical way of getting important informational messages to the medical profession in a very fast and, we believe, efficient form of communication.

Mr. O'KEEFE: Mr. Chairman, from your experience, Mr. Wilson, do you believe that there are too many medical compounds, drugs, on the market now?

Mr. WILSON: Sir, I must confess I do not know. I am in the publishing business. I am not qualified to give an opinion on pharmaceutical compounds, really.

Mr. O'KEEFE: Not compounds, the amount or the number of them.

Mr. WILSON: Oh, I am sorry. Well, again I am neither a physician nor a pharmacologist and I really cannot give you even an educated guess. I just do not know, sir.

Mr. O'KEEFE: Do you think the price is too high, that is at the retail price level?

Mr. WILSON: I will give you my personal opinion. I think that the costs of drugs are too high for the indigent. I think any cost of drugs for the indigent is

too high. I do not believe that the cost of drugs for the average Canadian is too high, from the figures that I see. What is it, $9 a year per person? This to me seems like a very minimal investment in one's health for the value received. This is a personal opinion. That is based on, not my connection with the pharmaceutical industry, but my position as a husband and a father of three children with the average number of runny noses and so on. I resent paying money for pharmaceuticals; paying money for having the rear end of my automobile repaired but this is a fact of life in Canada.

Mr. O'KEEFE: But there is a very great difference there, Mr. Wilson. When you get a tire repaired or get a new tire for your automobile, you have a choice of brands, but when you get a prescription from a doctor you have absolutely no choice. You go to the druggist and you take what he gives you, what the dctor prescribed.

You must have been in business for a few years at least.

Mr. WILSON: Yes, sir.

Mr. O'KEEFE: You know that drugs have advanced. Would you agree with that statement that they have advanced over the last five years?

Mr. WILSON: In reading the submissions to this Committee I see where some drugs have advanced and some drugs have come down in price. I think it was the Lederle Submission to this Committee which showed that their prices in the antibiotic field which they are in, have come down with the exception of the times when the sales tax has increased. So I think it is really a question of what drugs we are talking about. Some have gone up in price, some have come down in price.

Relative to my own income, the cost of drugs is not overbearing and I am getting into a personal situation but this is really—

Mr. O'KEEFE: It depends on how healthy your wife and children are, of course.

Mr. WILSON: I am buying a fair amount of pharmaceuticals for my family. The interesting thing I think is that I see them growing up with relatively little time lost from school. The investment I make in pharmaceuticals, I guess more than $9 per child per year, is very small for the fact that they are getting a day to day education without lying in the hospital as my wife was at that age, but again I am getting personal. My apologies for that.

Mr. O'KEEFE: Would you agree that there are some, or any even, unnecessary drugs sold or advertised?

Mr. WILSON: I really do not know, sir.

Mr. O'KEEFE: Well, then, when you advertise drugs of the same basic type where there is very little difference in the compound, or no difference in the compound as we have had in evidence, would you say they were unnecessary drugs?

Mr. WILSON: No, sir. I can give you an example. We had examples to the contrary this morning. I have seen some. My function in this business is price competition in this industry. Within the last six weeks I have talked with the president of a Canadian company, as he was introducing a new product, and he told me "I've got my competition where I want them. I am coming out with a

product that has so many doses at a lower cost per package than my competition, I have got them on the run." This is price competition. I have seen this happen in this industry. I have not seen it, however, come out in any reports of this meeting.

Mr. O'KEEFE: The doctor makes the choice, does he not?

Mr. WILSON: That is correct, and this company was making, and is making, headway, if I may use that phrase, with the medical profession by pointing out that they have a product that because of their efficiency, I suppose in manufacturing, they are able to deliver to the end consumer at a better price than is the competing product.

Mr. O'KEEFE: In other words, you are pressurizing the doctor.

Mr. WILSON: It is which?

Mr. O'KEEFE: Pressurizing the doctor, applying pressure to the doctor.

Mr. WILSON: Well, I think it is informing the physician that we have a product. You may be prescribing this type of product for some of your patients. We have now brought one out on the market that is more economical for your patients. I think this is a competitive way of doing business.

Mr. O'KEEFE: I agree, but I should hate to think, Mr. Wilson, and I am sure you would, too, that this *Medical Post,* good as it is, would be the only evidence on which the doctor could rely to prescribe for his patients.

Mr. WILSON: I agree with you entirely and I hope that the submission of the *Medical Post* has not indicated that this is the fact, that the medical profession is prescribing solely on the information that it receives in the *Medical Post* or in all medical publications.

The physician has available to him many sources of information. He has his confreres with whom he talks about latest drug developments. This we know. He has information coming to him through detail men, and I think good information. He has information coming to him from papers being delivered by leaders within the medical profession and certain of their disciplines. All of these information sources provide him with the background upon which he is making decisions.

Mr. O'KEEFE: Do you think all those sources are essential?

Mr. WILSON: Yes, sir.

Mr. O'KEEFE: Well, if the 15 per cent suggested was applied to your organization, how would it affect you?

Mr. WILSON: Well, first, Mr. O'Keefe, let me say that I am convinced the product that we are turning out is sufficiently good that, notwithstanding a 15 per cent allowance, we would be able to remain in business. Our development certainly would be slowed down. There is no question about it.

Mr. O'KEEFE: What do you mean by development?

Mr. WILSON: The development of the paper. A paper of this nature is a constantly changing thing. We are trying to improve it issue by issue. It is a good paper now but it will be a better paper next year.

Mr. O'KEEFE: You do not mean exclusively advertising, then?

Mr. WILSON: I mean advertising, also. This would slow our growth, and advertising provides us ultimately with the funds to continue to develop the paper. Without these funds we are in a very precarious position.

Mr. O'KEEFE: Did you say that advertising was 55 per cent of your revenue?

Mr. WILSON: No.

Mr. O'KEEFE: Maybe I misunderstood.

Mr. WILSON: This is a rough target really that we would like to achieve eventually, sir. It is not what we are presently experiencing.

The CHAIRMAN: You said the content eventually might be 55 per cent advertising and 45 per cent editorial?

Mr. WILSON: Yes. That is our eventual objective, yes.

Mr. O'KEEFE: Mr. Wilson suggests you must develop the paper; would this 15 per cent over-all ceiling stop development or slow it down?

Mr. ROBERTSON: Certainly, sir. This is primarily in the editorial area, sir, about which we would be concerned. In the publishing business you cannot sit still; you cannot turn out the same quality of publication next year that you are turning out this year.

Mr. O'KEEFE: I quite understand that but what I do not quite understand is how 15 per cent on advertising would affect your editorial content.

Mr. ROBERTSON: Let me put it this way, sir. The effect this might have on us—

Mr. O'KEEFE: Remembering, that this also applies to your competitors.

Mr. ROBERTSON: Yes. What I was going to say is that it is difficult to be able to forecast exactly how it would affect us because presumably the pharmaceutical companies, who are our major advertisers, would have to readjust their spending patterns and reallocate them. How they reallocate them depends on how it affects us. They may give us a high priority on their list or a medium priority or maybe no priority at all. It is a pretty difficult thing for us to really suggest exactly how it would happen. However, in the total we would see this—

Mr. O'KEEFE: Yes, I see that, Mr. Robertson, but if this 15 per cent applied right across the board to everyone, how would it affect your present state? You would all be on the same basis.

Mr. ROBERTSON: Yes, but obviously there would probably have to be a cut back in the number of dollars spent in the medical journals, if this were applied. Let us say they took, whatever it might be, 20 per cent out of each journal which they are presently using. If we had 20 per cent less revenue than we have now and could never grow beyond that we would have to forgo publication of the *Medical Post* because we would not be able to sell copies and it would no longer be available to the medical profession. I would suspect that there might be other medical journals which are that close to the break even line that they might also have to go out of existence. Some would survive, but which ones would, depends on the choice by the pharmaceutical companies.

Mr. O'KEEFE: I believe you have answered this question, Mr. Robertson, but I did not quite get the answer at that time.

How much of this is American advertising?

Mr. ROBERTSON: Mr. Wilson suggested that approximately 90 per cent of it is priced here in Canada or is in some way changed for Canadian usage.

Mr. O'KEEFE: Are you saying that 90 per cent is Canadian?

Mr. ROBERTSON: Yes, or is material which is adapted for use in Canada.

Mr. O'KEEFE: But that is not quite the same, is it?

Mr. ROBERTSON: No. Some of the material, you see, such as the visual concept and art work might be originated in another country but the content, the copy in the ad., would be written for Canada in Canada. It is hard to say.

Mr. O'KEEFE: You are safe in saying that the Canadian content is not less than 90 per cent?

Mr. WILSON: Are you talking, sir, about the—

Mr. O'KEEFE: The cost of your advertising.

Mr. WILSON: The cost of the advertising?

Mr. O'KEEFE: Of course, the advertisers, but not necessarily the advertisers. It is the actual cost of this advertising which you have in your paper here. How much of this is paid from American sources and how much is paid from Canadian?

Mr. WILSON: I would estimate, sir, that 75 per cent of the advertising lineage in this paper is being billed to Canadian advertising agencies.

Mr. O'KEEFE: Thank you, Mr. Chairman, that is all.

Mr. ISABELLE: Mr. Chairman, could I ask a question?

Do you not think that with your experience this is a little bit sophisticated for a piece of advertising for doctors only?

Mr. WILSON: That is a nice question. I will give you a personal opinion. I think that from my experience in the publishing business the medical profession is among the most sophisticated readers that I have yet encountered.

Mr. ISABELLE: Yes, we have psychiatrists.

Mr. WILSON: I mean this sincerely, sir.

Mr. O'KEEFE: Could I ask just one more question, Mr. Chairman. Maybe this is not a fair one but in your experience, Mr. Wilson and Mr. Robertson, do you know of any drug which you advertised which caused a new disease, as we heard mentioned this morning?

Mr. ROBERTSON: No, sir. There are side effects to most drugs, of course, which are identified in these advertisements but as far as causing a disease, I have never before heard of this.

Mr. O'KEEFE: You heard it this morning?

Mr. ROBERTSON: Yes. I heard it this morning for the first time.

Mr. O'KEEFE: You would not agree with it?

Mr. ROBERTSON: I am just wondering whether the word "disease" is correct. In my interpretation, a disease is something like measles.

Mr. O'KEEFE: If instead of disease, we use the word "death"?

Mr. ROBERTSON: I suppose this has happened.

The CHAIRMAN: As was said this morning, penicillin will cause death in certain people. It is advertised in here; not necessarily any brand.

Mr. O'KEEFE: The suggestion was that the drugs are being prescribed unnecessarily. Of course, you have nothing to do with that. I am not asking you this question, I just want your comment.

The CHAIRMAN: First of all, ladies and gentlemen, it is agreed that we print today's brief as an appendix to today's proceedings? I wonder if I, as Chairman, can ask a question here?

We have an example of an ad.—I will not identify it in any way—but we have a two page ad. here. Suppose next week a story comes out to your attention that the drug in question here has something wrong with it or that some doctor feels it is not a good drug and suggests that you should publish this information in your paper. Here you are being offered a story which is in opposition to one of your customers who is paying for your publication. What would be your policy in this case?

We have an example of an ad.—I will not identify it in any way—but we have a two page ad. here. Suppose next week a story comes out to your attention that the drug in question here has something wrong with it or that some doctor feels it is not a good drug and suggests that you should publish this information in your paper. Here you are being offered a story which is in opposition to one of your customers who is paying for your publication. What would be your policy in this case?

Mr. WILSON: Rather than using this hypothetical case may I give you an actual example of the type of material we have published which could be deemed contrary to the best interest of a particular advertiser which, I think, sir, is what you are driving at here.

Mr. O'KEEFE: The interest of the consumer who has to take it.

Mr. WILSON: We print or publish medical information that, in the judgment of our editors and our advisers, is pertinent and of value to the Canadian medical profession. If it happens to be an item on a pharmaceutical and it is from a reputable source, then we publish it. I will give you an example. We recently published on the front page a headline and I think I can quote it verbatim: "Why measles vaccine gives poor immunity". This was a report from a paper by a Canadian physician, who enjoys some reputation, delivered at a joint meeting of the New England and Canadian Paediatric Societies down on the east coast. He was referring to a particular product that is marketed in Canada by one of our advertisers. This notwithstanding, in the judgment of our editors, was important information from a person who had a reputation within the medical community and therefore should be reported on. This was not the only example. If a paper were to be read tomorrow on this particular product—

The CHAIRMAN: Pointing out that the company he is referring to is possibly still advertising in the paper.

Mr. WILSON: I will give you a little aside on this particular one if you are interested. In my work I spend some of my time with pharmaceutical manufac-

turers doing business with them. In this particular instance the judgment of myself as manager of the paper was questioned on running this particular story.

Mr. O'KEEFE: Running the story or running the ad?

Mr. WILSON: No; it was the advertiser that was questioning our judgment on running a story on this paper delivered by the doctor. My point to him was that our prime concern is providing a worth-while service to the medical profession. If we duck stories that might affect an individual pharmaceutical manufacturer's product that should be printed it would be a matter of months until the medical profession felt that we had been bought, if you will. We would have no readers and, you, Mr. Advertiser, would not have this efficient vehicle to get your informational advertising to the medical profession.

Mr. O'KEEFE: Will you please continue with that ad?

Mr. WILSON: If tomorrow a physician, in the judgment of our editors, knew what he was talking about delivered a paper on some bad side effects of this product, then we would run it.

Mr. O'KEEFE: You would not?

Mr. WILSON: We would run the story.

Mr. ROBERTSON: They are questioning whether you would run the advertisement.

Mr. WILSON: Oh, the advertisement?

Mr. O'KEEFE: Yes. That was the question I thought the Chairman asked.

Mr. WILSON: Oh, was that your question, Dr. Harley?

The CHAIRMAN: Well, not really but that is looking at it from the reverse side of the coin. You have already answered my question, Mr. O'Keefe has really posed a problem for you.

Mr. WILSON: Yes, he has, and I think at this particular juncture—I do not want to appear to be evading this question—I would be about to start talking with our medical advisory board to get some direction from them.

Mr. ROBERTSON: If I might put an opinion in there, I think we probably would run the advertisement depending on the degree of severity of the situation. Presumably, if it has been discovered that this is an extremely hazardous drug, the Food and Drug Directorate would call for the withdrawal of the product.

Mr. O'KEEFE: Has that ever happened, in your experience?

Mr. ROBERTSON: I believe there have been some drugs withdrawn in recent years but so long as the Food and Drug Directorate allows products to be distributed and sold we cannot very well refuse to accept the advertising on the product.

Mr. O'KEEFE: You would then base your judgment on the Food and Drug Directorate people rather than on your own board of directors?

Mr. ROBERTSON: Well, I would say that the Food and Drug Directorate should be more qualified to know the marketability of a product than our people would be—that any individual physician would likely be. They have the machi-

nery and the processes for checking the products to a more sophisticated degree than an individual physician would. If suddenly there were—heaven forbid—another thalidomide situation, I do not think there would be any question of our withholding any such advertising until the question had been resolved. On the other hand, if new side effects arise—there are side effects on most drugs—then it is a matter of conveying this information to the doctor that there are some new problems which have arisen with this drug so that if he is going to continue to use it he is using it with full knowledge of the hazards involved.

Mr. O'KEEFE: Would you base your decision on the Food and Drug Directorate people or your 10 medical men whom you have listed here on your medical advisory board? Who would make the decision?

Mr. ROBERTSON: Well, our advisory board would come into play, sir, more in the area of the content of an advertisement; whether it is an honest, complete presentation on the product more so than the product itself. With the product itself, we would rely more on the Food and Drug Directorate decision on whether this product has approval to be marketed.

Mr. O'KEEFE: This seems to be a fine distinction, but I will have another go at another doctor.

Mr. ROBERTSON: I am sorry if I did not make it too clear. The advisory board is used really on the information disclosure in the advertisement rather than on the value of the product. This is the Food and Drug Directorate's area, we feel, to judge whether this is a product that can safely be marketed in the country.

Mr. O'KEEFE: Thank you, Mr. Chairman and gentlemen.

Mr. LAIDLAW: Just to sum this up, then, sir, you publish this scientific magazine for the medical profession and, in so far as the advertising is concerned, you treat your advertising in exactly the same way as your sister magazine, *Maclean's*, treats advertising, say, from General Motors. Am I correct in that statement? You are publishing a paper; you do not look behind your advertisements.

Mr. ROBERTSON: Well, I am not sure I am quite clear on your point, sir. We do watch the content of the advertisements to see that they do conform with the proper—

Mr. LAIDLAW: Well, what I meant was, for example—I will not quote the company—on page 11 there are certain tablets being advertised under a trade name and it makes certain claims in the advertisement and goes on to say:

> Its unique resinated form is well tolerated—permits conveniently spaced dosage and a minimum of narcotic.

Now, these are claims put in by the firm who has chosen to advertise in the *Medical Post*. You do not look behind that. You assume that this is a correct claim?

Mr. ROBERTSON: We would check into it to see that they do have the references. Where they are making a therapeutic claim we would check to see that they do have the references for these claims, sir.

Mr. LAIDLAW: The point I wanted to make is just how much you did examine them. I feel, myself, that the drug advertisements must be treated in a little more thorough way than normal advertising.

Mr. ROBERTSON: Oh, yes, sir; definitely.

Mr. LAIDLAW: That is all I have to say, Dr. Harley.

The CHAIRMAN: Are there any further questions. Well, we seem to have kept the witnesses just in time to have them miss their train.

Mr. ROBERTSON: I have a comment I would like to make, if I may, sir. It is in reference to the presentation we heard this morning. There was a recommendation, I believe or a suggestion that there be a control placed on advertising. It would be limited to official journals, I believe, association journals was the implication. I would like to put forward a case against that. I can understand the reasoning behind that suggestion, but personally I feel it is a very impractical proposal in that I do not think you can force a doctor to read anything. He has to want to read and, as such, there has to be a choice of reading material available to him. I do not think that every doctor is going to find the same satisfaction out of reading exactly the same journal that his colleague does. Some prefer one type of reading and some prefer another. If the only medical journal that existed was one sort of official organ, I really question that this is in the interests of the Canadian public. I would suspect there would be a certain percentage of doctors who would read such a journal casually, if at all, and they would not be as well informed as their colleagues would be. So, a free choice of reading material, we think, is very vital. We are not alone in this, there are other independent publishers of medical journals here in Canada, in the United States, in Great Britain, and so on. This is a very healthy situation in our estimation. If we are to survive and to grow and to have a place in this market we have to excel; we have to strive to give doctor the finest reporting that we can possibly give him. We have to spend a great deal of money sending our editors to cover meetings and visit clinics and ferret out the important developments that are happening in medicine all over Canada and in the important medical centers in other countries of the world. If we did not have this incentive to make this publication successful I really question this hard digging for medical advances would take place. Our doctors, I think would be less well served and consequently the public would be less well served. I am just making a plea for the independent publication here and free enterprise.

The CHAIRMAN: Ladies and gentlemen, we would like to thank Mr. Wilson and Mr. Robertson from Maclean-Hunter organization for coming before us today. The meeting is adjourned until next Thursday morning when Mr. Bass a retail druggist from Vancouver will be before us at 9.30 a.m.

APPENDIX "A"

ETHICS AND THE PRESCRIPTION DRUG INDUSTRY WITH REFERENCE TO CONSUMER COSTS

A Private Brief Submitted to the

Special Committee on Drug Costs and Prices

November 15, 1966

(By Alan S. Davidson, M.D.
of Toronto)

It goes without saying that I am very grateful to the Commons Committee for this opportunity to discuss a subject that has occupied my interest for many years, ever since I was a student detail man for a large ethical manufacturer. In my value system, improved methods of treatment are essential to medical progress and I have continually been attracted to this field. One cannot study pharmaceutical therapeutics without being confronted by the obvious relationship between Drug Industry's ethics and the cost of treatment.

This then is a synthesis of the views of many authorities on this complex subject. I can assure you that I did not quote anyone unless I felt he was highly qualified to comment. The references are listed so that you can check them to your own satisfaction. If time permits, a more detailed list of references will be provided on the official date of presentation.

DEFINITIONS, ASSUMPTIONS, BASIC ORIENTATION

1.0

Cost

In my view your Committee, while striving for enviable fairness and objectivity is viewing "cost" from a rather narrow and literal perspective. You seem to be attempting to compare the Drug Industry with other forms of industry *without* consideration of other factors that could have a serious bearing in cost. If drugs are unnecessary, ineffective or dangerous, there is surely an undesirable cost to both manufacturer and consumer. Wasteful market-dividing "copy research", unnecessary promotion and marketing expenses, unnecessary or too lengthy product monopoly, inadequate federal supervision, "administered pricing"—all contribute to pharmaceutical costs. Cost must be interpreted in the broadest sense.

1.1

ETHICAL VS. GENERIC MANUFACTURERS

Here the implications are subtle and rather amusing—if the big companies are "ethical", then the smaller generic manufacturers must be the opposite. It is hoped that you will reach your own conclusions, but I define them as follows:

An *ethical* manufacturer or its parent firm

1. Conducts basic and applied pharmaceutical research.
2. Originates novel products.
3. Favours trade name product recognition as a guarantee of product quality.

A *generic* manufacturer

1. Does little or no research.
2. Originates no new products but markets established products instead.

There may be exceptions to these criteria but the generalizations are fairly valid.

1.2

RESEMBLANCE BETWEEN CANADIAN AND AMERICAN FIRMS

Canadian firms strongly resemble their American counterparts and are often subsidiaries. (3) Manufacturing, promotional and marketing practices are simi-

lar, hence commentary on American Drug Industry methods is relevant to the Canadian scene. No understanding of Canadian industry is possible without a thorough review of American government inquiries and publications. (Both official and commercial.)

1.3

SOCIAL CONTROL OF HEALTH SERVICES

Social control of the health industry and helping professions has been imposed for centuries and does not have to conflict with Democracy or free enterprise. Prevision of health services is a privilege, not a right.

In ancient times a surgeon's carelessness or ineptitude could lead to mutilation or amputation of his hand. During the Industrial Revolution legislation was enacted to provide better working conditions and to discourage child labour. In the past century, transportation (railroads, shipping, automobile), communications, food and drugs (patent and prescription) have all experienced variable government control.

The above restrictions seem to have met general acceptance,but where health is concerned an ironic inconsistency appears—the feeling that health services should be left alone.

For example, veterinary pharmaceuticals were subject to greater legislative control in the United States, than products for human use—from 1913 to (1a) The Kefauver Harris Bill changed that.

1.4

If drug control is the joint responsibility of Industry, Medicine and Government, inadequate control is the fault of all three. No profit can be realized from pillorying one element of the drug control system. Perhaps the Kefauver Hearings were unfair to Industry when abundant evidence of Medical irresponsibility or inability was presented, but this should motivate us to be more objective.

1.5

PERIOD OF LITERATURE SEARCH

This Brief is based on a literature review concluded in 1961, with the exception of the books by Estes Kefauver (2) and Morton Mintz (1). Some might conclude that it is outdated but actually there has been little change except:

1. Kefauver Harris Bill (U.S.A.).
2. Enforcement of compulsory licensing in Canada.
3. A possible reduction in the number of new products marketed.
4. Perhaps greater enforcement of safety and efficacy by the Canadian F.D.D.

1.6

OBJECTIVITY

It is unavoidable to avoid a bias or set in a presentation to an inquiry because the witnesses are forced to extreme positions by the imposed adversary system. This Brief attempts to be objective but is of course loaded against the drug manufacturers. It is my opinion that the Committee must erase biases in reaching an objective conclusion.

2.0

THE RELATIONSHIP BETWEEN GOVERNMENT AND INDUSTRY

2.1

The history of drug control legislation seems to follow a pattern not unlike that seen in other areas of business practice. In England, railroad safety laws were not enacted until chaotic trends were evident. Ships were not equipped with lifeboats until the Titanic grazed an iceberg. Drug safety laws appeared in the U.S.A. after 108 people were poisoned by a hasty "ethical" producer. (1b)

2.2

But drug inquiries seem to differ slightly—inaction being the common result. As I read them and observe their effects, I can't avoid the uneasy feeling that I am watching an ancient spectacle with simple plot and certain outcome. It is much like the modern wrestling match—bulging goliaths wracking each other with death-dealing blows. The inexperienced observer would be certain that injury was inevitable.

But suddenly the fight is over, the winner shouting defiance, the loser trotting to the dressing room to prepare for the next act. No one is hurt (unless by accident), the audience has its emotional catharsis, nothing happens. At least in wrestling, the adversaries take turns winning; in drug inquiries the people are too often the loser (1c).

2.3

Historically, legislative control of the ethical drug producers has been expedient, erratic, impulsive, sometimes excessive and often too late. The legislative pendulum swings lazily from apparent indulgence to harsh restraint. Canada often follows the United States in docile synchrony.

2.4

In the U.S.A. no controls existed until the turn of the century, and then emphasis was directed to patent medicine fraud. (1d) The prescription drug industry was left alone until a number of patients were poisoned by a toxic sulpha mixture (see before). Elaborate safety legislation was then (1938) introduced, with some controls on product labelling (1e), but proof of effectiveness was not considered necessary. The doctor was presumed able to make that judgment (1e).

2.5

Manufacturers were compelled to amass elaborate testimonials of product safety to obtain marketing approval from the Food and Drug Administration. (2a) This arrangement appeared satisfactory since most manufacturers were professionally controlled and the number of new products was not excessive (1f).

2.6

By the end of World War II, subtle trends were apparent—the professional administrators relinquishing control to hard-headed businessmen and their advisors. These advisors were marketing and advertising specialists. With them came an unfortunate change in business ethics. American government complacency

was not shaken until the 1950's when tranquilizer and antibiotic marketing excesses were so apparent that intervention was indefensible. The Blatnik hearings* investigated the former (without result) but the Federal Trade Commission was able to prove that the tetracycline industry was guilty of patent fraud and price fixing (2b).

Eventually the Kefauver Harris Bill was enacted, but only after the thalidomide** crisis focused public attention. This law tightened safety requirements, made efficacy approval a government responsibility, curbed advertising excesses, and forced the adoption of simple generic names (2c).

2.7

As far as I can tell, no new Canadian legislation has resulted, but we have been the indirect beneficiary of American laws. We are possibly more careful about safety and efficacy, we allow compulsory licensing, but our controls are substandard. New drugs of dubious novelty or utility are marketed, we still have combination drugs (two or more active agents) cluttering the scene and prices are substantially unchanged.

2.8

Change cannot occur without bold and imaginative government action taken at times when crisis is not the major precipitating force. Crises may reveal a glaring fault but rarely expose fundamental errors in basic practice or orientation. Market inundation with dubious or identical drugs is so overwhelming that its causation is hard to grasp.

3.0

THE INDUSTRY

3.1

BREAKDOWN OF THE SALES DOLLAR

In my opinion the drug Industry has misrepresented itself to the Medical Profession for a number of years. In May, 1958, D. B. Mahoney, Advertising Manager of the Frank W. Horner Ltd., Montreal, addressed the Ontario Medical Association Convention on advertising practices and expenditures (5). Quoting an AMA lay publication he stated "most prescription drug firms spend an average of 5 per cent or less of the retail sales of a drug to inform your doctor of their product".

In July of the same year, Stanley M. Conder, chief apologist for the Canadian Pharmaceutical Manufacturers Association wrote me that 5 per cent of retail sales "went to promotion according to the February 16, 1957 issue of the JAMA". On the average, he reassured, they spent 21 per cent on research from net profits before taxes. This compared with 15.3 per cent for the chemical industry as a whole.

Conder also quoted the JAMA to the effect that promotion increased sales volume to reduce costs to the consumer. After reviewing the subject I would think that he would have considerable difficulty in providing examples.

** Hearings before a Subcommittee of the Committee on Government Operations, House of Representatives, Eighty-fifth Congress Washington: 1958

* Kevadon

As you know, these figures are a far cry from established fact (7-11;3a), and one cannot help wondering whether these Industry representatives were ignorant of the painful truth or engaging in wishful self deceit.

3.2

The same impression results from the elaborate statistical presentation before the investigational committees including your own. Actual research, promotion and basic material expenditures are arrived at only by laborious digging. The figures are shocking to some. In reviewing your proceedings I found myself resurrecting my slide rule in an attempt to arrive at actual research and promotion expenditures.

3.3

The same information (or misinformation) is supplied to the lay public through stories and advertisements in magazines and industry sponsored throwaways designed for the doctor's waiting room. (i.e. Waiting Room Digest). Paid advertisements or testimonial articles depict Industry's relentless march of progress toward the conquest of disease. (Laudatory articles on the Medical profession are also contained to give a semblance of balance to the editorial policy).

3.4

The Industry claims that competition justifies high promotion expenditures and net profits. It implies that this "competition" is healthy, leading to better products at lower prices. Many would disagree, saying that:

(a) product competition leads to market overloading and product misuse (2d), the market being relatively fixed.

(b) product competition rarely leads to price reductions. Prices are determined by the product category leader (concept of Administered pricing) (2e).

(c) outmoded products are not displaced unless grossly inferior or dangerous.

(d) frantic product competition forces premature introduction of inadequately tested and approved products (2f).

(e) the resulting market overload leads to artificial obsolescence (2f). For some time now physicians have jokingly quoted the cynical maxim "Hurry, hurry, use this drug while it still works".

3.5

EXAMPLES OF ADMINISTERED PRICING (U.S.A.)

1. Meprobamate, a patented tranquilizer originated by Carter Products (Carter's Little Liver Pills) was sold at a fixed price dictated by Carter after comparison with competitive forms of treatment. Although Wyeth Laboratories were licensed to sell it as Equanil, their price was the same.

2. Chlorpromazine* became the American price leader for a succession of equivalent phenothiazine tranquilizers (1q) despite different research and basic ingredient costs. The basic technique of increasing potency by "molecule manipulation" had been known to the Industry for some time and had previously been exploited in creating a large family of anti-histaminics.

(*) Largactil (Canada), Thorazine (U.S.A.)

3. Meticorten* set the price for its adrenal steroid competitors despite economies in manufacture of the competing products (1h, 2h) i.e. A .75 mgm. tablet of Decadron or Deronil (the same) sold at a similar price to the public as a 5 mgm. tablet of Meticorten, although the effect was the same (2i). Less active chemical was required for a therapeutic effect yet the consumer had to pay the same price as for the less efficient Meticorten.

4. Tetracycline was priced identically by 5 cross-licensed American manufacturers (2j), one of them holding a fraudulently obtained patent (2k). Here the leader set and maintained the price, even after obvious economies in manufacture should have led to price reduction.

All these companies regard themselves as "ethical". Generic producers would feel no ethical obligation to follow the leader, but seem to have difficulty getting the drugs to sell and often cannot afford the required promotional expenditure.

3.6

PRICING METHODS

Two basic methods appear to be employed in setting drug prices.

(1) Pricing according to what the market will bear (2i).

(2) Pricing against competitive forms of treatment (2l).

Different prices in different countries are explained on the basis of standard of living or average earning capacity. If the going gets rough, Industry's professional apologists remind us that liquor, tobacco and undertakers cost more. Is such reasoning logical or valid?

Senator Kefauver had this to say: "If this is the standard for judgment, clearly this view has merit. No one wishes to minimize the medical advances that have been made even in our own lifetime, and all of us hope that this is just the beginning. But is service to the public the proper standard for a judgment of the reasonableness of price?

Whenever an essential commodity is concerned should price be determined by its importance to the public welfare?—The justification of high price in terms of value of the service to the public is the *ideology of Monopoly*" (emphasis mine) (2m).

This pricing philosophy is even more reprehensible when the consumer is captive to the physician's choice of product. The doctor prescribes, the patient obeys, but the manufacturer calls the shot.

Examples of pricing to meet the competition are numerous but three will suffice.

1. After Chlorpromazine** showed promise as one of the most exciting developments in the treatment of mental illness, the price of promethazine*** was increased 25 per cent (51). Both compounds had similar chemical structures and effects, both originated from the same French drug firm, but promethazine had been priced lower—presumably to meet the price of equivalent anti-histaminics then being pushed for the common head cold. One guesses that insanity was considered more serious—hence the higher price.

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* Prednisone—marketed by Schering Corporation

** Largactil (Canada), Thorazine (U.S.A.) } Both marketed by SKF in U.S.A.,

*** Phenergan } Rhone Poulenc in Canada.

2. Tolbutamide*, a cheaply synthesized anti-diabetic agent was priced against insulin, a biological product expensively extracted from animal pancreatic tissue (75). Admitting the need for a return on research investment, it was still over-priced. No economy was passed on to the consumer who might have to take it for years (2h).

3. Dexamethasone (Decadron or Deronil) previously mentioned, was priced against hydrocortisone—an earlier adrenal steroid. Margin above direct costs was $142.11 per gram for Dexamethasone and $6.36 for Hydrocortisone. Both sold to the customer at 23 cents per tablet (75). Since the basic principle of molecule manipulation was well known (see before) one could hardly believe that the newer product required much expensive research. No doubt promotion costs made the difference since Dexamethasone was running against Prednisone for which Schering's promotional costs were 32 per cent of the sales dollar (2p).

3.7

THE "SUCCESSFUL DRUG"

To be a success in the pharmaceutical race to greater profit and confusion a drug must meet the following criteria.

(1) partial or slight efficacy (12)
(2) multiple supposed applications (12)
(3) for diseases subject to periodic or spontaneous recovery (12)
(4) for diseases influenced by suggestion (placebo effect) (12)
(5) must be first on the market (52,100)
(6) must be patented and have a trade name (13)
(7) must be marketed by a firm capable of expensive, effective, sustained promotion (13,29)
(8) must have few serious side effects (12)

Combination products (two or more ingredients) meet such criteria very well because they are often marketed before efficacy and safety of the component drugs are known. The efficacy of such drugs is uncommonly hard to measure (3e, 14).

A drug does not have to be proven effective to be a striking success (12,15,16,101). Since mental illness meets almost all of the above criteria, it is not surprising that the psychotrophic drug market is loaded with products of dubious or equivalent effect (13,17,18,51,53). Sales volume is apparently a function of promotional intensity according to John Godden writing under the nom de plume of "Brother Timothy" in an east coast journal (19)**. Louis Lasagna said much the same thing at the Kefauver Hearings (76).

3.8

ADVERTISING, PROMOTIONAL AND MARKETING EXCESSES

Drug house marketing and promotional tactics have been exhaustively discussed in at least two American inquiries. They are well documented by Mintz and Kefauver so I shall merely list the criticisms with a detailed bibliography:

* Orinase
** Now an Associate Editor of the CMAJ

(a) Excessive, confusing promotional intensity (20,17,3f)
(b) Subtle deceptiveness (21,22,23)
  (1) over simplification (24,25)
  (2) concealment of similarity to another competitive product ( )
  (3) omission of important data (26,102)
  (4) spurious bibliographies (15,103)
  (5) misquotation (24,103,104)
  (6) misdirection—promotion of dubious applications backed by inadequate clinical evidence (26,27,28)
  (7) depth advertising ( )

With regard to the latter, you would probably be interested in a confidential study done by Dr. Ernest Dichter of the Institute for Motivational Research (26). This study is most revealing and warrants detailed review because of the ethical questions raised, but a few quotes are sufficient:

"It is the modern physician with his foibles, fears, hopes and insecurities who is the theme of each ad and of each communication, *rather than the scientific and medical qualities of the drug*". (emphasis mine).

"Permit the doctor to feel wise rather than make him feel foolish".

This report will be referred to in a later section but cannot be quoted at length because of copyright restrictions. If the Committee is interested, perhaps permission could be obtained to include it in the appendix to these proceedings.

After reading Dichter's report and examining samples of drug advertising, it is quite easy to see that the emotional or subconscious approach to the physician became quite popular. The physician's knowledge of the therapeutics was rarely challenged, self doubt about professional ability was never stirred*, product qualities and hazards were treated superficially, and the whole thing was dressed up in fancy multi-coloured art work.

In his private newsletter, Dichter once stated his philosophy very clearly. "The busy customer, confused by a multiplicty of identical products of different manufacturers 'makes his choice partly on pseudo-rational arguments and partly on subconscious, purely emotional factors'—the customer attempts 'subconsciously to grasp the intentions of the company'—a favourable company image, one which sells, is an 'image of a humane company whose intentions are those of a friendly, understanding, warm person' ".(30)

The Horner Company of Montreal followed Dichter's advice to the letter, obviously using its promotional budget to build a favourable company image—that of a happy, modest endeavour more concerned with the physician's leisure time than its own sales. For years it sponsored (and still does) the Physicians Art Salon at the CMA convention. The winning paintings and photographs were then made into a desk calendar, distributed annually to all physicians in Canada. Horners must have done well because I understand that they are now American owned—but they might not meet my criteria for being "ethical".

* With occasional glaring exceptions i.e. The Sherman Company ran a provoking advertisement in which the caption read "Doctors can't cure shingles"? Apparently they felt that they could do the job with Protamide, but their substantiating bibliography left much to be desired.

3.9

THE PHONEY SYMPOSIUM

What could be a more effective provotional gimmick than sponsoring a "scientific symposium" on a subject such as depression, mixed anxiety and depression or family planning? If the manufacturer can enlist the support of a University and ensure the participation of eminent medical authorities (expenses paid), product success is almost certain. Not uncommonly a medical association publishes the proceedings as a special supplement of its Journal. Things could not be better for the manufacturer.

To be fair, such symposia usually cover a number of topics unrelated to the drug, but the implication is there—"Drug X may be useful and Company Y was kind enough to pay the bill". (See later on Ste. Adele Conference).

In a stirring editorial entitled "Anyone for a Symposium" (31) Walter Modell commented six years ago, that the symposium had been downgraded and misused—"the perversion of an important post-graduate educational instrument into an insidious promotional device".

A renowned authority on therapeutics, Modell noted that:

(a) There were far too many symposia.

(b) Poor quality research gained stature from being published—"a device to have unpublishable stuff published".

(c) Symposia resembled dramatic productions with "the same performance and the same players". "These performers would seem to proceed from one stopover to the next, like the old Chautauqua circuit lecturers".

(d) "The weary travellers" had to get some sort of compensation and he suggested that rapid accumulation of a personal bibliography might be one form.

Modell concluded that symposia were then held for "the sole purpose of drug promotion and were the cheapest form of *prestige* obtainable" (emphasis mine). Such gimmicks fit in with Dichter's view that a company must create an image of scientific respectability (29).

4.0

EXAMPLES OF INDUSTRY SPONSORED CANADIAN SYMPOSIA

1. Imipramine* was heavily promoted by Geigy through a McGill University Symposium on "Depression"( ). Upon return from the conference, Professor A. B. Stokes** of Toronto angrily commented—"I have just experienced professional rape". I can assure you that Dr. Stokes is a mild-mannered person, not accustomed to such language. His anger was, therefore, considerable.

2. Parnate and Parstelin were the unofficial subject of a symposium held at Ste. Adele Quebec in 1958 ( ).

3. In April of 1966, Ortho Pharmaceutical (Canada) Ltd. sponsored a symposium for Clergy and Physicians on "Counselling in Family Planning".

* Tofranil (Geigy)

** A. B. Stokes (see glossary)

Modestly held at Toronto's Inn on the Park, the meeting attracted renowned authorities on the subject and a large audience. Only one out of fourteen topics covered oral contraceptives but undoubtedly the message got through. The Anglican Church kindly published the proceedings with Ortho footing the bill.

4.1

THE PARAMEDICAL LITERATURE

Numerous free magazines, journals, books and records are made available to the physician who is a good (high volume) prescriber. It is assumed that high prescribers are good physicians—an assumption that is open to question. Industry control of advertising policy and editorial views is variable, ranging from complete control to subtle influence. Some drug houses publish their own magazines—some of which are very good (i.e. Ciba Clinical Symposia). The Industry, however, subsidizes through advertising a vast number of flashy, expensive magazines peripherally related to the practice of medicine. Interspersed between scientific and artistic articles are subtle testimonials to the good-hearted altruism of "your prescription drug manufacturers". Advertising standards have been lower in these publications, although layouts were more expensive.

A perceptive reader can soon identify those publications captive to industry direction. They usually present a biased viewpoint and sometimes ignore authorship.

4.2

****Canadian Doctor* is a good example, supposedly published independently and with a medical editorial advisor*. One rarely finds criticism of the Industry in this dubious publication, but medicine and its leaders are rather constantly glorified. In November 1960, this magazine published anonymously a "factual" essay on the contribution of the Drug Industry to medical progress (32). It took little time for me to identify the author as Stanley Conder and the essay as the PMAC Brief to the Ontario Select Committee on Drugs. When I protested, the editor first ignored me, then published a devastating but pathetic rebuttal—quoting another doctor who disagreed with me (33).

4.3

Others have objected to the "clouded parentage" of publications such as *MD* of Canada and have claimed that this journal channeled $250,000 to a Division Chief of the American FDD Antibiotics division (32). John Godden contends that *MD* and similar publications are supervised by a "Dummy Board" of eminent physicians who are never consulted (32). Clifford Scott, a Montreal psychiatrist, expressed concern about anonymous authorship in a subsequent letter to the CMAJ (34).

Editor Felix Marti-Ibanez, M.D. of *MD* magazine had some kind things to say about drug advertising in 1960 (35).

"To be fully *informative, MD,* like other *medical journals* should also contain advertisements. Years ago advertisements were mere propaganda in the worst taste; today they constitute a *reliable* source of medical information

* In 1960, but now has full fledged medical editor.
** NOTE: See Evidence at the opening of the meeting for correction of this paragraph.

—Pharmaceutical advertising began by presenting the physical iconography of drugs; later it dramatized their properties; and now it presents the *concept encompassed* by each product". (emphasis mine)

Freely translated this means advertising has got progressively worse. Dr. Marti-Ibanez obviously could not "bite the hand that feeds".

4.4

In my view, *Applied Therapeutics* was suspiciously captive at the same time for its Editor noted (in 1961) increasing criticism of the Industry and explained it on the basis of an increased "irritability index" related to our changing climate. He sternly announced "we do not intend to publish unofficial or hysterical outbursts made at times or by persons where the irritability index is far above the norm" (36). This Editor's own irritability index mounted when he later ordered Thalidomide* advertising withdrawn from the journal because of its tragic toxicity; but in the Fall of 1961 he published "The Untold Story of the Drug Hearings"—a summary produced by the American Pharmaceutical Manufacturers Association (37).

Applied Therapeutics has since adopted a more strict editorial policy and insists that advertisements meet the PMAC code but it is almost completely dependent upon advertising revenue.

4.5

DRUG INDUSTRY RESEARCH TRENDS

The Industry makes a big issue of its world-wide research expenditure, implies that it pays a large share of Canada's annual medical research bill and claims responsibility for many important drug innovations (32). It has the audacity to take credit for penicillin, insulin and diphtherial toxoid ( ) all discovered privately by Fleming, Banting and Ramon respectively.** Industry tells us that a vast research empire will collapse if we curtail its profits or limit new product patents.

Available Canadian figures reveal that government pays substantially more for medical research than Industry ever has. In 1955-6 the Federal and Provincial governments paid three times as much as the Industry (38). (I am certain that comparable figures are available for the U.S.A. and will attempt to locate them).

Much Industry research consists of frantic molecule manipulation designed to break patent control of a lucrative market (2r). Truly basic research is eclipsed by applied or developmental research of poor quality. Kefauver states "Big business, it is argued, means big research laboratories, big expenditures for the release of the inventive talents, big technological developments. Thus whatever may be lost in the way of competitive activity among firms is more than compensated for by the steady flow of important inventions which enrich the lives of us all" (2r)—This idea "is not based upon an examination of the significant developments in important industries to pinpoint their origins"—"By dint of sheer repetition it (this concept) has become accepted as fact" (2r).

* Kevadon—Merrill Company

** Also see Commons Committee on Drugs No. 4, P. 121

With the exception of adrenal corticoids and "thiazide diuretics" North American Industry has not dazzled the therapeutic field for 20 years. (See Mintz P. 559)

4.6

THE COST OF MARKET OVERLOAD

It is not easy to quantify (in dollars) the cost of market overloading with drugs of dubious novelty, utility or safety. The cost must be phenomenally high, but there is another cost more evident to the perceptive observer—new diseases caused by drugs. So common are serious drug toxic reactions that Moser (39) runs a column in *Clinical Pharmacology and Therapeutics* entitled "Diseases of Medical Progress". The more drugs in use, the greater chance of undesirable interaction and inevitable "cost" to the unfortunate consumer.

4.7

Market overload leads to product obsolescence and pained lamentation on the part of the manufacturers (54-56, 77). Dale Console once remarked—"they (the manufacturers) stress that there are many failures for each successful drug. The problem arises out of the fact that they market so many of their failures" **(57).**

Ironically, good medicine can be practiced with a relatively small number of drugs. While in group General Practice, I found that we used 15-20 basic drugs 90 per cent of the time. In my intensive treatment unit for alcoholics, no more than 5 basic drugs are required.

Market overload means heavy promotion and confused bewildered physicians. The physician ceases to exist as that "invaluable buffer between Industry and patient" (13, 15, 23, 39, 40, 58, 59, 105, 106).

4.8

CANADIAN MARKETING EXCESSES

Dartal (Searle) was marketed here in competition with Stemetil (Poulenc), Trilafon (Schering), Stelazine (SKF) and Moditen (Squibb)—all simple variations of the phenothiazine structure. Frederick Meyers* a pharmacologist from UCLA, testified to the Kefauver hearings that Dartal hydrolysed to Trilafon and acetic acid as soon as it touched water (60). In a personal communication he advised me that it was so unstable that it required a special coating to prevent breakdown before use and it could not be marketed as an injectable because it became another compound with the addition of water or saline. This drug was sold for a number of years in Canada and is still available as one component of a combination drug.

When I wrote the Searle Company, their reply was interesting, because they attempted to deny that quick hydrolysis took place (41). They further implied that they had not made any arrangement with their competitors to divide the market (41). Meyers states that a patent interference took place, with Searle being the winner and Schering having to pay royalties (43). Ironically, Dartal was never successful (42), Trilafon and Stelazine were.

* See glossary

In this case:

(1) Two manufacturers attempted to divide the market, when one product was all that was needed. (Actually the manufacturer of prochlorperazine (A) was involved in the same patent proceedings and also had to pay royalties to Searle. This product was marketed as Compazine in the U.S. and as Stemetil in Canada.

(2) Searle concealed basic information from an inquiring physician.

(3) Searle marketed a product that was basically a fraud (43).

(4) The Canadian Food and Drug Division missed this hoax which should have been apparent to anyone versed in chemistry. No action was taken when I advised them at a Convention.

4.9

Monase was marketed by Upjohn of Canada as a new treatment for psychosomatic disorders—with no substantiating evidence other than four uncontrolled clinical reports (44-47) and a host of unpublished medical testimonials. Only one of these referred to psychosomatic disease (stomach trouble). Upjohn advertised that Monase was not a monoamine oxidase inhibitor, although it was (48), and minimized the hazards expected from a drug in this class (46). Monoamine oxidase inhibitors had fallen into disfavour (liver damage) presumably between the time that the product was named and marketed.

I could never determine how this company could promote such an application so lavishly with no evidence, but finally came upon a memo (from the University of Toronto Faculty of Medicine, Department of Psychiatry—Drug Research Committee) indicating that Monase had been a failure in depression but might have some use in psychosomatic conditions. Monase was eventually withdrawn because of suspected toxicity.

In this case:

(1) The drug's chemical class was misrepresented.

(2) It was recommended for a vague and unproven application.

(3) The advertising contained a misleading and spurious bibliography.

(4) It was marketed before adequate efficacy or safety testing.

5.0

Parnate (SKF) was not only marketed (in 1961) as a unique antidepressant, but also as a combination drug (Parstelin) before efficacy and safety were clearly established (48, 1j). In this case, the manufacturer sponsored (with the assistance of the CPA) a "symposium" on "Mixed Anxiety and Depression" held at Ste. Adele, Quebec. Although the conference theme was supposedly scientific and the speakers respected authorities, the true theme was the value of Parstelin for such disorders. A Fellowship qualified Toronto psychiatrist attended this meeting and confided to me "the participants seemed to feel obligated to SKF for paying all their expenses. One man had done a controlled study which did not show much therapeutic advantage but he felt compelled to say that the drug (Parnate) must be useful".

Within two years, rare but occasionally fatal side effects were identified ( ) but not until the Spring of 1964 was Parnate withdrawn—both here and in the

U.S.A. Of course, Parstelin was withdrawn in Canada. (It had never been approved in the U.S.A.)

The American FDA decided to hold an inaugural efficacy—safety hearing in June 1964, but at the last minute SKF agreed to a drastic revision of the product brochure, and the hearing was cancelled. Mintz contends that the APA "torpedoed" this hearing, when SKF would have had great difficulty proving either novelty or utility. At that time only four control studies had been reported and the results were far from impressive (1L).

In this example:

(1) Parnate was marketed before efficacy and safety were established.

(2) The Canadian Food and Drug Division was lax in permitting its combination with Stelazine before efficacy and safety were known.

(3) The Canadian Psychiatric Association unwittingly or otherwise supported, assisted and published a phoney symposium on a drug product.

(4) The manufacturer refused to describe serious side effects until threatened with a public hearing.

5.1

Meprobamate was introduced to medicine in 1955 as a novel and safe "minor tranquilizer". Marketed in Canada as Miltown (Ayerst McKenna and Harrison) and as Equanil (Wyeth) it was an instantaneous and phenomenal success. Federal approval had been given on the basis of two uncontrolled studies (12,49). Within two years it was proven to be addicting (1m) and to have rare but serious side effects. Furthermore, controlled studies showed it to be little more than a placebo (49,1n).

Almost 10 years after its introduction, it was finally removed from the "drugs of choice" listing of the U.S. Pharmacopoeia (1p).

Meprobamate-benactyzine combination (Deprol) was marketed on equally dubious grounds (1q,1r,61,107). (Actually one then unpublished paper by Alexander*.) Deprol was quite successful too.

In this case:

(1) A useless product was permitted to be marketed.

(2) Its potential hazards were minimized by its American originator (See Mintz).

(3) Evidence of ineffectiveness was ignored by the Medical Profession, perhaps because the facile and deceptive advertising made better reading.

(4) The product still enjoyed sales success and provided and extremely high profit margin to its originator.

(5) The drug was combined with another rather dubious compound, marketed on slim evidence of value before true efficacy could be established.

* Reference 4.

5.2

THE MEDICAL PROFESSION

Anyone reading the American hearings or "The Therapeutic Nightmare" cannot escape the uneasy feeling that the individual physician and his official organizations have failed to protect the public against drug manufacturing excesses. One may feel that Mintz was unnecessarily hard on organized medicine but if you read the entire proceedings as he did, you cannot avoid a feeling of intense indignation and betrayal. I know because I reached this conclusion long before Mintz wrote his book.

5.3

What makes it all the more upsetting is the fact that Academic and Official Medical Bodies don't appear concerned. I can assure you that I made repeated efforts to interest the CMA, the University of Toronto Faculty of Medicine and individual colleagues in this subject, but was rather consistently reassured or discouraged. This attitude was best summarized in a written commentary by Dr. John Lovett Doust of the U of T Department of Psychiatry*. "It seems to me that it (your thesis) expresses the chip that still rides on your shoulder. You sound in it just like Jules Gilbert**—in his many attacks on the "legit" drug industry—attacks which hitherto fail to reveal the millions of dollars he himself is making with his gimmick. Your paper in essence is a diatribe, a polemic, an anguished cry of protest directed towards an industry. You may be, and probably are entirely correct, but the area of your concern is that of the moralist, the business man or the politician rather than the province of the doctor or physician".

5.4

Organized medicine and the individual doctor seem to identify with the Industry in a common fear of government control. Doctors are extremely uncomfortable about the prospect of Medicare and appear to sense that Industry is fighting a similar battle. The AMA and APA gave absolutely no assistance to the Blatnik enquiry into tranquilizer advertising practices. Their spokesman said that he was not qualified to talk about the drug business and that his associations were not unduly concerned about advertising practices. (See Mintz). When the proposed Kefauver Bill was announced, the American Medical Association strongly objected to the "proof of efficacy requirement". Apparently Industry was not opposed to this requirement but the AMA felt that this was the beginning of government interference with business and practice of medicine. (Also see Mintz).

5.5

Perhaps too, organized medicine is too dependent on Drug Company advertising revenue to maintain a healthy attitude of objectivity. In 1958 I asked Dr. A. D. Kelly *** to explain whether or not the CMA was unduly dependent on advertising revenue. He replied that in 1957 all advertising (not just drugs)

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* Chairman of the now defunct U of T Dept. of Psychiatry Drug Research Committee.
** Toronto generic manufacturer.
*** Then general secretary of the CMA.

contributed $317,000 of the total CMA revenue of $579,239 and that the Journal made a profit of $30,000. He concluded with "We are not quite in the position of being dependent upon advertising revenue for our existence, but its absence would make Journal publication very expensive and would result in considerably increased membership fees".

By 1960, the editor of the CMAJ noted (50) that the Journal budget had passed the half million mark, almost all derived from advertising. He questioned dependency on advertising revenue since the fortunes of the Journal might suffer from official pronouncements or policies of the CMA relating to the Industry.

On page 531 of the same issue (50) I noted that the CMA had declined to offer a brief to the Restrictive Trade Practices Commission because the subject was basically economic and outside Medicine's area of knowledge.

On page 559 it was reported that drug advertising regulations had been adopted by the CMA for its publications.

Recently the CMA advised that total advertising revenue (including non-pharmaceutical and classified ads) was $604,000 compared with $430,000 obtained from fees. The CMAJ made a profit of $87,000 presumably directed to general revenue. One cannot help but feel that this dependency has had some bearing on CMAJ editorial policies. I can assure you that uncomplimentary references to the Industry were edited out of one of my articles, and the second was refused partly because the editor was "loathe to undertake to publish an article at this time (1964) which, in whole or in part, directs yet another attack against the pharmaceutical manufacturers". Dr. T. W. Anderson, editorial co-ordinator of Applied Therapeutics told me that he considered this policy to be foolish. He felt that there was nothing wrong with controversy if the opposite side and the audience were given an opportunity to take part in the debates. Such was common practice in the United Kingdom and was sadly lacking in Canada—in his view. I felt this opinion was rather interesting, coming from the Medical editors of a Journal that was completely dependent upon advertising revenue.

5.6

Yet the individual physician seems to have many grievances, if one stays away from Industry originated loaded questionnaires. Ernest Dichter (29) while working for the manufacturers, attempted objectivity and noted from his general practitioner sample that:

1. Only 50 per cent regarded the manufacturers as allies.
2. Most were concerned about competitive trends leading to premature marketing.
3. They had stronger feelings about advertising than other consumer groups.
4. They were concerned about drug costs, diminishing advertising believability and pressure.
5. They felt that the manufacturers were going over their heads to the laity using the mass media.
6. They considered the companies too dogmatic about their products.

Witnesses at American hearings and Canadian physicians have said much the same thing—that they are now the captives of Industry Education. "Education" (13). There is considerable feeling that postgraduate therapeutics education is out of the hands of the medical schools and associations.

6.0

THE PHARMACIST

In my view the Pharmacist is the unfortunate pawn, the unwilling scapegoat in the current struggle. He has to collect the fee for overpriced products prescribed by someone other than the consumer. Most pharmacists tell me that they are swamped by the pharmaceutical deluge, burdened with stocking products that too often lose favour before they are sold.

That they are sometimes guilty of unethical practices I do not doubt, but I do not think that they overcharge. Improved standard packaging and automated dispensing systems could make their work easier and lead to some price reduction. It seems unreasonable if not degrading in this 20th century to have University trained professionals counting pills for their customers.

7.0

CONCLUSIONS AND RECOMMENDATIONS

1. Government, Medicine and Industry have not protected the prescription drug consumer.

2. Government control (Canada and U.S.A.) has been erratic, impulsive, expedient and inadequately enforced.

3. Legislation and its enforcement must be strengthened to force Industry to curtail promotional and marketing excesses.

4. Good pharmaceutical research must be encouraged by government.

7.1

Government control can be administered through

(a) legislation—directive—restrictive or prohibitive

(b) admonition.

Kefauver says that admonition by government may lead to temporary change (i.e. freezing steel prices) but progressive admonition has a declining effect (2s)—somewhat like admonishing a recalcitrant child. The Drug Industry is already controlled by legislation but needs additional restraints. These can be of the form "A Drug manufacturer must—" or "A Drug manufacturer must not"—do a certain thing. The penalty can be a fine (which I find rather useless) or restriction of privileges. The latter seems preferable to me—a manufacturer losing the privilege to market his products until federal standards are met. Since this penalty is severe, the manufacturer should have right of appeal to a special advisory board. (See later.)

7.2

Canada already has laws covering efficacy and safety. I feel that these should be applied more strictly by a vastly improved Food and Drug Division. Increase in personnel is not enough if the top men lack the imagination or

required scientific and administrative abilities. New drugs should not be passed unless there is substantial proof of novelty and safety.

Old drugs should also be covered by these laws, so that manufacturers are required to prove efficacy and novelty for them. In the case of duplicate products, the originator should be given marketing privileges, unless his product is more toxic than its successors. Enforcement of such laws could be done progressively, so that manufacturers were not exposed to undue hardship as their products were withdrawn.

Drug standards (efficacy, dosage variations, safety) should be a government responsibility so that generic drug consumers are assured of product equivalency.

Toxicity reporting should also be a government responsibility*, with a system that was centralized and simplified. Side effect reporting could be done through direct telephone communication or pre-stamped postal report forms. In such a system, the drug detail man would be redundant, no longer required to keep the manufacturer informed, the Food and Drug Division would do that.

7.3

To control advertising, specific legislation combining the best parts of the Kefauver-Harris Bill and the PMAC code should be enacted. This law should be periodically amended in response to recommendations of a Permanent Advisory Committee representing Medicine, Industry, Pharmacy and Government. This same Committee could hear appeals from Manufacturers who had lost their licenses because of illegal activities.

One part of the Kefauver Bill compels the manufacturer to print the generic name of the drug directly under the trade name, in type one-half the size. Such a measure would help Physicians to relearn generic terminology.

7.4

Advertising can be further controlled by strict legislation aimed toward the advertising outlet, rather than the percentage expenditure (as recommended by the Restrictive Trade Practices Commission). The following sample legislation is recommended.

7.5

ADVERTISING TO PHYSICIANS

1. Shall be directed through detail men, official medical publications, direct mail pamphlets and brochures.

2. Detail men must have a University degree in Pharmacy, Pharmacology or a biological science.

3. All advertising must conform to the rules contained in Section 7.3 (law based on Kefauver Bill and PMAC code).

4. Illustrations must be confined to the product, its container and its packaging.

5. An official medical journal shall be designated as one which:

(a) is controlled by a medical editor and advisory board.

* Of course this is already done, but not too effectively. Doctors hate to waste a dime, resent having to stamp a FDD 123 Form and most certainly would not phone Ottawa directly.

(b) obtains revenue from paid subscriptions amounting to 80 per cent of circulation or more. Such subscriptions must be sold at a fair market price for the publication concerned.

(c) emphasizes scientific articles related to Medicine and allied fields.

The sections of this law may be implemented gradually over a period of two years to enable manufacturers to meet the new provisions.

7.6

DURATION OF PATENT PROTECTION AND COMPULSORY LICENSING

I really have mixed feelings about this because I do not know how long a drug manufacturer should be protected to make a fair profit on his research expenditures. I suspect that no one else does either. The proposed five year limitation seems fair but its effect could only be determined by experience.

I see nothing wrong with compulsory licensing if the product originator gets a fair license fee for his invention. The Hilliard Committee report seems to penalize the generic manufacturer by requiring him to make an elaborate and costly new drug application when continued proof of efficacy quality control and safety should be all that is necessary.

7.7

STIMULATION OF PHARMACEUTICAL RESEARCH IN CANADA

Money obtained from manufacturers' sales tax on prescription drugs should be directed to a Government Agency that will promote medical and pharmaceutical research of the highest calibre. This money could be used by the National Research Council or preferably by a newly endowed equivalent of the American National Institutes of Health.

GLOSSARY

1 "Administered Pricing"—an industry leader sets the price, competitors match it.

2 F.D.D.—the Canadian Food and Drug Division, much the same as the American F.D.A. (Food & Drug Administration).

3 Blatnik Hearings—investigated prescription tranquilizer advertising excesses. See bibliography.

4 Molecule manipulation—slight change in a chemical structure sometimes affecting potency and side effects often providing a patentable variation. Such drugs are called congeners.

5 Efficacy—effectiveness.

6 Kefauver Hearings—see bibliography.

7 CMA—Canadian Medical Association.

8 CMAJ—Canadian Medical Association Journal.

9 AMA—American Medical Association.

10 JAMA—Journal of American Medical Association.

11 PMAC—Pharmaceutical Manufacturers Association of Canada.

12 Minor tranquilizer—a mild tranquilizer with sedating and muscle relaxant effects.

13 APA—American Psychiatric Association.

14 FDD 123—a short report form for reporting drug toxicity to the Canadian FDD.

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APPENDIX "B"

Submission to the

HOUSE OF COMMONS SPECIAL COMMITTEE
ON DRUG COSTS AND PRICES

(By the Medical Post)

This submission is presented to the Committee by The Medical Post, a newspaper published for the Canadian medical profession by the Maclean-Hunter Publishing Company Limited, Toronto.

The submission outlines probable results to medicine and to health services should the government legislate restrictions on advertising by Canada's pharmaceutical industry. It covers the following points:

(1) The function of specialized publications.

(2) The role of the Canadian medical press.

(3) The financing of publications.

(4) The probable results of an artificially controlled medical publishing economy.

THE FUNCTION OF SPECIALIZED PUBLICATIONS

The prime function of Canada's business press is to provide readers with rapid and accurate news and to disseminate specialized information of advances that can further their businesses, trades, or professions. To perform this function the business press is staffed with highly qualified writers and editors who seek out news and interpret developments of special significance.

The editorial content of these publications provides a wealth of practical ideas, theories, knowledge, and new product information to the Canadian business, industrial and professional communities. The business press is vital if our industries, businesses, and professions are to keep pace with those of other advanced nations.

The Report on the Royal Commission on Publications 1961, is quite clear in its assessment of the responsibilities of periodicals for encouraging the growth and development of Canada. Quoting in part from the Report.

> "—communications are the thread which binds together the fibres of a nation. They can protect a nation's values and encourage their practice. They can make democratic government possible and better government probable. They can soften sectional asperities and bring honourable compromises.

They can inform and educate in arts, sciences, and commerces. They can help market a nation's products and promote its material wealth. In these functions it may be claimed—claimed without much challenge—that the communications of a nation are as vital to its life as its defences, and should receive at least as great a measure of national protection".

THE ROLE OF CANADA'S MEDICAL PRESS

The medical press is an important and indeed a necessary part of the continuing educational program for Canadian physicians. Advances in the medical profession have been extraordinary during the past fifteen years. Many of these advances have taken place after the graduation from medical school of the majority of today's physicians.

Most physicians depend upon the medical press to alert them to new techniques and developments. Without access to medical publications physicians would be seriously handicapped in the learning and the application of new techniques of diagnosis and treatment.

Medicine, unlike the law, is primarily international. A new technique in thoracic surgery developed in Germany can be of extreme value to Canadian patients. A report on rickets from Sweden might be the key to a similar problem in Canada. It is the responsibility of the medical press to bring to Canadian doctors such information, whether it originates in Canada or abroad.

Without this function of communications the calibre of health services to the Canadian people will likely deteriorate, and will not compare favourably with service provided by other advanced countries.

As an example of the progressive medical press in Canada, the introduction of *The Medical Post* in September, 1965 is particularly relevant.

This medical newspaper has brought to the medical profession an entirely new dimension of communications. It reports within days significant developments in health and medicine from both Canadian and international sources.

Here is an example of a significant development in medicine that was not carried in the general press, but was made known to the medical profession by *The Medical Post* within one week of its announcement.

In April, 1966 the editor of this newspaper taped a talk by Dr. Martin Hoffman on the malfunction of the thyroid. Five days later a report on this appeared in *The Medical Post*. Complete transcriptions were made available to the medical profession. Appendix A contains a complete file of physicians' requests for this transcript—a representative group of physicians from coast to coast.

This is but one item of literally thousands that are published for the advancement of Canadian medicine in this newspaper. This is the type of communication of knowledge, ideas, and theories that the medical press handles daily—useful knowledge that adds to the health and welfare of us all.

FINANCING OF PUBLICATIONS

All major communications media must ultimately be financed through the investment in them by advertisers. The Report on the Royal Commission on publications, 1961 made quite clear the economic facts of life on the communications industry. Quoting in part from that Report:

> "Today the revenue obtained from the reader's subscription to a magazine often is insufficient to cover the publisher's cost of obtaining that subscription. No Canadian magazine of any sizeable circulation looks to advertising for less than one half its total revenue. The majority derive

around 75 per cent of their income from this source, and a few close to 90 per cent."

Specialized periodicals and the medical press are no exception.

Advertising revenue eventually must underwrite the major portion of costs of a publication. Otherwise mass communications cannot exist, since the cost to most readers would be prohibitive. This is not a peculiarity of Canadian media, but is the way of life of modern communications throughout the world of free societies.

Speaking before the Brand Names Foundation, Inc. in New York on April 13, 1966, the Hon. John T. Connor, U.S. Secretary of Commerce, said:

"Beyond all the economic considerations, the newspaper at our doorstep, the radio at our fingertips, the business periodical that is a courier of vital facts, the news and entertainment of television, the educational and cultural value of magazines—few would be within prices most people could pay were it not that advertising, especially the Brand Name advertiser, underwrites the principal cost".

The major cost of a responsible publication is the editorial development and content, the ingredients if you will.

The prospects of eventual profit from advertising revenue encourage Canadian publishers to invest heavily in editorial development to provide readers with beneficial content, presented in an easily usable form. In the medical field these investments can be substantial.

As an example, *The Medical Post* has five full-time editors and staff writers. In addition the editor commissions medical reports from forty-seven special medical writers in Canada, United States, Great Britain and Australia.

The full-time staff of this newspaper will have travelled this year throughout North America, to bring firsthand to the Canadian medical profession significant medical news and developments.

Without the prospect of potential advertisers having free access to advertising investments, it would be economically impossible for a publisher to invest in this type of editorial development, so beneficial and necessary to the profession.

PROBABLE RESULTS OF AN ARTIFICIALLY CONTROLLED MEDICAL PUBLISHING ECONOMY

Artificially curtailed advertising investments by the pharmaceutical industry would severely limit the growth of medical communications in Canada, and diminish their quality.

Today, Canadian physicians have approximately 25 medical publications from which to choose their reading material. There is an almost complete lack of Canadian specialist's publications.

In contrast, the British physicians can choose from 125 publications, and their counterparts in the U.S., some 275 medical journals.

Significant developments in health and medicine will continue. But without an efficient and sound medical press, rapid dissemination of information of such advances would be seriously curtailed. Canadian physicians would be less in-

formed than their counterparts in other countries. News of discoveries and developments which would add to the health and welfare of Canadians would take months or years to reach practicing physicians should the present high level of medical journalism be curtailed.

The practice of Canadian medicine and therefore the calibre of health services would not keep pace with those in other free countries.

November, 1966.

OFFICIAL REPORT OF MINUTES
OF
PROCEEDINGS AND EVIDENCE

This edition contains the English deliberations and/or a translation into English of the French.

Copies and complete sets are available to the public by subscription to the Queen's Printer. Cost varies according to Committees.

LÉON-J. RAYMOND,
The Clerk of the House.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 19

THURSDAY, NOVEMBER 17, 1966

WITNESS:

Mr. S. S. Bass of Vancouver, B.C., Proprietor of London Drugs Limited.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1966

25287—1

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

MINUTES OF PROCEEDINGS

THURSDAY, November 17, 1966.
(28)

The Special Committee on Drug Costs and Prices met this day at 9.50 a.m. The Chairman, Mr. Harry C. Harley, presided.

Members present: Messrs. Asselin (*Richmond-Wolfe*), Brand, Enns, Forrestall, Harley, Howe (*Hamilton South*), Hymmen, Isabelle, Johnston, MacDonald (*Prince*), Rynard, Tardif (12).

In attendance: Mr. S. S. Bass, of Vancouver, B.C., Proprietor of London Drugs Limited.

Also in attendance: Mr. A. M. Laidlaw, Q.C. of Ottawa, Legal Counsel for the Committee.

The Chairman introduced Mr. Bass.

The Committee proceeded to consider the brief submitted by Mr. Bass.

The witness was questioned.

Agreed,—1. That Mr. Bass' submission be printed as an appendix to this day's proceedings. (*See Appendix "A"*)

2. That a letter of November 11, 1966, from Hoffmann-La Roche Limited to the Chairman of the Committee about manufacturing in Canada, be printed as an appendix to this day's proceedings. (*See Appendix "B"*)

3. That a letter of November 9, 1966, from Dr. George F. Wright, Ph.D., President of Empire Laboratories Limited to the Chairman of the Committee be printed as an appendix to this day's proceedings. (*See Appendix "C"*)

4. That a letter dated November 8, 1966, addressed to the Chairman of the Committee by Mr. Tom I. Hughes, General Manager of The Ontario Humane Society, in answer to statements made to this Committee by the Executive Vice-President of Ayerst, McKenna and Harrison Ltd., be printed as an appendix to this day's proceedings. (*See Appendix "D"*)

Mr. Bass was further questioned by the members and by Mr. Laidlaw.

The questioning concluded, the Chairman thanked Mr. Bass for his brief, and at 11.30 a.m., the Committee adjourned to 9.30 a.m. Tuesday, November 22, 1966.

Gabrielle Savard,
Clerk of the Committee.

25287—1½

MINUTES OF PROCEEDINGS

EVIDENCE

(Recorded by Electronic Apparatus)

THURSDAY, November 17, 1966.

The CHAIRMAN: Gentlemen, I think we might start the meeting this morning. There is no correspondence that I want to deal with at this time. We have with us this morning Mr. Bass from Vancouver. I expected he would have trouble getting here, but he seems to be here and in good physical condition, so we will ask him to introduce himself and we will ask him questions on his brief.

Mr. BASS: Gentlemen, to give you a bit of my background, I would say that I am the largest drug store operator in Canada per square foot. We fill on an average between 1,500 to 2,000 prescriptions per day. I would say we are also the lowest priced prescription house in Canada, and we are offering low priced prescriptions at a fairly good profit.

The CHAIRMAN: You are a graduate pharmacist?

Mr. BASS: Yes, I am a graduate pharmacist from Manitoba and I hold my licentiate in British Columbia.

Mr. HOWE (*Hamilton South*): Do you pay the same price for the drugs that you dispense as other stores do?

Mr. BASS: That is a hard question to answer Dr. Howe. We buy fairly well.

Mr. HOWE (*Hamilton South*): Is this because of quantity buying?

Mr. BASS: Volume buying, that is correct.

Mr. HOWE (*Hamilton South*): But your margin of markup is smaller, and your reasonable profit is based on volume sales, I would presume.

Mr. BASS: It is, yes.

The CHAIRMAN: Dr. Brand?

Mr. BRAND: I understand, due to bulk buying, that you certainly do have low costs or low prescription prices. Do you think this is feasible for small drug stores in small towns?

Mr. BASS: Well, it has to be feasible, Dr. Brand, because when we started our heavy merchandising I was doing, I think, about five prescriptions a day, and—

Mr. BRAND: Did you buy in bulk at that time?

Mr. BASS: No.

Mr. BRAND: Were you able to dispense as cheaply as you do now?

Mr. BASS: Well, I was dispensing as cheaply as I do now, but I did not buy in as large a quantity at that time.

Mr. BRAND: But you could still do it even at that time?

Mr. BASS: I could still do it.

Mr. BRAND: And your profit margin was still reasonable?

Mr. BASS: It is yes. A handsome return.

Mr. BRAND: A handsome return?

Mr. BASS: That is right.

Mr. BRAND: And how would you describe a handsome return?

Mr. BASS: Well, the chances are that we will be dropping our prescription price again this year by at at least 15 per cent.

Mr. BRAND: This is a fascinating brief, I get quite a kick out of it.

Mr. BASS: Thank you.

Mr. BRAND: I think maybe you will too, by the time we get through! If I may quote that old aphorism, "Everybody is out of step but my Charlie", do you really believe this, that everybody is wrong except yourself?

Mr. BASS: No. When you say everybody is wrong, what do you put that under?

Mr. BRAND: I notice you take a swipe at everybody except London Drugs Limited.

Mr. BASS: Well, you can take a swipe at London Drugs, but it is pretty hard to swipe at London Drugs for what they are doing. I mean we are strictly interested in the public.

Mr. BRAND: You say in your brief, "My first criticism is that the government is not showing a real interest in the public's problem in its method of investigating the high cost of drugs". On what do you base that statement?

Mr. BASS: Well, it is like everything else. You have had a commission going here in Ottawa for almost two years. If you were really sincere this investigation could have lasted a year and brought some definite results to the public, either in legislation or behind-the-scenes type of price reductions.

The CHAIRMAN: I should say to Mr. Bass in defence of the committee that while the committee was constituted, I think, last year, we had no sooner started our sittings than we were involved in a general election. The committee on the cost of drugs has really only been sitting less than one year, and in earnest only for the last three months, I would say.

Mr. HOWE (*Hamilton South*): Mr. Chairman, Mr. Bass used the word "commission". I presume he meant "committee", which is an entirely different thing. In the second place, as the chairman has said, we have met for much less than a year and we have not come forth with any resolutions. Now, to say that we are doing nothing about it—I am not a part of the government—that parliament is doing nothing about it, or this committee is doing nothing about it, has not yet been determined.

Mr. BASS: Well, usually what happens, it is various committees; you people come out and you do an awful lot of work and put a lot of time into it.

Mr. HOWE (*Hamilton South*): That is over-theorizing, is it not, Mr. Bass?

Mr. BASS: Well, I do not know if it is or not, but when it gets to parliament it is swept under the rug for some reason.

Mr. HOWE (*Hamilton South*): I am not disagreeing with the method. I believe there is a lot to be learned about our system here, but to generalize and put this committee in that class, you do not know yet what we might come up with or what might come of it. Let us hope that it will be a miracle this time.

Mr. BASS: I hope so.

Mr. BRAND: I would hope, Mr. Bass, that by the time we get through the questions today you will believe that we are not exactly doing nothing.

Mr. BASS: Well, I do not think I am criticizing the committee; it is the government more than the committee.

Mr. BRAND: I will go along with that any day!

Mr. HOWE (*Hamilton South*): You must remember, Mr. Bass, that there are a lot of prejudiced opinions.

Mr. TARDIF: Mr. Chairman, Mr. Bass must have a great deal of experience in administration if he is able to criticize the government because he has different opinions than it has.

Mr. BASS: Excuse me, sir, when I say the government, it is not in regard to what government is in power. I am not singling out any particular government. They all pretty well work the same.

Mr. TARDIF: Well, I cannot sit here, Mr. Chairman, and accept the fact that every problem that is presented to parliament is swept under the rug. I do not believe that, and I do not think anybody around the table agrees with that either.

Mr. BRAND: I wonder if we could get back to the brief. You say in your brief, "You need only refer to the stock market reports to see how lucrative the manufacturing business is. Study a bit deeper and you may find that "research" is used as a cover for drawing out profits". Now, I wonder if you could elaborate on that statement? That is quite a sweeping statement.

The CHAIRMAN: What page are you on, Dr. Brand?

Mr. BRAND: The first page of the brief. There is no number on it but it starts with "Gentlemen" at the top. It is the last paragraph of the third actual page of the brief.

Mr. BASS: Well, by that I mean the drug manufacturers on the stock market have been increasing the share valuation at a very high pace in the last three or four years. Most of our Canadian drug manufacturers, I would say pretty well all of the major brands, are controlled by American parent companies. They contribute to the parent company research. Now, to what extent it is funnelled off, or what is creamed off from the Canadian manufacturer to the American manufacturer, is hard to say.

Mr. BRAND: This is a general statement which you cannot really back up. You just have that certain feeling that this is what is going on?

Mr. BASS: You will notice that I say I am not too familiar with the manufacturing. I did not delve into it too much. I imagine you people will be able to come with that answer as time goes on.

Mr. BRAND: On that same page you say, "Are you going thoroughly into their operations or insisting upon an examination of their books to find out

where the high volume of profit is concealed?" Do you have anything specific to back this up or any suggestions to make, or is this just again a feeling this is what is going on?

Mr. BASS: Yes, it is just a feeling.

Mr. BRAND: Well now, you say on page 2, "Sales tax no solution". We have had a lot of various opinions on this, including that of some of the high officials in government, and they have varied. In your statement you refer to "only a very minute part of the saving" and, "the manufacturer would, in all likelihood, absorb it into his costs with the excuse of 'the increasing cost of production' ". Do you have anything to back this statement up?

Mr. BASS: Well I can back it up. In the last year or so they have taken off additional discounts with the excuse of the high costs of operation. If they would do a thing like that on discounting, where they have given us additional discounts, there is no reason why the 11 per cent would not be absorbed by them also as an excuse of the cost of doing business.

Mr. BRAND: I get the impression from your brief that you have indeed been through some of the minutes of these committee meetings.

Mr. BASS: Yes, I have.

Mr. BRAND: And if so, in there you will find that some of the manufacturers stated quite definitely, and I recall them quite recently, I think it was Ayerst, McKenna and Harrison, who pointed out that they would remove the 10 per cent immediately from their costs, and this would be passed right along to the retailer. Are you intimating that this is not correct?

Mr. BASS: I would say it is not, because Ayerst is one of the companies from which we received at one time an additional discount on one of their preparations and it was removed about a year ago. The discount was quite substantial. I think it was a 25 per cent discount that we received. Now, if they are going to absorb a 25 per cent discount in their operation, what is 10 per cent in comparison?

Mr. BRAND: Now, you say a product should be written off after a certain length of time. What length of time?

Mr. BASS: Well, that would depend on the cost. I would say that five years would be a sufficient time, depending on the volume of the product.

Mr. BRAND: If it is costed properly?

Mr. BASS: That is correct.

Mr. BRAND: In other words, it could be very high, very much higher than perhaps it is now?

Mr. BASS: That is right. It is possible.

Mr. BRAND: Do you think it would be better to do this and write it off in a much shorter period of time?

Mr. BASS: Yes.

Mr. BRAND: Then you get on to this premarin product and you say, "That a generic of the same product is about one-fifth the cost of theirs." What product were you referring to? Is it exactly the same product?

Mr. BASS: It would be almost identical in the generic form.

Mr. BRAND: Almost identical. Do you have the name of that drug?

Mr. BASS: No, I do not.

Mr. BRAND: Could you get that for us? I think it is important. I do not like to see statements made generally unless you can back them up with some specifics.

Mr. HOWE (*Hamilton South*): As I understand it, premarin is made from a natural hormone where the others are a synthesized product with not necessarily the same action.

Mr. BASS: I doubt that. I would not argue with the difference in manufacture, but the action I would say would be the same.

Mr. HOWE (*Hamilton South*): On what do you base your opinion that the action would be the same? Do you have the opportunity to observe patients in such a comparative way that you could say that this action is different or the same?

Mr. BASS: Only through what the doctor prescribes and whether they come back for more. The doctor would be able to observe the patient's reaction.

Mr. BRAND: I do not honestly think, sir, that you are in a position to make a statement like that. There is enough evidence now of the difference between some of the naturally-occurring hormones and some of the synthetics and the side effects varying between the two, so I wonder if you would continue to support that statement of yours in view of all this evidence which I can certainly produce.

Mr. BASS: Well, I can only base this on the quantity of the drug that we use.

Mr. BRAND: I presume you are talking about cost alone?

Mr. BASS: Yes, and also the movement of products.

Mr. BRAND: Do you think movements of products and costs are more important than quality?

Mr. BASS: No, I believe in quality as well as cost in a product.

Mr. BRAND: Do you buy from generic houses, do you buy from members of the P.M.A.C. group or from whom?

Mr. BASS: Yes we do.

Mr. BRAND: From both?

Mr. BASS: We buy from both. In fact, 90 per cent of our product purchases would be from the P.M.A.C. group.

Mr. BRAND: Why is that?

Mr. BASS: We are buying P.M.A.C. drugs pretty well within a range of, say, 20 per cent of the generic because I am not fully convinced of the quality of products from generic houses.

Mr. BRAND: Oh, I see. This is what I wanted to know. Despite the fact that they presumably sell to you at approximately the same price as to other drug stores you can sell this at a lower price?

Mr. BASS: I can.

Mr. BRAND: Despite the very low price at which you sell some of these very excellent products, do you still maintain the manufacturing costs for that particular product are too high?

Mr. BASS: I believe they are.

Mr. BRAND: By about how much? What would be your estimate?

Mr. BASS: I would say a good 40 per cent.

Mr. BRAND: Forty per cent too high?

Mr. BASS: That is right.

Mr. BRAND: Where do you think they wrongly spend their money?

Mr. BASS: Well, it is hard to say where, from the financial structure, without seeing the manufacturing operation. It is hard to say where their heavy dollar is going.

Mr. BRAND: At page 3 of your brief you mention manufacturing cartel, and you make another sweeping statement as follows:

> I fail to see how they can convince us that all plants run at exactly the same costs—including administrative costs, handling or research. I know manufacturers have a certain percentage going into research, but is it exactly the same in every factory?

Now, the evidence that has been presented to us has shown some wide variations in the manufacturing costs, the costs of research, administrative and handling costs. I do not know what basis you have for this, unless you are suggesting that the briefs presented to us previously have in fact been falsified.

Mr. BASS: I do not think I can refer for instance, to anything in the contraceptive pill line. There are quite a number of them on the market and I do not think that you have a variance of 2 or 3 cents between each company.

Mr. BRAND: You mention 20 pills for an approximate cost of $2.40. What do you sell them for?

Mr. BASS: $1.39.

Mr. BRAND: $1.39 at London Drugs, Vancouver.

Mr. BASS: That is right.

Mr. BRAND: You say in the brief, "And the manufacturer's price has not been reduced one penny since they were first introduced". Can you back that statement? I think it is wrong.

Mr. BASS: The cost to us is still the same today as it was when they first came out.

Mr. BRAND: Let us go back about ten years. What did five milligrams of enovid, a product of Searle cost you at that time?

Mr. BASS: I do not believe it was out ten years ago, doctor. I think enovid is only about five years old.

Mr. BRAND: No, it is older than that. I am not talking about its use as a contraceptive, because then you get into a different field, you get into volume selling to women who do not want to have any children. However, enovid has been used for many years for various other gynecological problems and it was sold at a very much higher price when it was first brought out by the Searle company in this country.

Mr. BASS: I could not give you the cost ten years ago, but take it within the last three years, when the great bulk of the contraceptive pills came out, they quite often were priced similar to enovid and ortho.

Mr. HOWE (*Hamilton South*): How much increase in volume have you had in this past five years?

Mr. BASS: Well, it ran from three prescriptions a day to about, as I said, 1,500 to 2,000 a day.

Mr. HOWE (*Hamilton South*): On this one drug?

Mr. BASS: No.

Mr. HOWE (*Hamilton South*): Well, I am talking about the one drug.

Mr. BASS: On the one drug—this would just be a wild guess, doctor—it is a fantastic amount.

Mr. HOWE (*Hamilton South*): Is this because your business has increased or because the business on that contraceptive pill has increased, with your over-all total being the same?

Mr. BASS: I think this would be it.

Mr. HOWE (*Hamilton South*): Do you follow my point?

Mr. BASS: Yes. I think the total business has increased as well as the usage of the pill.

Mr. TARDIF: You say in your brief that drug manufacture is a cartel. This is the equivalent of implying that they are guilty of price fixing. You know, Mr. Bass, there is a law against price fixing and I wonder if you have any proof of that, because if the manufacturers are guilty of price fixing there is another method of stopping that.

Mr. BASS: Well, how effective is the method? I would like to know, because I have been involved in that, too. I have had to fight manufacturers pretty well all the way through. When we first started discounting we ran into the problem of non-supply.

Mr. TARDIF: I would say that the method is very effective if the accusation is based in facts rather than imagination. If you have facts about this, I think you would be making a contribution against price fixing.

Mr. BASS: We have made a contribution and it is still sitting on the desk of the Department of Justice. There are several cases going back over the last five years.

Mr. TARDIF: May I ask when that was drawn to the attention of the Department of Justice?

Mr. BASS: I could not say, but I would imagine it went on in the investigation stage about three or four years ago. There is one case in particular still sitting on their desk.

Mr. TARDIF: In the next clause you say that the cost of research is much less than the manufacturers would have the public believe. That is tantamount to an accusation that the manufacturers are fixing their books, because the cost of research, no doubt, is entered in their books.

Mr. BASS: Is it entered in the books or is there a certain amount of it creamed off to the parent companies?

Mr. TARDIF: Well, I do not know, I am asking you because you appear to know. You put it in your brief.

Mr. BASS: I think it was put in more as a questionnaire than a statement. It is a question, more or less, to the Committee.

Mr. TARDIF: It is a case of, "There is a rumour that—".

Mr. ENNS: I believe you made the statement that you operate the largest drug store per square foot in Canada, is that correct?

Mr. BASS: I said the North American continent.

Mr. ENNS: The North American continent. Would you be able to tell us what percentage of your business deals with the sale of prescription drugs and how else is the volume of your trade made up?

Mr. BASS: I would say the prescription end of it would probably be about 28 per cent of our total volume.

Mr. ENNS: Would there be any other way of explaining your ability to retail the prescription at a reduced figure compared to other drug stores? For example, do you not charge rental space to the prescription department, or lighting, or you are selling more coffee than anybody else? Is there any other way that makes it possible for you to reduce your prices?

Mr. BASS: I would say we probably operate one of the closest to what you would call a drug store. We have no, as you say, coffee, soda fountains, tires, sundries, we major in prescriptions, drugs and photography.

Mr. TARDIF: You carry tires? Did I hear that correctly?

Mr. BASS: I said we do not carry tires.

Mr. TARDIF: Oh, you do not. I thought you said you did.

Mr. ENNS: I want to follow this up a bit more. How large a staff do you maintain in the prescription part of your store? How many other pharmacists do you have?

Mr. BASS: There would be a total staff of about 25 in there.

Mr. ENNS: This is in the whole store?

Mr. BASS: No, just the dispensary.

Mr. ENNS: Twenty-five just working in the dispensary. How large is your total staff then?

Mr. BASS: One hundred and twenty five people.

Mr. ENNS: That is all, thank you.

Mr. FORRESTALL: Mr. Bass, you make some comments about the pharmaceutical association itself. At page 6 you say in actual fact the pharmacist is being called on less in his daily task than the associations would like the public to believe. You go on to say that university requirements for pharmaceutical degrees, or whatever the proper name for them is, should be reduced to two years from five, and you support that by saying that in our armed services prescriptions are dispensed by orderlies and in our hospitals by nurses. I would

be very interested in why you are taking a whack at the standards of your pharmacists from an educational point of view.

Mr. BASS: I do not think I am taking a whack at them, it is just what is happening to pharmacy today at the retail level. There are various facets to pharmacy. There is the retail level, there is the research level, advanced, teaching, and so on. At the retail level I do not think we need the amount of teaching that is going into teaching today because the prescription is pretty well prepared for you. It is labelled. This is too much knowledge.

Mr. ENNS: You are suggesting that dosage forms are coming from the manufacturer in packaged lots?

Mr. BASS: Pretty well.

Mr. ENNS: So that your—

Mr. BASS: It is not like it was years ago when we had to know dosages when we were compounding. You had to know the dosage of each individual chemical that was going into the prescription.

Mr. ENNS: How much of your business, for example, would be in this form?

Mr. BASS: There would be almost none in compounding.

Mr. ENNS: There would be almost none at all?

Mr. BASS: It might be about 1 per cent.

Mr. ENNS: And 99 per cent is just a matter of taking a package off the shelf or a bottle out of a box?

Mr. BASS: That is correct.

Mr. ENNS: Good Lord.

Mr. TARDIF: In the next clause, Mr. Bass, you claim there is a published financial report of a pharmaceutical firm that declared $88 million worth of sales and $44 million of profit. I presume that is gross profit?

Mr. BASS: That is gross profit.

Mr. TARDIF: Are you willing and ready to tell us the name of that firm?

Mr. BASS: It was published in the *Financial Post*. I believe it was the Searle Company. I think if you look into their reports you will find they came out with a net of $17 million.

Mr. HOWE (*Hamilton South*): Just to follow that up for a moment, is this net of $17 million based on investment or gross sales?

Mr. BASS: It is based on gross sales.

Mr. HOWE (*Hamilton South*): Do you have any idea what this profit is based on in vested money, which is really the right way to estimate profit?

Mr. BASS: I am afraid I could not say, doctor.

Mr. HOWE (*Hamilton South*): One must assume that a small investment with a net profit of $17 million would be higher than the percentage represented in the percentage of gross sales.

Mr. BASS: That is correct.

Mr. HOWE (*Hamilton South*): That was not my question, I just followed that one up. You say enovid, we will go back to it, or any one of the contraceptive pills sells usually for $2.40, and that in buying them you get a 40 per cent discount, and doing a little bit of arithmetic here it would indicate that you pay $1.44 for a package of 20 enovid, or any one of the contraceptive pills, which you sell for $1.39. To my way of thinking this indicates a loss of 5 cents, so the more you dispense the more you lose. Is this correct?

Mr. BASS: The discount, I think, is a little better than 40 per cent. I think enovid costs us $1.20.

Mr. HOWE (*Hamilton South*): So, you get this $1.20 price because of your volume sales, or is this the usual price?

Mr. BASS: That is pretty well the usual price.

Mr. HOWE (*Hamilton South*): Can you afford to sell your drugs at a 19 cent profit, including your dispensing fee, on all your drugs in this way and still support 25 pharmacists, who are each doing roughly 80 prescriptions a day?

Mr. BASS: Now, it is not 25 pharamacists; that would be the total staff. We have not got 25 pharmacists.

Mr. HOWE (*Hamilton South*): Are people other than pharmacists dispensing drugs?

Mr. BASS: Just pharmacists dispense.

Mr. HOWE (*Hamilton South*): How many pharmacists do you have?

Mr. BASS: I believe there are about ten pharmacists.

Mr. HOWE (*Hamilton South*): So they are dispensing up to 200 prescriptions a day?

Mr. BASS: Right.

Mr. HOWE (*Hamilton South*): Without any help from anybody else in the store?

Mr. BASS: All they do is just strict dispensing, nothing else. They average about 125 to 150 prescriptions a day. I may not be correct in the ten, but our pharmacists will turn out 125 to 150 prescriptions per day.

Mr. HOWE (*Hamilton South*): A man can do this efficiently, can he?

Mr. BASS: Right.

Mr. HOWE (*Hamilton South*): Now, one other specific that I happen to know the price of. Let us take Librium, which is one of the higher selling tranquillizers on the market today, which has a normal retail value of $12, which would put on it roughly a cost of $7.20, again if my arithmetic is correct. I presume it is, I have a pencil here. What would you sell 100 Librium for?

Mr. BASS: $6.19.

Mr. HOWE (*Hamilton South*): $6.19. So, according to that you are losing $1.01?

Mr. BASS: No.

Mr. HOWE (*Hamilton South*): Then you must get a greater discount on this than other stores.

Mr. BASS: No, it is not that. The other stores are buying it the same as we are. I mean they are getting better than 40 per cent on Librium.

Mr. HOWE (*Hamilton South*): What do you pay for Librium?

Mr. BASS: I pay $4.88 or $4.98.

Mr. ISABELLE: Is that for 50 or 100?

Mr. BASS: For 100.

Mr. HOWE (*Hamilton South*): We are talking specifically. Now, if you pay $4.98 per hundred and you sell them for $6.19, that is not a bad markup with volume sales. Are you claiming, for example, that other drug stores get them at this price—I am going to pick your higher figure—of $4.98?

Mr. BASS: Yes, they are.

Mr. HOWE (*Hamilton South*): Then they are getting about a 60 per cent discount on the retail price of $12, because I am sure the $12 is correct.

Mr. BASS: I believe that is the list on Librium. I would say the majority of stores are probably getting $12 for it or better.

Mr. HOWE (*Hamilton South*): Yes, $12 with or without the dispensing fee?

Mr. BASS: That is right.

Mr. HOWE (*Hamilton South*): What would you sell 25 Librium capsules for?

Mr. BASS: $1.98.

Mr. HOWE (*Hamilton South*): $1.98. You are selling it for $6.19, so that would work out to a little under $8,—

Mr. BASS: That is right.

Mr. HOWE (*Hamilton South*): —a hundred in 25 lots.

Mr. BASS: Yes.

Mr. HOWE (*Hamilton South*): And yet what quantity do you dispense that volume from?

Mr. BASS: What do you mean by what quantity?

Mr. HOWE (*Hamilton South*): What size bottle do you dispense 25 from?

Mr. BASS: We dispense it from a bottle of a thousand.

Mr. HOWE (*Hamilton South*): A bottle of a thousand. So, why would you take more for 25 than you would for 100, that is, prorated per capsule, because you are not breaking anything down, are you?

Mr. BASS: No, I am not breaking anything down but our cost is based on cost of operation.

Mr. HOWE (*Hamilton South*): Well, does it take more to count out 25 pills per pill than it does to count out 100?

Mr. BASS: No, the amount of time to count the 25 is less but I have got to put up four prescriptions for the 100. In other words, it does not take me very much more time to count 100 than it does the 25.

Mr. HOWE (*Hamilton South*): I see, you are working on a scale or schedule the same as other pharmacists do but at a lower level?

Mr. BASS: That is correct.

Mr. HOWE (*Hamilton South*): Thank you.

Mr. BRAND: Are there any other stores that sell at around the same prices as you?

Mr. BASS: Not close.

Mr. BRAND: What would be the closest?

Mr. BASS: You mean the closest in the way of price?

Mr. BRAND: Yes.

Mr. BASS: Probably close to the $8 mark.

Mr. BRAND: Let us say for 25.

Mr. BASS: I could not say, doctor.

Mr. BRAND: Do you think anyone sells close to $2 for 25?

Mr. BASS: I would be guessing if I said yes or no.

Mr. BRAND: Well I know Woodward's drug store in Vancouver sells them at $2 for 25 pills.

Mr. BASS: We never priced another store.

Mr. BRAND: I think a survey that was done some time ago indicated that Vancouver, British Columbia, certainly in Vancouver, had probably the lowest across the board prescriptions of any place in Canada. Do you think this has anything to do with the way you sell drugs? Do you think you have helped bring down the price with your large volume and cheaper selling of prescription drugs?

Mr. BASS: Yes, I would say that is the answer to lower prices.

Mr. BRAND: Have you ever considered expanding to other major centres in order to spread the largesse around? Halifax is the highest, I understand.

Mr. FORRESTALL: That is why we want him in Halifax.

Mr. BASS: We would like to but I believe each province is governed by its own provincial regulations and, as you notice in the brief, you have to be a pharmacist in order to operate a drug store.

Mr. BRAND: Have you tried to expand into other provinces?

Mr. BASS: I could not. It is out of the question entirely.

Mr. BRAND: Well, you are a pharmacist.

Mr. BASS: Yes, but only in British Columbia.

Mr. BRAND: I see.

The CHAIRMAN: He is only licensed in British Columbia.

Mr. BRAND: You could not obtain licensing in any other provinces?

Mr. BASS: No, I cannot unless I sit for the examinations.

Mr. BRAND: So you feel if you were able to set up a London Drug Store in London, for instance, that you would bring down the cost of drugs in that city?

Mr. BASS: Oh yes, the way we operate I would say probably the cost would drop one-third.

Mr. BRAND: You have taken a lot of swipes at manufacturers here, although I notice you mention that you do not know too much about them. If you buy Librium at the figure you have given us and compare this to some of the prescriptions for 25 Librium that go up as high as $5.98 for what you are selling for $1.98, who do you think is getting the largest markup, the manufacturer or the druggist?

Mr. BASS: The retailer.

Mr. BRAND: The retailer?

Mr. BASS: Yes.

Mr. BRAND: Who do you think is mostly at fault now for the high cost of drugs? Is it the manufacturer or the retailer?

Mr. BASS: I would say both. The retailer is probably more at fault than the manufacturer.

Mr. BRAND: Certainly some of the retail prices are much higher in percentage of profit than even the figure you quote here of $44 million gross profit for the Searle Company. If there is a difference, for example, of $1.98 and $5.98 on 25 Librium capsules, surely the profit there is pretty darn high.

Mr. BASS: It is.

Mr. BRAND: You still think they are both equally to blame?

Mr. BASS: Yes, I think it can be reduced from both ends.

Mr. BRAND: Who do you think could do the most reducing from the viewpoint of the consumer?

Mr. BASS: From the viewpoint of the consumer, I would start with the retailer.

Mr. BRAND: Have you ever considered going into the food business, in view of what recently occurred?

Mr. BASS: I love the drug business.

Mr. BRAND: That is no answer but we will accept it. It is out of line anyway. You say the amount spent on research is far less than the manufacturers would have the public believe. I have not been impressed that they have spent that much. Do you mean it is less than that?

Mr. BASS: I think the manufacturer is spending quite a bit. We have to give them their due. They are spending quite a bit of money, how much I could not say.

Mr. FORRESTALL: I would like to go back to the suggestion that people at your level of the business are not all-powerful but are simply in a position to make substantial efforts toward the reduction of the cost of drugs. Are the provincial pharmaceutical associations themselves—you describe them as a cartel, getting back to your observations—nearing the point when this should perhaps, in your opinion, be brought to the attention of another body of government?

Mr. BASS: You will find further on there is mention made of an action in the Supreme Court where the judge admonished our association and said the way they handled themselves should have been brought to the attention of the legislature.

Mr. FORRESTALL: What evidence do you have to suggest this yourself? Is this evidence that was written out in your effort, through the courts, to overcome what I understand was a non-supply situation? Did your evidence arise out of your investigation into those matters?

Mr. BASS: What do you mean?

Mr. FORRESTALL: You are suggesting that this cartel—cartel has a certain distasteful connotation—

Mr. BASS: Let me put it another way. Perhaps I should say, instead of using the harsh word "cartel", it should be "lead towards a cartel". I think you will find this at the bottom of page 10 where I refer to Mr. Justice Ruttan's statement, which reads:

> If in the exercise of its very wide powers, which in the present case may close the appellant's professional career and ruin him financially and socially, the council is to be governed by motives of convenience, then the time may well come when the Legislature will review the exercise of these powers.

That is a very powerful weapon for a closed organization to have.

Mr. FORRESTALL: This is why I am asking if the time has now come?

Mr. BASS: To go back over the history of our low pricing of prescriptions, when we first started there was quite a furor raised in the drug business in Vancouver. Naturally this affected members that sat on council. There was a lot of pressure put on the association that instead of acting as a body they should act impartially. They cannot help but act with feeling if their pocketbook is affected.

Mr. FORRESTALL: Are you a member of your own provincial association?

Mr. BASS: I have no alternative.

Mr. FORRESTALL: If you are not a member then you cannot—

Mr. BASS: You cannot practice.

Mr. FORRESTALL: —even practice. In another part of your brief you suggest that is a bad thing. You suggest that possibly drugs could be dispensed by other outlets. I am not sure what you mean.

Mr. BASS: Well, no. I say drugs are being dispensed by other non-professional people like nurses and orderlies.

Mr. FORRESTALL: I should use the word "sold" or "retailed", then.

Mr. BASS: I think you will find I say that retail drug stores should be allowed to be owned by others than pharmacists, but the operation of it has to be in the hands of a pharmacist.

Mr. FORRESTALL: I am sorry, but are you suggesting in your brief that drugs should be retailed, perhaps, in chain stores, grocery stores? Are you suggesting this?

Mr. BASS: Yes, sure, let the large volume people help merchandise it, but it still has to be handled by a pharmacist. It would still have to be handled on a prescription form. I do not for a minute say drugs should be put on the open shelf.

Mr. FORRESTALL: You are suggesting it would, perhaps, be in the interest of the public if in my area of Canada, for example, Dominion stores were to open a dispensary unit in one corner of their massive store—

Mr. BASS: Right.

Mr. FORRESTALL: —for the dispensation of drugs.

Mr. BASS: They would lower the cost of drugs. They can operate efficiently where a high profit is not necessary.

Mr. ISABELLE: Mr. Bass, I am still amazed at London Drug Limited, Vancouver, B.C. I do not know why you chose that name but I imagine you had good reason. Now, you said you were selling between 1,500 and 2,000 prescriptions a day?

Mr. BASS: That is correct.

Mr. ISABELLE: Do all patients pay you in cash or do you have a credit card system?

Mr. BASS: We have a charge system as well.

Mr. ISABELLE: Who pays for this? Is there any charge?

Mr. BASS: No charge at all.

Mr. ISABELLE: No charge at all. You do not give away any thermometers, or anything like that?

Mr. BASS: No gimmicks.

Mr. ISABELLE: Are you selling only drugs on prescription?

Mr. BASS: Only.

Mr. ISABELLE: Only that?

Mr. BASS: Well, when you say "only drugs on prescription", what comes out of the dispensary is only drugs on prescription.

Mr. ISABELLE: Yes. That is what you own there, a dispensary?

Mr. BASS: No, it is a general drug store.

Mr. ISABELLE: Do you have dolls and things like that?

Mr. BASS: No, no dolls. We have patent medicines and photography. We have three departments.

Mr. ISABELLE: You also said that the doctor-owned dispensary keeps prices up?

Mr. BASS: Yes.

Mr. ISABELLE: Could you tell us why?

Mr. BASS: They have a captive audience. They have to refer you back. I did not get a chance to look into it, but in the spring of this year in British Columbia there was a civil action where one group of doctors sold their medical practice which had a dispensary in it, and I believe they charged $30,000 goodwill for the pharmacy. When the new group of doctors took it over the profit which had been indicated was not there, and I believe the court awarded the new purchasers a reduction in cost. It does not seem right for a doctor-owned clinic to be worth $30,000 a year profit from a captive audience. How many times does a doctor have to be paid for his services?

Mr. ISABELLE: Could that be done anywhere in British Columbia?

Mr. BASS: It could be done anywhere in Canada.

Mr. ISABELLE: Is there any law that prevents that?

Mr. BASS: No, there is not; it is free enterprise.

Mr. ISABELLE: I do not think that is allowed in cities in the province of Quebec.

Mr. BASS: Yes, you can do it in the province of Quebec as long as the pharmacist owns the dispensary. There are ways of getting around it as far as the doctors are concerned. Anybody can own a dispensary.

Mr. ISABELLE: I agree with you on that, but it is not a doctor-owned dispensary. The dispensary is within a doctor-owned building.

Mr. BASS: That group is also a group that runs its own clinics and owns its own dispensaries. In Vancouver I think there are about three of them, and I would say you would probably find them right across Canada, although I could not say for sure.

Mr. ISABELLE: Coming back to something you said that I do not understand completely, you said that you have a credit card system in your own dispensary.

Mr. BASS: Charge accounts.

Mr. ISABELLE: Charge accounts? It is not a credit card system?

Mr. BASS: No, it is not. It is a charge account.

Mr. ISABELLE: And you say you are carrying those accounts free of charge?

Mr. BASS: That is correct.

Mr. ISABELLE: Do you send bills every month?

Mr. BASS: Yes, every month.

Mr. ISABELLE: This must cost you a lot of money.

Mr. BASS: It costs us about fifty cents an account to handle.

Mr. ISABELLE: You also said that you are selling librium for $6.19 a hundred and you are paying $4.98 for it. Are you going to tell me that with a little over a dollar profit you are able to carry credit charges?

Mr. BASS: Yes, we are, doctor.

The CHAIRMAN: For purposes of clarification, can you tell us how many of your 1,500 prescriptions would be on credit, and how many for cash?

Mr. BASS: The greatest majority would be cash. I would say at least 90 per cent would be cash, if not more.

Mr. ISABELLE: There is a system in this area where credit cards are used, or charge accounts, but people are paying about double for their prescriptions, although they do get a thermometer free.

Mr. BASS: I would not give it to them. If it were me they could buy it. There is a difference, I think, with the credit card companies. I believe they charge 7 per cent, or something like that. That is why we have never believed in credit cards. We can carry our own credit.

Mr. ISABELLE: In other words, you are not making money, you are just being charitable?

Mr. BASS: No, I am making money. I do not say I am not making money.

Mr. ISABELLE: You are being charitable.

Mr. BASS: You can call it charity, but I do not think it is charity if I am making a profit.

Mr. RYNARD: Mr. Chairman, Dr. Isabelle has covered some of the questions what I was going to ask, but there is one thing that rather puzzles me. I wonder what really determines the price of drugs? If you can buy a drug at $6 a thousand and sell a drug made by another manufacturer at $41 a thousand, why would a person manufacture the drug and sell it at $41 if he can buy it for $6? Why does he go into the manufacturing business? Why does he have a plant at all, because there is clearly a profit of $35 a thousand?

Mr. BASS: Is that not a comparison of the brand name to the generic drug?

Mr. RYNARD: I do not know. It might be a bit misleading or I am taking it up wrong. It says, "at prices of about $6 per thousand and make a reasonable profit."

The CHAIRMAN: What page are you on, Dr. Rynard?

Mr. RYNARD: Page 5. "We wonder what really determines the price of drugs". The point I am trying to make, Mr. Chairman, is that he says he is already making a profit at $6 a thousand, and he also says there is another manufacturer who sells this drug at $41. If this is true—and I expect there is enough data to support it—why in the world does the second manufacturer go into the business at all? There is clearly a profit of $35 a thousand, and I would suggest that he could just put up a building and make a lot more money by not even manufacturing that drug.

Mr. BASS: He is still making a profit at the $6 level.

Mr. RYNARD: Why go into it at all? This is a different manufacturer. You say here, "whereas another manufacturer".

The CHAIRMAN: That is a quotation from the Canadian Drug Manufacturers brief and I think that the answer was that the $41 manufacturer is the one who was in business first. This is my assumption.

Mr. RYNARD: Do you mean that had his plant going, and then he could not afford to shut it down?

The CHAIRMAN: No, he was perhaps the innovator of the drug. I believe that is what is inferred here. The innovator of the drug sells it for $41, and the generic man comes along afterwards and makes the same drug and sells it for $6, and they are both making a profit.

Mr. RYNARD: Then you are talking about two different types of drugs. You are talking about a brand name and you are talking about a generic name. This should be specified in your brief, because this would be very misleading to somebody picking this up and casually reading it.

Then the other question I want to bring up is the matter of pharmacies in doctors' offices and the shortening of the course. It seems to me that what you are recommending is that we should streamline our pharmacy course.

Mr. BASS: But only for the retail store.

Mr. RYNARD: How would you deal with this at the university level? Are you suggesting that the pharmacy course should be shortened so that we can get

more pharmacists at a cheaper rate, and that they would not need the high salaries they now receive for their work?

Mr. BASS: That would be one of the things, doctor. Take, for instance, the case of a science student. He graduates with his Bachelor of Science. He then has his Master's degree and his Ph.D. There are these standards in the science profession. Pharmacy should have the same thing. At the retail level the knowledge required to fill a prescription is not as great, for instance, as for a pharmacist in research. In fact, I can foresee the day when the knowledge that we will need as a pharmacist will be pretty well computerized, where the doctor will probably have as he has a telephone between his office and a pharmacy—a computer in his office. He will diagnose, put in his card, and will probably have a variety of drugs from which he can select.

Mr. RYNARD: Mr. Chairman, the reason I brought this up is that within the last few years doctors, if they were running a dispensary, have had to put in pharmacists, or somebody who was trained, as a requirement of, I suppose, the Ontario Pharmacy Act. I am just wondering about this. I agree with you that to dispense you do not have to be as highly skilled today as you did a few years ago when you took the drugs off the shelf and mixed them. You had to be pretty well trained and equipped to do this, because you could make a mistake very easily. Now you are picking them off the shelf, and I agree with this. Here we have a trend that indicates that those doctors operating those clinics have to put in a trained pharmacist. They are going to make a profit out of it, and you are saying here—and I am not in disagreement with this—that a pharmacist requires less knowledge today than he did ten years ago. I am rather in agreement with you on this. But here we are working apparently at cross-purposes, are we not?

Mr. BASS: Well, you still need a pharmacist, doctor, to be in charge of the pharmacy.

Mr. RYNARD: All I can say is let us streamline his course. Then the clinics would not have to pay him that much money and therefore they would not have to make that much profit.

Mr. BASS: Well, let me ask you this. Why should a clinic have a pharmacy in the first place? Is it a convenience for the doctor, a convenience for the patient, or is there an extra profit for the doctor?

Mr. RYNARD: I rather agree with you in the bigger places. There are small places where a drug store would not be able to operate, and in those cases it would be a great convenience to the people if the doctor had a little pharmacy in his office.

Mr. BASS: That would probably be in a small town, and this would be the only drug store in the town.

Mr. RYNARD: That is right. So, your recommendation is that they streamline the pharmacy course, and that this in itself would correct some of the problems we have with the doctors and with the high priced drugs?

Mr. BASS: I believe it would.

Mr. TARDIF: I do not know too much about librium because most members of parliament do not need it, but I am told that 10 milligrams of librium sells here at $12 for 100 and $8.25 for 50. Did I hear you correctly that in Vancouver you sell it at $6.19 for 100?

Mr. BASS: You heard correctly.

Mr. TARDIF: Under the name of librium?

Mr. BASS: Yes, of librium. There is no necessity for substitution in British Columbia.

Mr. TARDIF: I do not think it should be done in other provinces either without the permission of the doctor.

Mr. BASS: They can in Alberta.

Mr. TARDIF: I see.

The CHAIRMAN: I should say that when you use the word librium it implies a trade name brand and therefore he has no alternative but to use librium rather than the generic name diazepox.

Mr. TARDIF: I asked that because I was wondering why in some provinces they are allowed to substitute a similar product under a different name.

Mr. BASS: You will notice in parts of the brief I asked that where prescriptions are written for the generic name, it is always the responsibility of the pharmacist to make sure that the product he is putting out is a quality product, and if he dispenses a generic for librium, which in the mind of the pharmacist is an equally good product, then you would use it.

Mr. TARDIF: Thank you, sir.

Mr. HOWE (*Hamilton South*): Mr. Chairman, I found out by phoning a regular drug store in town here that they can buy librium in 5,000 lots for $4.68 per 100.

The CHAIRMAN: In 5,000 lots?

Mr. HOWE (*Hamilton South*): Yes.

The CHAIRMAN: What does he pay in 1,000 or 10,000 lots?

Mr. HOWE (*Hamilton South*): I did not find out the price for 1,000. For lots of 100 he pays $6.48. He gets 40 and 10 per cent off $12, and on 5,000 he gets such a discount that it comes to $4.68.

On the contraceptive pills he gets 40 per cent and 4 per cent and 10 per cent, and again I got my pencil working here and found out that he gets $2.40 worth of contraceptive pills for $1.24, which he sells for $2.40. He gets his librium for $4.68 which he sells at $12. What I would like to ask in lieu of this information is could a small druggist make a living at your selling price?

Mr. BASS: Yes.

Mr. HOWE (*Hamilton South*): Because it is dependent on him buying large quantities, which he possibly could not do if his volume sales were not such that it would merit him tying up however much money it is for 5,000 librium capsules on the chance that he might not sell these in a year.

Mr. BASS: That is correct, doctor, but when I first started, as I mentioned earlier, I think we were doing about five prescriptions a day. I was not in any position to buy any large quantities until I knew what products were moving. If I did pay $6 per 100—

Mr. HOWE (*Hamilton South*): You are not going to tell me then when you bought librium in small quantities at $6.48 per 100 that you were then selling them at $6.19, at which you are selling them now, and taking a 29 cent loss?

Mr. BASS: No, but I probably sold them at that time for about $6.98. I think when I first started we used $1 over cost, which has been changed today. I would have sold that $6 bottle of librium for $6.98.

Mr. HOWE (*Hamilton South*): You have been able to reduce your prices based on the fact that you are doing volume sales?

Mr. BASS: That is correct. But I have reduced them further as my purchasing powers increased.

Mr. ENNS: Our aim is, of course, to see if there is any way in which the cost of drugs can be reduced to the consumer. It seems our witness this morning, Mr. Bass, suggests that at the retail level there seems to be the greatest possibility of effecting control of prices. Would you, Mr. Bass, feel the Committee might benefit from further questioning of other retail outlets such as your own, or do you consider yourself to be unique? Perhaps we cannot get others like your own.

Mr. BASS: I think you will probably find that there are several operators like ourselves in Canada.

Mr. ENNS: Where there is a similar result, namely, that in that community there is a substantial reduction in the cost of drugs?

Mr. BASS: That is right.

The CHAIRMAN: Perhaps in explanation, and this is something I was going to mention later, there is a company in Toronto, which Dr. Howe brought to our attention, which runs a mail order pharmacy service and who have offered to come before the Committee. I have tentatively accepted that invitation.

The president and, I think, the executive director of the Canadian Pharmaceutical Association are in the room today and they have already agreed that they are willing to come back any time. I think that will probably be some time next year in the middle of January, approximately, but in this same session, I would assume.

Mr. TARDIF: Mr. Chairman, from reading this brief it is evident that more retailers should appear before the Committee, because this gives us an entirely different picture from the one we have been getting from the manufacturers.

The CHAIRMAN: As I said, this is going to be done.

Mr. TARDIF: If this session is reported in Vancouver it might be necessary for Mr. Bass to increase the staff in his dispensary.

The CHAIRMAN: I was going to ask Mr. Bass during the time that he increased his prescriptions from three to 1,500, how much advertising did he do?

Mr. BASS: We did quite a substantial amount of advertising. We tried to make the public conscious of the necessity of comparing the prescriptions at the shop. It is their piece of paper after they have seen the doctor. It is the same as when they shop for food.

Mr. ENNS: May I just ask a question to follow this up. There are communities where it is never possible to expect a market for 2,000 prescriptions a day, such as a community of 10,000 or 12,000 people, and yet we want pharmacists in

those communities. It just will never be possible for operations in small communities to compete with your prices?

Mr. BASS: No, but you take a pharmacy which is dealing with, say, 100 prescriptions a day, or taking 200 prescriptions a day, which is not unusual, an average community could meet our prices.

Mr. ENNS: This kind of operation could operate at your prices?

Mr. BASS: Yes. There may be about a 10 per cent difference in his buying.

Mr. ENNS: Why would you think then that they are not competing with your prices? Is it because the skill of the pharmacist is involved in the merchandising of products other than prescription drugs?

Mr. BASS: That would be part of the answer. I would say that the average pharmacist has very little knowledge of administration. His business sense is not of the best. He just has a corner store. You can go back and see what happened to the grocery trade many years ago. The reason for the large super chains coming into existence was methods of administration.

Mr. FORRESTALL: I have one further slight observation. I am delighted with Mr. Bass' appearance and I would hope that in the future we will get more of his level, and that they come in not necessarily through their association. It would be delightful to have the association back but I would prefer to have them here on an independent basis, as I gather is Mr. Bass.

The CHAIRMAN: Yes, he is.

Mr. ISABELLE: Mr. Chairman, do you also intend to bring in the corner store pharmacists, the small drug store owner? I think it would be interesting.

The CHAIRMAN: I think from what Mr. Bass has said he was a small drug store owner.

Mr. ISABELLE: But not any more. There are still lots of those small drug stores.

The CHAIRMAN: I think we should probably wait until we have the Pharmaceutical Association back, and if they are unable to give us satisfaction we will move on to other areas.

Mr. ISABELLE: I have a question to ask Mr. Bass, Mr. Chairman. What is the percentage of the prescriptions you get from Vancouver doctors who prescribe generic drugs?

Mr. BASS: It is very small, doctor.

Mr. ISABELLE: They go for brand names?

Mr. BASS: Pretty well brand names.

Mr. BRAND: I have one question to start off with. Do you buy from the wholesalers or from the manufacturer?

Mr. BASS: Most of it is directly from manufacturers. There are certain manufacturers that only sell to wholesalers.

Mr. BRAND: So you do buy some from wholesalers?

Mr. BASS: Oh yes.

Mr. BRAND: Do you have to own any shares in the wholesale firm?

Mr. BASS: No, it is not like in Ontario, Saskatchewan and Manitoba.

Mr. ISABELLE: What kind of advertising are you doing?

Mr. BASS: What do you mean by that?

Mr. ISABELLE: Do you use radio or T.V. to advertise?

Mr. BASS: We use all mediums, doctor. Radio and T.V., and the newspapers are the largest.

Mr. ISABELLE: What percentage of your balance sheet does that represent at the end of a year, 50 per cent, 30 per cent, or what?

Mr. BASS: The per cent of a dollar spent would be about 2 per cent.

Mr. BRAND: I was interested in the implied criticism of the pharmaceutical associations here—

An hon. MEMBER: Why? He was pretty direct.

Mr. BRAND: Yes, I agree he is pretty direct. I wonder if you would like to be a bit more specific. For example, on page 6 you say:

> A pharmacist who gets "out of line" on prices will be called before the disciplinary committee and may have his licence suspended or even cancelled.

Do you have any indications of this, or is this one of the lawsuits that you were involved in with the Supreme Court?

Mr. BASS: That is from a personal experience I had with our association. The only problem I had with the association was at the time I started to discount prescription prices.

Mr. BRAND: You were called before the disciplinary committee?

Mr. BASS: On a pretext, which is a round about method and, and my licence was cancelled.

Mr. BRAND: Did they give you any reason for cancelling your licence?

Mr. BASS: On the pretext that was brought before them where a news commentator had come in that knew the staff and he had bought a hypodermic needle and an eye dropper. He dubbed it as a narcotic users kit, and he got up in the association and inquired about this as a news commentator who was interested at the time, and they convinced him that he should lay a charge, which he did. I was brought before council and, if you notice further down the remarks of Justice Ruttan, I was not given a chance.

Mr. BRAND: However, as a result of an action in the Supreme Court you got your licence back?

Mr. BASS: That is correct.

Mr. BRAND: But you are convinced this was on the basis of the fact that you were discounting drugs?

Mr. BASS: There was no doubt about it in my mind.

Mr. BRAND: Do you know any other pharmacists who had the same difficulty with the Pharmaceutical Association?

Mr. BASS: I was the first in British Columbia to discount drugs to this extent.

Mr. BRAND: When you say that any person should be permitted to operate a drug store, do you really mean this?

Mr. BASS: I certainly do because I think—

Mr. BRAND: Could one of the messengers in the House of Commons operate one?

Mr. BASS: Yes. I do not think it would degrade pharmacy, I think it would lift it up because, as the one gentleman mentioned, if Dominion Stores decided to put a dispensary into a corner of their large floor area, I think the dispensary would be run on a much higher level than a lot of drug stores are operated today. There would also be a much higher protection level for the public because they are not interested in the mechanics of the pharmacy outside of administration.

Mr. BRAND: Woodwards is a large department store in Vancouver and it has its own pharmacy.

Mr. BASS: That is correct.

Mr. BRAND: Does a pharmacist own that?

Mr. BASS: No, that is owned by Woodwards.

Mr. BRAND: So, you do not really have to be a pharmacist to own a drug store in Vancouver?

Mr. BASS: No, but you have to be a pharmacist to operate it.

Mr. BRAND: Well, that is what confuses me here. You do not mean just "own", then; any person could own a drug store?

Mr. BASS: Any person should be allowed to own it.

Mr. BRAND: You say "operate".

Mr. BASS: But he has to have a pharmacist to operate it.

Mr. BRAND: You do not spell that out. This is not true in every province, to your knowledge?

Mr. BASS: The laws are pretty well the same in every province. The worst, I would say, is the province of Quebec.

Mr. BRAND: If you set up a London Drug Store here, why could you not have a pharmacist operate it?

Mr. BASS: Because the pharmacist has to own 51 per cent of the shares of the corporation.

Mr. BRAND: The same as Saskatchewan?

Mr. BASS: That is correct.

The CHAIRMAN: But this would not be the case with Woodwards, Dr. Brand, would it?

Mr. BASS: Well, they are a pre-1946 corporation and at that time anybody was able to own a pharmacy and the majority of the directors had to be pharmacists but a majority of the shares were allowed to be owned by the average layman.

Mr. BRAND: How about shares in London Drugs? It sounds like a good investment.

Mr. BASS: It is, but there are none available.

Mr. ISABELLE: Is there any prepaid "pharmacare" plan in British Columbia?

Mr. BASS: I believe M.S.A., the doctor group, have one now with $25 deductible.

Mr. ISABELLE: Do you belong to one of those plans?

Mr. BASS: Well, that is open to any pharmacy. The patients are allowed, I think, a $25 deduction, and then they present their bills to the M.S.A. and they are refunded.

Mr. ISABELLE: Is that about the same as the plan in Ontario called the green shield plan?

Mr. BASS: I am not too familiar with the green shield plan, I could not say.

Mr. ISABELLE: There are only certain pharmacies—?

Mr. BASS: In British Columbia any pharmacy can dispense.

Mr. TARDIF: On page 8 you have a paragraph there which states that if the Income Tax Department checked the books of retail pharmacists it would probably contribute to reducing the cost of drugs. What method would that apply to in this case?

Mr. BASS: Well, I can only refer to a case which happened in Vancouver seven or eight years ago with the optical society where the doctors were found to be in league with Imperial Optical, and for every prescription for a pair of glasses they sent down to the dispensing office they received a kickback, and it amounted to hundreds of thousands of dollars.

Mr. TARDIF: Would you say that this applies to the medical profession, that the medical profession are getting kickbacks from the retail pharmacists who fill their prescriptions?

Mr. BASS: I would say in some cases it may apply. I could not name any offhand. That is why I say if the tax department was able to look at books—

Mr. HOWE (*Hamilton South*): Is this factual or is this just a guess? Let us be fair to both doctors and pharmacists in this regard. We all suspect it but I think the evidence here should be based on fact, not guessing.

Mr. BASS: As I say, it was not fact, doctor; that is why I referred to the optical case.

Mr. TARDIF: If someone read this but did not have the opportunity of asking questions they would be under the impression that the Income Tax Department overlooks checking of books in retail drug stores. I do not believe that is a fact either.

Mr. BASS: It is not meant in that vein. If the Income Tax Department—the same as they discovered this optical case—brought it to light. I do not say there is or there is not, but it is a possibility.

Mr. TARDIF: I have no medical knowledge but if I were reading this, and I was not a member of this committee, I would believe that the general practice is that the doctor gets a kickback from the druggist. This I do not believe. I know

that many people talk about it without being in a position where they could prove it.

Mr. BASS: That is why I referred to the Income Tax Department, because I do not have any specific proof where I can name a doctor who is getting a kickback. The only proof would be in medically-owned clinics.

Mr. TARDIF: Mr. Chairman, without specific proof I think that this paragraph should not have been included in the brief.

Mr. HOWE (*Hamilton South*): In our country you are not guilty until proven so. Otherwise you are innocent. I think that not only this brief but this conversation that we have had here indicates the possibility of being unfair to both professions. I think it should be explained sufficiently to delete its intent.

Mr. BRAND: What section of the Food and Drug Act is it? I did not get a chance to look it up.

Mr. BASS: Under the Food and Drug Act you are not allowed to advertise any dispensary drug.

Mr. BRAND: If I need any drug that requires a written prescription.

Mr. BASS: That is correct.

Mr. TARDIF: How do you get the message to the people that you are going to sell a prescribed drug cheaper than your competitor?

Mr. BASS: Just by the word "prescription"; compare your prescription. Shop around with it.

Mr. TARDIF: You notice if a medical man gives you a prescription for librium that most of them write in a manner that cannot be read anyway. I could not possibly tell what it is, so how can I make a comparison because the doctor does not tell me it is librium. He says, "This will cool you off, Tardif", and I take his word for it.

Mr. BRAND: I think you would find the writing of the average doctor is fairly legible.

The CHAIRMAN: I think you take your prescription, which you may or may not be able to read, into a druggist and say, "How much is that going to cost me?" If he says $5, then you take it to another druggist and ask him the same question. You do not necessarily have to get it filled.

Gentlemen, perhaps we will take a short recess now. I was going to ask if it is agreed that we print this brief as an appendix to today's minutes of proceedings and evidence. While we have a well recorded quorum, it might be well to put on the record as an appendix to today's proceedings some communications we have in answer to several questions which have come up. We have a letter from Hoffman-La Roche explaining some of the discrepancies in the figures about exports. Is it agreed that this should be printed as part of today's proceedings? We have a letter from Empire Laboratories making an explanation of something that was asked for in the Minutes. We have a letter from the Humane Society of Ontario. They had written us asking to appear because of the question about premarin and horses. I wrote back and said that this kind of evidence really was beyond the terms of reference of the Committee and suggested he write us. He has done that and I think it would be reasonable

to print his letter as an appendix to today's proceedings. May I have a motion for these to be printed?

Some hon. MEMBERS: Agreed.

Motion agreed to.

Mr. BRAND: On page 9 you say:

> One immediate solution to the high cost of drugs would be an amendment to the Pharmacy Act—

That is a provincial act, I presume?

—to allow the use of the generic form in filling prescriptions?

Now, what do you mean by "generic form"? I do not understand that, sir.

Mr. BASS: Well, it is the generic drug form I am referring to. Instead of describing it by a brand name it is described by the chemical name.

Mr. BRAND: But you have indicated to me that you are selling most likely lower than any other drug store in Canada in your prices, you are certainly among the lowest, and only a very small percentage of the purchases you make are those of generic firms. You also said that some of them you would not buy because you were not sure of quality.

Mr. BASS: That is correct.

Mr. BRAND: So how do you equate the two?

Mr. BASS: The reason we are using so many brand names is because most of the prescriptions in British Columbia are brand name written. If I had the choice of dispensing, there are a few good generic houses in Canada on your popular or your maintenance drugs.

Mr. BRAND: Would you like to name which are the good ones?

Mr. BASS: No, I do not want to be put on the spot.

The CHAIRMAN: I should point out, as I did in the last meeting, when this question came up, that I read into the record several quotations—unfortunately some of the members were not here—saying that any witness before a parliamentary committee has immunity for anything he says in front of the committee. It does not apply when he is outside the committee, but while he is inside the committee.

Mr. BRAND: So you would not have to go to the Supreme Court if you said anything here.

On page 14 you say:

> This is a comparison between the cost per 1,000 tablets for Butazolidine and the Canadian-produced Phenylbutazone. The base price for the Butazolidine is $45 to the trade, and the price for Phenylbutazone is $6!

Now, do you feel that most of the Phenylbutazone tablets are pretty good tablets?

Mr. BASS: Yes, I think so.

Mr. BRAND: Have you seen that brief presented by the Canadian Pharmaceutical research group a couple of months ago about the nine brands, of Phenylbutazone out of 35 which were really not fit to be sold?

Mr. BASS: No, I did not see that brief.

Mr. BRAND: Do you think it would be useful for you to see that brief before you purchase any more Phenylbutazone?

Mr. BASS: I would be very much interested in it.

Mr. BRAND: It is apparently on the market. We do have Phenylbutazone which is not up to standard that is now circulating on the market in this country.

Mr. BASS: I agree with you on that.

Mr. BRAND: In other words, you have to look very closely into the operations of whichever generic house you happen to buy from, is that right?

Mr. BASS: We do.

Mr. BRAND: Do you have to look closely into the operation of any of the P.M.A.C. groups that you buy from?

Mr. BASS: I do not have any alternative there.

Mr. BRAND: Would you do so if you had the alternative? Would you question the quality of their products?

Mr. BASS: It is not a question of questioning the quality of the products. I have to dispense what the doctor prescribes.

Mr. BRAND: No, but do you now question the quality of some of the products from the P.M.A.C.?

Mr. BASS: No, I do not.

Mr. BRAND: But you do question that from some of the generic houses?

Mr. BASS: I do.

Mr. BRAND: What do you think is the solution to this?

Mr. BASS: I think stronger control from the Food and Drug Directorate. There should be closer liaison between the two departments and closer checking of the products put out.

Mr. FORRESTALL: On page 11, Mr. Bass, of your magnificent hatchet job you get into the fantastic cost of samples in the promotion of drugs. Could you elaborate and tell us a bit about what you know of your own certain knowledge about the role samples play from the point of view of direct cost to the manufacturer?

Mr. BASS: You can walk into many doctors' offices and you will see not five and six samples of a drug, but you will find full bottles of them, hundreds and five hundreds, of fairly costly preparations. I do not think there is a doctor in the country could not almost open up his own drug store.

Mr. TARDIF: That is an exaggeration, of course.

Mr. BASS: No, I do not think so because there is some fairly heavy sampling done. I can only talk from the experience I have had in British Columbia.

Mr. TARDIF: If he opened his own drug store with the samples he gets for nothing it would be minimum stock no doubt.

Mr. BASS: That is correct.

Mr. FORRESTALL: Minimum but effective, I would think. From your own knowledge, would one per cent or two per cent of the drugs in British Columbia be given out by doctors free, or something else done with them?

Mr. BASS: I could not say, I do not know.

Mr. FORRESTALL: You have no knowledge of what it might be?

Mr. BASS: No.

Mr. FORRESTALL: Just from observation, though, you have chosen to use the word "fantastic."

Mr. BASS: We are in contact quite a bit with doctors and they will proposition us and say, "I have a box of samples, what is it worth? Give us so much for it."

Mr. FORRESTALL: Would you buy those?

Mr. BASS: No, I would not.

Mr. FORRESTALL: You would neither buy them nor sell them if they came into your hands?

Mr. BASS: That is correct.

Mr. FORRESTALL: You include in your brief a "Dear John" letter from one of the drug manufacturing firms. You use this to point out that they are serving what you term "their own selfish interest". You point out in three paragraphs that they are going to remove slow moving products and slow moving package sizes.

Mr. BASS: Well, I pointed this out to show just what was happening. This was a resolution passed by the Canadian Pharmaceutical Association. It shows the pressure that these various pharmaceutical associations are applying to manufacturers to standardize prices, and this is a result of it.

Mr. FORRESTALL: This is the type of thing then in your opinion that does substantiate this practice?

Mr. BASS: This has to raise the cost of drugs.

Mr. TARDIF: Mr. Chairman, you said that—and I know this was only figuratively speaking—a doctor gets so many samples that he could open his own drug store. In the process of getting these samples I presume that he has to give the representative of the manufacturing firm an interview?

Mr. BASS: That is correct.

Mr. TARDIF: If he wants to open a drug store he has to have a variety of these drugs, so he would have to give every representative of every manufacturing firm who calls on him an interview. Do you think it would be profitable for the doctor to spend his time talking to representatives of manufacturing firms when he should be seeing patients, and at a much higher rate I am told?

Mr. BASS: Well, it is the only way the doctor has of knowing what is new on the market.

Mr. TARDIF: Well, that is exactly what the manufacturing firms think. There is no method for the doctors to know the new discoveries or what products are available on the market because they would not have the reading time, so they

get it in concentrated form from the sales representative who has been trained by his firm. Is there any other method of doing that? If they are going to give the doctor a lot of samples, and you claim it is costly and I do not disagree with you, is there any other method by which the manufacturer can advise the doctor or acquaint the doctor with the products that they are ready to sell?

Mr. BASS: I think you are going to see the day, and it is not too far off, when they are going to use computer centres where the doctor will get his information, because he is getting to be a very busy man today. It may reach a point where he would not even interview a detail man. It would just be by a central system, or something else will be devised.

Mr. BRAND: Mr. Chairman, while we are on this subject, I know the word "fantastic" is a little bit difficult to define in dollars and cents but I happen to know that doctors across Canada received 16 ounce bottles of tussionex, which is made by Strasenburgh, and which is worth retail roughly $35 a bottle.

An hon. MEMBER: How do you get it?

Mr. BRAND: How do you get it?

An hon. MEMBER: You have to be a nice fellow. I got some.

Mr. BRAND: I got some too, but this is rather expensive sampling.

The CHAIRMAN: Did you sign a form for it?

Mr. BRAND: No, it was not sent for. It was given by the detail man in the office and then signed for.

The CHAIRMAN: But you did sign for it?

Mr. BRAND: Oh, yes, Mr. Chairman, everything was legal.

Mr. RYNARD: Mr. Chairman, I just wanted to come back to place one thing on the record here so that I will understand it and it is simply this. The witness said that he could not trust some of the generic firms, he just could not accept their product.

Mr. BASS: That is correct.

Mr. RYNARD: On the other hand he said that he could trust the brand name drugs. What I am thinking is and he has stated this—that you would have to investigate those generic drug firms much more than we are doing. In other words, you would have to send out a whole army to check on them. I am wondering how you are going to equate this cost and what the cost is finally going to be. How are you going to cut the cost to the consumer if you are going to add on the costs of government inspection, which would be a big item in itself, and it does not guarantee that you are not going to get bad runs. How is it going to guarantee this unless you have a man there sampling them? This is what I would like to know.

Mr. BASS: Well, you have your mechanics of inspection now in food and drugs.

Mr. RYNARD: Only in a small way.

Mr. BASS: That is right. But it is only a question of enlarging it, which should be done. I do not say that P.M.A.C. should not also be closely inspected, but on their drugs I have no alternative. It is a doctor's choice and I must dispense what he prescribes.

Mr. RYNARD: But you have already said you accept your brand names.

Mr. BASS: I have to accept them because that is what is being called for.

Mr. RYNARD: But you have said you would accept them on quality anyway.

Mr. BASS: That is right. But on the generic there are certain houses that I would not accept because they have not got the facilities in my opinion. They do not manufacture themselves, they farm out the manufacturing, and you do not know where they are buying their drugs.

Mr. RYNARD: What you are saying in effect—maybe I am misinterpreting you—is that you could not be dead sure of any generic drug. This, in effect, is what you are saying, is it not?

Mr. BASS: No, there are certain generic drugs of which I can be fairly sure.

The CHAIRMAN: Perhaps we should have on the record, in lieu of what is said at the bottom of page 8. The following: "if this Committee would move to repeal section CO1044 of the Food and Drug Act". Perhaps we should put that on the record to make it complete. Actually he is referring to the regulations of the Food and Drug Act, and CO1044 reads: "No person shall advertise to the general public for human use a Schedule F drug". Schedule F drugs are those which require written prescriptions.

Mr. FORRESTALL: I have one request to make of the Committee. I have been very impressed with Mr. Bass' presentation and his apparent attitude. It might be argued that he is going to do a lot more business when he goes home tomorrow but I think this serves a most useful end. I wonder, to further this line of enquiry, if it would be proper for me to ask the Committee if they would consider asking the management of the chain in Halifax known as Lawton's drug stores to appear before us.

Mr. BRAND: I think it is important due to the fact that Halifax has some of the highest drug prices in Canada, Mr. Chairman.

The CHAIRMAN: I am sure the Steering Committee would be glad to consider it.

Mr. FORRESTALL: If they would I would be grateful.

The CHAIRMAN: Could you spell that name?

Mr. FORRESTALL: L-A-W-T-O-N'S.

The CHAIRMAN: Thank you.

Mr. FORRESTALL: I do not know whether the name is pluralized or not.

Mr. ISABELLE: Perhaps they should form a shoppers' anonymous and go after low priced co-operative drug stores.

Mr. FORRESTALL: Halifax does remain one of the higher priced drug areas in Canada. I have been thinking in my own mind that this costing problem was more at the drug manufacturing level. Now I am not so sure.

The CHAIRMAN: Are there any other questions of Mr. Bass? Mr. Laidlaw.

Mr. LAIDLAW: Mr. Chairman, may I ask Mr. Bass one question. Would you be satisfied, Mr. Bass, to fill prescriptions with generic drugs made by these particular companies provided, of course, the doctor prescribed them and provided these companies were under the inspection of the Food and Drug Directorate?

Is this your problem? That if you were satisfied that the Food and Drug Directorate were overseeing the operation of the generic drug companies you would not have any hesitation in purchasing those drugs?

Mr. BASS: No, I would not, Mr. Laidlaw.

Mr. LAIDLAW: Thank you.

Mr. BRAND: Mr. Bass, on page 11 in this "Dear Mr. Pharmacist" letter it says, "Like prices for like quantities" are offered to both retail pharmacies and hospitals. This is in accordance with the Canadian Pharmaceutical Association's resolution". Two questions arise out of that. Which drug firm was this?

Mr. BASS: I believe it was Warner-Chilcott.

Mr. BRAND: Could you tell me how long ago they equalized these prices?

Mr. BASS: Probably about a month or six weeks ago.

Mr. BRAND: In other words, they have raised their prices to the hospitals to offset their loss leaders?

Mr. BASS: They also raised their prices to the retailers. I had some of this information but as the air lines were on strike it did not get to me on time, but some of our prices were increased by this resolution.

Mr. BRAND: Yes, I happen to know that they raised some of their prices to hospitals. One particular product was raised by 532 per cent. It seems like a fair increase for agarol, which is what I believe it was.

Mr. BASS: That is right.

Mr. BRAND: This is presumably in line with good merchandising, which you seem to be in favour of, rather than having loss leaders as these undoubtedly were.

Mr. BASS: Well, it was loss leaders they were selling to the hospital.

Mr. BRAND: Oh yes. What was the resolution from the Canadian Pharmaceutical Association?

Mr. BASS: I have not got it here. I thought I had it.

Mr. BRAND: I will go on then. Dr. Howe mentioned this tussionex sample he got that was worth approximately $34 or $35 for 16 ounces. May I say, as one of those physicians that received that sampling, that I thank the company very much for giving me an opportunity to provide for my patients who could not afford these drugs. Admittedly this may be an expensive sample but not from the viewpoint of those who are unable to afford even the prices of London drugs. As my practice is not in Vancouver I did not have that advantage. Nevertheless, it was a very useful and a very humanitarian effort on the part of this firm. I want that clearly understood on the record.

When we come to sampling costs and boosts on that basis you make this statement: "Yes, it so happen that we are in a position to buy on the same basis as hospitals, but we cannot get them to offer to us on the same basis on quantity." What do you mean by that?

Mr. BASS: I mean by that, for example, if the hospital bought a half a million tablets they would be given a special price on them. Now, I asked for half a million tablet price, and if the maximum price for the manufacturer is 10,000

tablets, that is the basis they would quote on, whereas the hospital would be given a special concession on that half a million tablets.

Mr. BRAND: Which would be a loss leader, I presume.

Mr. BASS: Well, it is hard to say whether it is a loss leader or not. The agarol, as it so happens, is a loss leader because it has their name on it and they can leave it at the bedside of a patient. But if it is any drug at all that the patient is not familiar with, the hospital can buy that cheaper.

Mr. BRAND: Well, from Warner-Chilcott now you will have the same benefit as the hospitals, I presume?

Mr. BASS: According to their circular.

Mr. BRAND: Do you believe dispensaries are subsidizing drug stores sales. You say that at page 12.

Mr. BASS: The pharmacist in a dispensary is subsidizing front store sales by this fact. Suppose the pharmacist at a drug store fills 20 or 30 prescriptions a day, he had to be on duty whatever hours that drug store is open.

I suggest that if a pharmacist is allowed to work, say, the same as a doctor he has office hours. If his busy time of filling prescriptions is between three and five, he should be allowed to close his dispensary and still let the front store operate. This would reduce his cost.

Mr. BRAND: You mention on page 13 that the average pharmacist should be able to turn out about 12 prescriptions an hour. Now, working on an eight-hour day that is about 96 prescriptions a day, is that right?

Mr. BASS: Yes.

Mr. BRAND: Do you have above average pharmacists in your store to do 150 and 200 in a day?

Mr. BASS: No, but they are geared to filling. I am speaking of the corner store that is not geared to filling large quantities of prescriptions. I mean with one pharmacist on duty he has to do his telephoning to the doctors to get his repeats and he would have more work to do than the pharmacists working in our dispensary.

Mr. BRAND: You make this statement in your brief: "Even if the overhead is extremely heavy, and he pays his pharmacist $5 an hour, he still ends up with $20 an hour gross profit". Can you tell me of any drug stores you know of where they pay a pharmacist that kind of money?

Mr. BASS: I think you will find most of the pharmacists in Ontario are pretty well between the $9,000 and $10,000 a year figure.

Mr. BRAND: That works out to $40 a day here, which seems like a pretty good fee.

Mr. BASS: It is a good salary.

Mr. BRAND: I just do not know if any of the pharmacists I know are making that kind of money.

Mr. BASS: I think you will find your owner-owned pharmacies are making $10,000 a year or better.

The CHAIRMAN: This is assuming he was working a five day week. It would work out to about $10,000 a year.

Mr. BRAND: At page 14 you go on to talk about some of the evidence given before this committee. You mention one pink heart-shaped pill selling for $24 a thousand. The other is simply round and white and selling for $17 a thousand. This, of course, although it is not spelled out here, is manufactured by a so-called generic firm. Then you go on to say, "We can buy these in generic form at $3.60 per thousand". That discrepancy in price was from a generic house.

Mr. BASS: This should not have been in there, doctor. On the way down I realized this paragraph should be deleted from there.

Mr. BRAND: Why?

Mr. BASS: Because after reading it I realized that I was not too familiar with the drug that was referred to.

Mr. BRAND: It is produced by Empire Drug Manufacturing Company.

The CHAIRMAN: No, it is not.

Mr. BRAND: Is it not?

The CHAIRMAN: I think in all fairness the price list that Mr. Mackasey was quoting from—I stand to be correct—was from a drug firm called Lucas. They put out two drugs. The prices are right.

Mr. BRAND: I am sorry.

The CHAIRMAN: You mean that sentence should read, "We can buy these in another generic form"?

Mr. BASS: No, the whole paragraph should be deleted. I did not have the name of the pill. I do not believe it was mentioned.

The CHAIRMAN: It was tolbutamide.

Mr. BASS: If it was tolbutamide we are paying about $5 a thousand for that.

Mr. BRAND: I think actually we have made most of our points, Mr. Chairman. We could go on but I do not see much advantage in doing so.

The CHAIRMAN: Are there any other questions of Mr. Bass? If not, we would like to thank Mr. Bass for coming and presenting his brief from his viewpoint as an individual druggist from British Columbia. We thank him for coming and we wish him luck in getting back to British Columbia.

Mr. BASS: If I could mention one thing before you adjourn, Mr. Chairman. A fact you might look at, which I have not studied too deeply, is the tariff on importations from the United States on the same basis as was done with automobiles. I think you will find drugs can be bought in the United States for at least, I would say, about 25 per cent less. We could import them instead of buying in Canada. If there was no tariff area there that should also reduce the cost, because most of the drug companies here are United States-owned. I do not think there is a large independent drug house that is not United States-owned today.

Mr. BRAND: There is one.

Mr. BASS: Which one is that?

Mr. BRAND: It is owned by Labatt's. It is Canada-Duphar.

Mr. BASS: I think they just took that over about a year ago, was it not?

Mr. BRAND: It was bought by an American firm and bought back by the beer barons.

Mr. RYNARD: Mr. Chairman, what you are saying is that we could slip across the border and buy our drugs over there.

Mr. ISABELLE: You will find it very low.

Mr. RYNARD: Yes.

The CHAIRMAN: The more purified or in more final form you bring it, in, of course, the higher the tariff.

Mr. BASS: If you bought it as a finished product. Right now there is a complete tariff running about 40 per cent for importation on top of the cost.

The CHAIRMAN: On a finished product?

Mr. BASS: On a finished product, yes. I am speaking of a finished product.

Mr. RYNARD: Therefore it would pay us to have the same thing as they have in the automobile business?

Mr. BASS: That is right.

Mr. RYNARD: We have no Canadian drug firms anyway.

Mr. BASS: Right.

The CHAIRMAN: Are there any other questions? Thank you, Mr. Bass.

Mr. BASS: Thank you.

The CHAIRMAN: The meeting is adjourned until Tuesday, when we will have a brief from the Patent and Trade Marks Institute before us. The brief has been in your hands, I think, for about a week. It is very well documented.

APPENDIX "A"

Submission

to

THE PARLIAMENTARY SPECIAL COMMITTEE
ON DRUG COSTS AND PRICES
LONDON DRUGS LIMITED

Vancouver, B.C.

by

S. S. BASS,
Proprietor

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Gentlemen:

It often has been said that the world is full of critics who fail to offer any solution to a problem under discussion.

My brief to you does not fall into that category. I criticise, but I offer solutions to the public outcry against the high cost of prescription drugs.

My first criticism is that the Government is not showing a real interest in the public's problem in its method of investigating the high cost of drugs.

It appears from reports I have studied so far, that the only excuse for the Government to rectify some of the existing conditions is from a political angle and not necessarily in the best interest of the people.

Your Committee has been asking questions of the manufacturer and asking questions of druggists but—Are you going thoroughly into their operations or insisting upon an examination of their books to find where the high volume of profit is concealed?

It is obvious that drug manufacturers have not been paying out millions and millions of dollars to bring about mergers unless they were assured of substantial profits in the future.

You need only refer to the stock market reports to see how lucrative the manufacturing business is. Study a bit deeper, and you may find that 'research' is used as a cover for drawing out profits.

—2—

Surely, where sickness is concerned, no one should be able to take advantage of the public by the imposition of unnecessary costs.

Sales tax no solution

Incidentally, I do not believe the 11 per cent sales tax has anything to do with the high cost of drugs because if it were eliminated tomorrow, only a very minute part of the saving would be passed along to the public. It is such a minute portion of the product cost that the manufacturer would, in all likelihood, absorb it into his costs with the excuse of "the increasing cost of production".

Write-offs and discounts

In the research laboratories, granted, medicine has advanced to where it has extended the life of man considerably in the past few years. When a product is brought out, it is costed and it should be written off after a certain length of time. This is not done because of the various discounts. For example:

At one time I used to buy a product from Ayerst & Company a product called Premarin. It has been on the market for 30 to 40 years, I used to be given an additional 25 per cent discount on the product, but about a year ago this discount was eliminated with the excuse of high production costs. Now they cannot support that high cost argument when you consider that a generic of the same product is about one-fifth the cost of theirs.

— 3 —

A recent article on the front page of The Vancouver *Sun* (August 11, 1966) reports contraceptive pills are "being used regularly this year by an estimated 750,000 Canadian women".

At 20 pills for an approximate cost of $2.40, this means Canadian women today are spending nearly $2,000,000 a month on contraceptive pills.

And the manufacturer's price hasn't been reduced one penny since they were first introduced!

Manufacturing Cartel

Drug manufacture is a cartel today. Similar products on the market of national brands are all similarly priced—there is no differentiation. I fail to see how they can convince us that all plants run at exactly the same costs—including administrative costs, handling or research. I know manufacturers have a certain percentage going into research, but is it exactly the same in every factory?

Research costs

The amount spent on research is, I believe, far less than the manufacturers would have the public believe.

I may have dwelt too long on manufacturing—I confess I am not familiar with every phase of it, although I have learned a great deal about it over the years—but I know that in my buying of large quantities I am still not convinced that the cost and processing of 100 tablets is the same as 100,000 or 200,000 tablets.

— 4 —

Excessive profit

In this regard, I have a financial report on one of the large manufacturing companies (I can name the company if this is requested) announcing sales of $88,000,000 last year and a profit of $44,000,000. On the basis of my own experience, a profit of 100 per cent is not necessary for the successful operation of any business and it certainly does not help to solve the acute problem facing the public in Canada today—the high cost of drugs!

If the manufacturer could set up his sales on the basis of increased discounts for increased quantity buying, the public would benefit. It is the public I am interested in, not the individual manufacturer who cries that he is not making money, while his company stock and dividends have increased ten-fold in the past five or six years.

A good example of what I am stressing is the Syntex Corporation, which brings out a contraceptive pill. Also, there is Ortho, with the first contraceptive pill. These pills must have been written off now with the quantity that have been used and yet their prices to the retail druggist have not changed one penny!

I would like at this point to refer to portions of a submission by the Canadian Drug Manufacturers to your Committee. While not representing all the manufacturers, this group does, I believe, represent a number of Canadian drug manufacturers. Page 10 of that submission says this:

— 5 —

> "We wonder what REALLY DETERMINES THE PRICE OF DRUGS ...We wonder why our members can sell drug 'A'—already on the market for over 10 years—at prices of about $6 per thousand and make a reasonable profit, whereas another manufacturer still sells the same drug in Canada for about $41 today, and sells the identical medicine in England for about $17 per thousand tablets. The sample (example?) is not unique.

The PERENNIAL ANSWER of course, given by all large pharmaceutical companies in their attempt to explain drug prices is, the 'high' cost of pharmaceutical research. JUST HOW HIGH ARE THESE HIGH COSTS?

"According to the Hall Commission Report, it is estimated to be about 3 per cent in Canada, based on sales. According to other reports in the U.S.A. it is about 5-7 per cent for most companies and only a few companies spend as much as 10 per cent on research, whereas they readily spend 35-40 per cent of their sales volume on all kinds of PROMOTIONAL ACTIVITIES..."

(The capital letters are as printed in the Canadian Drug Manufacturers' presentation)

Prices at drugstore level

Now I turn to prices at the drugstore level—a subject with which I have had more than 20 years' experience.

This is a simple case of economics and if the druggist is a poor business man he has to rely on front store sales to subsidize this pharmacy. He tries to maintain a professional standard but he feels he is entitled to X dollars for putting up a prescription. By the same token, he is selling beach balls, cigarettes, soft drinks and magazines, but does not feel he should mark up a portion of his income on them on the same scale as in the dispensary.

— 6 —

Let me ask you—what is involved in this modern day in dispensing a prescription?

All it is is a matter of counting, being able to use a typewriter, being able to use a razor blade properly and transferring pills from one bottle to another. A pharmacist does not need as wide a knowledge today as he did many years ago. He might like to make you believe that the great knowledge he has involves years of university and difficult exams but in actual fact he is being called on LESS in his daily task than Pharmaceutical Associations would like the public to believe.

Yes, his every action is controlled by various provincial associations which, through their disciplinary committees, help to control prices. A pharmacist who gets "out of line" on prices will be called before the disciplinary committee and may have his licence suspended or even cancelled.

I speak about this matter from personal experience when I first started modern merchandising of the prescription department.

Fortunately, I am not the type to be dictated to by any group where public welfare is concerned. I work very sincerely in the interest of the public and not in the interest of professions or associations. That is why I fought this matter through the courts and won a decision in the Supreme Court of Canada for the public.

—7—

Let anyone operate

After long experience and some considerable study of the situation, it is my belief that any person should be permitted to operate a drug store, provided he, or she, conforms to all the requirements of the law governing the distribution and sale of drugs.

Cut university course

This leads me to a second stage of my argument against the long university course needed today to produce a Registered Pharmacist. I firmly believe the cost of drugs could be greatly reduced throughout the land if University requirements were reduced to two years from the existing five.

I would remind the Honourable Members of this Committee that you do not have to be a doctor or a pharmacist to dispense a prescription in Canada today. In our Armed Services, prescriptions are dispensed by orderlies; in our hospitals they are dispensed by nurses.

Doctor-owned operations

The high cost of drugs can also be blamed on doctor-owned buildings which have a dispensary. The doctors who own the building must see that their pharmacist-tenant can pay the rent and they will direct prescriptions to him to make sure that the pharmacy is at least a paying proposition.

—8—

This must cost the public money, because the prices of prescriptions can be upgraded without the customer realizing it. He feels that he must follow the doctor's recommendation.

Another important factor is doctor-owned clinics with their own dispensaries. They control the prices to the public—direct lines from the doctor's office to the dispensary, intercom systems; possible drugstore "kickbacks" to doctors. This can be done by various methods—straight cash, gifts, charge accounts which are written off and so on. All this adds to the cost to the public.

Income tax inspection

I would point out, referring to my opening statements in this Brief, that the only way you gentlemen can stop this sort of thing is to have the Income Tax Department investigate certain drugstore books to determine what is going on. I refer you to the investigation of doctors who "worked closely" with opticians seven or eight years ago for benefits running into hundreds of thousands of dollars. This money was paid by the public. It was quickly disclosed to the public when the Income Tax Department investigated books.

One simple solution

Now, if this Committee would move to repeal Section C01044 of your own Food and Drug Act, I can almost guarantee that you would see the prices of prescription drugs drop 30 to 40 per cent.

—9—

This would allow the merchandising of prescription drugs through advertising media by name only. The public is not stupid—despite the opinions of some politicians. The public knows what prescription drugs they are taking and how prescription drugs are regulated by government controls, and that if a product is advertised it still cannot be filled without a doctor's prescription.

Allow generic form

One immediate solution to the high cost of drugs would be an amendment to the Pharmacy Act to allow the use of the generic form in filling prescriptions.

The individual pharmacist is always fully responsible for the medicine he sells and he must always be conscious of the need for high quality products from the manufacturer.

But the public would like to know—and should be so informed—what a prescription should cost them. If this simple fact were made known, the druggists would all follow in line with those in their profession who have a heart and feeling for the public and are sincerely doing the job they have taken up as their professional career.

Most powerful cartel

If you gentlemen would look into the operation of provincial pharmaceutical associations you would find that they are the most powerful cartel—or rapidly becoming so—in their efforts to protect their own members. All their legislation is geared for the protection of their members and NOT the protection of the public. And I make this statement as one of their members who is continuing to fight for a better deal for the public.

—10—

If you study the decisions of some of these associations you will find that they are not based on the PUBLIC interest. A druggist, for instance, who dispenses drugs in Schedule F or Schedule A—it makes no difference if it is phenobarb, dexemal, etc. A child on the street knows they cannot be dispensed without a prescription or approval of a doctor. For such an offence the druggist would be given a "slap on the wrist", with the warning to "be a good boy". Second offences are treated the same way. The associations are very reluctant to enforce the acts which are entrusted to them.

The Pharmaceutical Associations would control our advertising in the retail trade—although I have been fighting them successfully on this in our courts. Even today I am showing their officials bright, modern advertising copy before I dare insert it in advertising media. They operate on a basis of their own convenience rather than on the principles of Justice and good business practices.

In support of this statement, I have the written decision of the British Columbia Supreme Court in my own case. I quote the words of Mr. Justice Ruttan on May 4, 1959:

> "The Council" (the disciplinary body of the Pharmaceutical Association of British Columbia) acts as it sees fit.
>
> "If in the exercise of its very wide powers, which in the present case may close the appellant's professional career and ruin him financially and socially, the Council is to be governed by motives of convenience, then the time may well come when The Legislature will review the exercise of these powers."

And the provincial associations get together to prevail on the drug manufacturers to co-operate with them in their own, selfish interest.

I have recently received from an eastern drug manufacturing firm, a "Dear Mr. Pharmacist" letter announcing:

> "In an effort to keep abreast of the many changing aspects in retail pharmacy, we announce a new distribution policy effective Monday, August 8.
>
> "We have enclosed our new price list, the principal features of which are:

"*For Prescription Specialities*

1. Slow moving products and slow moving package sizes have been discontinued.
2. 'Like prices for like quantities' are offered to both retail pharmacies and hospitals. This is in accordance with the Canadian Pharmaceutical Association's resolution.
3. Prescription specialties are priced at a Suggested Price to Pharmacy. The Price to Pharmacy has been established for most of the products by deducting 40 per cent from the list price. . ."

Sampling boosts costs

Drug manufacturers spend a fantastic amount in "sampling" their products. They have discriminatory discounts when bidding for a hospital contract in comparison with the retail prices. Yes, it so happens that we are in a position to buy on the same basis as hospitals, but we cannot get them to offer to us on the same basis on QUANTITY.

— 12 —

The manufacturer is keen to get his product into hospitals for one reason that is frequently overlooked. He wants doctors to get to know his product and if he has it in sufficient quantity in every hospital in the country, this desire is soon achieved.

All these factors add up to additional cost to the public—cost which I believe is exorbitant.

Granted, the cost of doing business is up, but during the past three or four years I have proven that prescriptions can be put out at a low price, with a resultant profit in the store.

Dispensary regulation

The dispensary should not subsidize front store sales. In any drugstore, if the dispensary does not pay, it should be allowed to operate or be discontinued as the owner sees fit. But the pharmaceutical associations say in order to call it a drugstore you must have a pharmacist. This is ridiculous, because there is no reason why anybody who carries front store drugs should not be able to use a drugstore sign or drug department sign. I fail to see why a pharmacist shouldn't be able to close his dispensary and leave the premises during quiet periods.

— 13 —

The worst example of drugstore cartel is in the Province of Quebec where, again, the association dictates policy for the sole protection of its members and NOT the public. One of the major faults there, I would say, is limitation on chain store operations and their inflexible rule that no one but druggists can own drugstores. What does it matter who owns a drugstore as long as it is operated according to the law of the land?

Legislation for pharmaceutical associations—provided by a benevolent government—has created a provincial monopoly which is feeding like a leech on the public pocket book.

$20 an hour profit

The average pharmacist should be able to turn out about 12 prescriptions an hour, using the national mark-up of $3.35 for the average prescription price

paid by the public. He is making $2 plus on every prescription. That gives him approximately $25 an hour. Even if the overhead is extremely heavy, and he pays his pharmacist $5 an hour, he still ends up with $20 an hour gross profit.

If inefficiency is the only answer to their operation, the public should not have to pay for it.

Perhaps I can best bring home to this Committee the vast discrepancy between the cost and ultimate price of drugs by again quoting from a table contained in the recent submission to you by the Canadian Drug Manufacturers.

— 14 —

This is a comparison between the cost per 1000 tablets for Butazolidine and the Canadian-produced Phenylbutazone. The base price for the Butazolidine is $45 to the trade, and the price for Phenylbutazone is $6!

The submission adds:

> "We selected Phenylbutazone since this was the pharmaceutical discussed earlier during one of the hearings. We could have taken another item, however, the ratio would have remained about the same."

The same group, in an oral submission, also drew your attention to the seemingly extraordinary disparity between the price of raw materials and the ultimate product sold in dosage form in Canada.

> "Raw material—" said this submission, "usually is not too expensive, such as Librium (Diazopoxyde) which costs only about $150 per kilo in Switzerland, about $81 in Italy, yet it represents medicines sold in dosage form in Canada for about $3,500."

It has already been disclosed before this Committee—through pertinent questioning of witnesses by your Committee members—that one manufacturer produces two pills of the same drug content at two different prices. One is pink and heart-shaped and sells for $24 per thousand, and the other is simply round and white and sells for $17 per thousand. We can buy these in generic form at $3.60 per thousand.

Although I have stated that I am not any authority on the subject of drug manufacture, I do know that this is an obvious way of bilking the public by inducing them to pay more for a pill which may look more interesting than its counterpart but does not have any additional medicinal value.

— 15 —

That, Gentlemen, is another reason for the high cost of drugs in Canada!

Too many drugstores?

It has been intimated in submissions to this Committee, that there are too many drugstores and that this, in itself, keeps up the price of drugs. One submission has mentioned that some 50 drugstores have gone out of business in Ontario alone.

Are there too many gas service stations? Does their presence on every other street corner add to the price of gasoline and other petroleum products? This is a debatable point which I do not intend arguing in my submission. However, the closing of 50 drugstores in, say, Ontario, does not make me believe the cost of drugs will automatically drop. This mortality rate may be comparable with any other business, as far as I know.

Again, it supports my argument about inefficiency in drugstore operations. Also, I expect that many of these druggists who closed their own stores went into dispensaries in doctor-owned buildings, or in other, more successful drugstores at salaries higher then they were taking out of their own businesses. I mention this only in passing, as lack of detail in each case makes it impossible to draw any proper conclusion.

— 16 —

On the matter of inefficiency in drugstore operations, I would point out this pertinent fact:

My own stores and department stores which have prescription departments, do not use those departments as loss leaders. They are operated efficiently and, I know from my own experience, at a REASONABLE profit.

Conclusion

In view of the disclosures before the Kefauver Commission in the United States—and some facts which have already been brought out by your investigation—I sincerely hope this Committee will take some definite action to assist the public to obtain, at much lower prices, essential drugs which in many cases may be a matter of life or death for them.

APPENDIX "B"

HOFFMANN-LA ROCHE LIMITED

Address: 1956 Bourdon Street, St. Laurent, Montreal 9, P.Q.

NOVEMBER 11, 1966.

Dr. Harry C. Harley, M.P.
Chairman,
Special Committee of the House of
Commons on Drug Costs and Prices,
Parliament Building
West Block
Ottawa Ontario

Dear Dr. Harley,

While Frosst were being questioned about their exports, particularly as to whether they exported chemical substances or complete pharmaceutical dosage forms, what the export prices were, and to what countries they went, it seemed to us that there could once more be a misconception of what is really involved for the Canadian economy.

In a subsequent conversation with Mr. Bryce Mackasey, to whom a copy of this letter has been sent, he referred again to the desirability of encouraging manufacture in Canada. We explained our view of the relative facts which we would have put forward in our testimony to the Committee, if we had been asked the kind of question which has been asked of others. Mr. Mackasey suggested that we should put these views in a brief or letter to you. This we now do.

The point which is being constantly overlooked, in our view, is that most of the manufacturing activities take place and most of these costs are incurred already in Canada. What is sometimes not done in Canada is the chemical manufacture of the active chemical ingredient. But this is a lesser part of the manufacturing already taking place in Canada.

For example, the P.M.A.C. brief Appendix E-2 and E-4 shows that the total imports of $13.7 millions account for slightly more than one-third of the total manufacturing cost. It also shows that they represent only about one-seventh of the total costs incurred in Canada, namely—

Cost of goods sold	$35.4 millions
Distribution	4.3 "
Marketing	32.3 "
Administration	11.6 "
	$83.6 millions

Moreover, as Lederle and others have explained almost all the international firms carry numerous small selling drugs which it would be uneconomic to manufacture in Canada. Also in these imports must be many chemicals where

the opposite is true. Vitamins would be a case in point, where the sheer scale of production now needed to be competitive in cost would make it uneconomic to produce them in Canada. We made this point in our own testimony. Lederle pointed out that although they make an antibiotic completely from the fermentation stage, others do not. Costs of scale possibly entered into that, as it often does in chemical manufacturing. Small scale manufacture may often be considerably more costly and often it may anyway involve the use or consumption of raw materials which must themselves be imported.

Then again, the import price may have to include a mark-up to cover research or know-how so that if the import ceased and took place locally, Canada should pay a royalty or a contribution separately for that; which may offset the economic gain in local manufacture.

From the Roche brief you will see that we point out that the compulsory license cases have shown that the cost of the active ingredient for two of the major drugs would be small in relation to all the other costs incurred in Canada. We explained to Mr. Mackasey that the ostensible independent prices for all our drug imports during the whole 12 year period, which we explained in our testimony, and the confidential exercise we gave to Mr. Blakely, amounted to slightly more than 4% of the total drug sales during the same 12 year period. It is comparatively insignificant.

The testimony of Frosst really made these points in reverse. It seemed that they have often found it possible only to export the active ingredient from Canada, and necessary to manufacture the pharmaceutical form locally. Among the reasons are commonly tariffs, embargoes on finished imports, and general political pressures to have as much local manufacture as possible. There are often also other reasons which tend to compel local manufacture of the pharmaceutical form. Such may be the conditions of the local market, customs duty, language, or local regulations which create small but vital differences in either the pharmaceutical form of the packaging and labelling, or other presentation.

We suppose also, from what Frosst stated, that their experience may be that the export price of the substance may be only a small part of all the costs of making the dosage form available to the public in the importing country, and consequently its price there. This is, of course, the basic pattern in this industry, and is the main point we are making in this letter.

In short, we believe that there are many traps in discussing in too wide or general terms, where drugs should be manufactured. We also believe that any generally compulsive measures to compel or induce more manufacture of the basic chemical ingredients in Canada may have little real effect on Canada's economy generally or on the prices of drugs to the Canadian public in particular.

For these and other reasons, we do believe, as we stated in paragraph 30 (c) of our Brief, that if compulsory licenses to import were granted, as the Hall Report proposed in its Recommendation 67, that would not materially influence the level of the prices of drugs to the Canadian public in general.

Yours very truly
Hoffmann-La Roche Ltd
C. A. Nowotny
for
R. Hunter

APPENDIX "C"

NOVEMBER 9, 1966

Dr. Harry C. Harley, M.D., M.P.
Parliamentary Committee
on Drug Costs and Prices
House of Commons
Ottawa, Ontario

Dear Dr. Harley:

Firstly, I want to thank you for the orderly manner in which you and your Committee questioned me on November 8, 1966 which gave me a chance to bring out some information which I hope will be of benefit to the Drug Industry and to the public who depend upon it.

Secondly, I would like to include into your information one percentage of gross net sales which I neglected to mention, or which I was not asked for. That is the figure of 4.8% spent on quality control.

Thirdly, I would like to clarify a point in Mr. Mackasey's questioning which I neglected to make clear. In some instances, especially in respect of capsules, Empire is "undersold" by some of the smaller companies because they are not actual manufacturers in the material sense but, instead, import the finished dosage forms from abroad in bulk and merely bottle and label them in Canada.

It would be advantageous for me to say that these imported dosage forms were of inferior quality but I have analyzed many of them and in truth I must say for the most part that they are the equal of my own production. I can only assume that the European producers of dosage forms are more efficient than I am. Naturally I am searching for the reason.

However, there is an important factor which may not be readily apparent simply by looking at the base prices. That is the matter of supply which, on these overseas shipments, may be erratic. In consequence the market may be flooded with low priced drugs for a while. Our sales on this item will drop off, but then will resume once more and we know the reason. The shipment from overseas has been sold and the supply is temporarily suspended. It is for this reason that I do not lower prices to meet this competition.

It may be quite improper for me to send you this information by letter rather than by testimony before the committee which, I realize, must hold its examining proceedings in public. In any circumstance I want you to know that I am anxious to help the Committee in any way that I can. I would be willing to appear again if necessary; and if an appearance could be adjusted to my other responsibilities.

Finally, I wish to point out to you that if you wish to have me appear on November 24 it will be as an individual and not as a member of a group. Although I approve of Mr. Dan's effort to organize all Canadian Drug Manufacturers and have helped him even to the extent of appearing as counsel on July

7, I must emphasize that Empire has only expressed an interest in the "CDM" and is not a member of this or any other group. If you wish to have me appear on November 24 it must be to express and defend my personal views about patents.

Sincerely yours,

EMPIRE LABORATORIES LIMITED
George F. Wright, Ph.D.
President.

APPENDIX "D"

THE ONTARIO SOCIETY FOR THE PREVENTION OF CRUELTY TO ANIMALS

NOVEMBER 8th, 1966.

Mr. Harry C. Harley, M.P.,
House of Commons,
Ottawa, Ontario.

Dear Mr. Harley:

Thank you for your letter. I expected your reply because of the obvious nature of your Committee.

However, since one of the witnesses testifying before the Committee has chosen to introduce this matter into the enquiry, I do feel that the statement made by that witness should not be allowed to pass without rebuttal.

I refer to the statements made to the Committee by Mr. John A. Walker, Executive Vice-President of Ayerst, McKenna and Harrison Ltd., which were reported in the Globe and Mail. The statement in particular said "Furthermore, humane societies were keeping close watch on the conditions under which the mares were raised and their foals were sold." This statement, if correctly reported, is entirely untrue and misleading. There are approximately 200 farms in Quebec and a similar number in Ontario. There are nearly 100 farms in Manitoba. There are insufficient Inspectors in any Humane Society in the Province of Quebec to permit any inspection of these farms to be made.

In Ontario, which has the largest number of Inspectors, it has been found impossible to provide the services of an Inspector who could even visit these farms once a year. There are 42 Inspectors in the Province of Ontario, whose duties consist entirely of investigating complaints of cruelty and neglect of animals. It is understood that there are only three such Inspectors in the Province of Quebec. In Manitoba there are no Inspectors of any sort.

Of course, it may well be that Mr. Walker in making this statement to the House of Commons Committee, was aware of the constant requests by this Society to his Company for meetings to discuss how Inspectors could be made available. However, even if such negotiations should eventually lead to the appointment of Inspectors, this would only apply to the Province of Ontario. We know of no negotiations or discussions which would lead to the appointment of special Inspectors in either Quebec or Manitoba.

I would be grateful if this letter could be incorporated in the Minutes of Proceedings and Evidence of the Special Committee on Drug Costs and Prices.

Yours sincerely,

T. I. Hughes, General Manager.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 20

TUESDAY, NOVEMBER 22, 1966

WITNESSES:

Representing the Patent and Trademark Institute of Canada: Messrs. William L. Hayhurst, Q.C., Toronto, President; John C. Osborne, Q.C., Ottawa, Past President; Russel S. Smart, Ottawa, Councillor; Roger L. Goudreau, Montreal, Honorary Secretary-Treasurer.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1966

25289—1

SPECIAL COMMITTEE ON DRUGS COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

MINUTES OF PROCEEDINGS

TUESDAY, November 22, 1966
(29)

The Special Committee on Drug Costs and Prices met this day at 9.55 a.m. The Chairman, Mr. Harry C. Harley, presided.

Members present: Messrs. Brand, Goyer, Harley, Hymmen, Isabelle, Johnston, MacDonald (*Prince*), Mackasey, MacLean (*Queens*), Orlikow, Whelan (11).

In attendance: *Representing the Patent and Trademark Institute of Canada*: Messrs. William L. Hayhurst, Q.C., Toronto, President; John C. Osborne, Q.C., Ottawa, Past President; Russel S. Smart, Ottawa, Councillor; Roger L. Goudreau, Montreal, Honorary Secretary-Treasurer.

Also in attendance: Mr. A. M. Laidlaw, Q.C. of Ottawa, Legal Counsel for the Committee.

The Chairman called on Mr. Hayhurst to introduce the other representatives of the Institute.

The Committee proceeded to the consideration of the submission by the Patent and Trademark Institute of Canada.

Agreed,—That the above submission be printed as part of today's proceedings, with the exception of the appendices. (*See Appendix "A"*)

Mr. Laidlaw made a statement with reference to his being a fellow of the Institute.

Mr. Smart made introductory remarks, and answered questions. He was assisted by Mr. Osborne.

The Chairman thanked the Institute for appearing before the Committee, and at 11.55 a.m. the Committee adjourned to 9.30 a.m. Thursday, November 24.

Gabrielle Savard,
Clerk of the Committee

25289—1½

EVIDENCE

(Recorded by Electronic Equipment)

TUESDAY, November 22, 1966

● (9.55 a.m.)

The CHAIRMAN: Gentlemen, I think we might proceed with the meeting this morning.

We have before us the representatives of the Patent and Trademark Institute of Canada. You have had their brief in your possession for a week or more.

I will call on Mr. Hayhurst, the President of the organization, to introduce his colleagues who are representing the Institute today.

Mr. William L. HAYHURST (*Q.C., Toronto, President of the Patent and Trademark Institute of Canada*): Mr. Chairman, Madam Secretary and gentlemen. You have before you this morning a group of patent and trademark agents and solicitors.

The nature of our Institute is explained fully in the brief and I will not attempt to trespass on your time by going into it.

With me this morning on my right is Mr. John C. Osborne, the immediate past president of our Institute, of the firm Gowling, MacTavish, Osborne & Henderson in Ottawa. Mr. Osborne specializes in trademark work. On my left is Mr. Roger Goudreau, the honorary secretary-treasurer of the Institute, practicing with Goudreau, Gage and Associates in Montreal. Mr. Goudreau has the advantage of being bilingual. If there are any questions in the French language, I am very sure he can handle them most capably. Beside Mr. Goudreau is Mr. Russel Smart, who is a member of our council or executive committee. Mr. Smart is of the firm of Smart and Biggar of Ottawa. He is a barrister who practices in the Exchequer Court and has a great deal to do with litigation on patent and trade mark matters, particularly relating to drugs. Mr. Smart is the author of the brief which has been presented to you.

We are very grateful for the opportunity to be here today. We hope that our brief will be of use. Mr. Smart will introduce the brief when the Chairman is ready for it. That is all I have to say, for the moment.

The CHAIRMAN: Before we call on Mr. Smart, is it agreed that we should print today's brief, with the exception of the appendices, as an appendix to today's proceedings? I think that when you read the brief you will find the appendices are in relation to the Institute and have no real relevance to the brief itself. Is that agreed?

Some Hon. MEMBERS: Agreed.

The CHAIRMAN: Before we begin the questioning and discussion I think Mr. Laidlaw has a statement he would like to make at this time.

Mr. A. M. LAIDLAW (*Counsel for the Committee*): Mr. Chairman, I would like to call the attention of the Committee to the fact that I am a fellow of the Patent and Trademark Institute of Canada, the organization which is appearing here today. I would like to assure the Committee that I had nothing whatsoever to do with the preparation of this brief. Also I would like to assure the Committee that no member of the Patent and Trademark Institute came to me to ask any questions. I think we are wearing entirely two different hats here. I am still the servant of the Committee.

Thank you, Mr. Chairman.

• (10.00 a.m.)

The CHAIRMAN: Thank you, Mr. Laidlaw.

Mr. Russel SMART (*Ottawa, Member of Council, Patent and Trademark Institute of Canada):* Mr. Chairman, members of the Committee, this brief is nothing more or less than a plea for clear, specific, practical legislation. Being the group that we are in the Patent Institute, we are specifically concerned with the Patent Act and the Trade Marks Act. We are not concerned with food and drug legislation; we are not concerned with social service legislation, combines legislation nor health and welfare legislation. All of these have their own public interest to serve; all are important; all require their own place. Our submission, basically, is that that place is not in the Patent Act nor in the Trade Marks Act but is in legislation specifically designed to effect the specific purposes I have enumerated.

The primary function of the Trade Marks Act and the Patent Act is to define the rights and liabilities that are incidental to patents and trademarks and that is the function which has proven very difficult to achieve. It is a function that becomes nearly impossible to achieve in the presence of diversity of purpose within the legislative intent of the act itself. As a man cannot serve two masters, a single piece of legislation cannot well serve two or more diverse public interests.

We come before this Committee with this brief for two reasons. Firstly, because legislative changes relating to drug patents and trademarks have been proposed to this Committee by others—and we have our own comments and proposals in that connection which are enumerated in this brief. Secondly, there is an indirect but, in our submission, important connection between confusing or diffuse legislation and drug costs. The cost of litigation itself and that of patent prosecutions—the cost of obtaining patents and registering trade marks—are an item of cost to the people who are concerned, and legislation that invites litigation or prolonged periods of administrative process works against lower costs. Those are the principal purposes for our being here.

That is all I have to say by way of introduction. I, myself, and the others with me will be glad to answer any questions that any members may have.

The CHAIRMAN: Thank you, Mr. Smart.

The meeting is open for questions.

Mr. ORLIKOW: Mr. Chairman, I am not going to ask many questions. Not being a lawyer, I may have had some difficulty in following their detailed technical criticisms and suggestions on the present legislation but, in the final analysis I think what the Patent and Trademark Institute of Canada is saying to

us, although they disclaimed any direct interest or involvement in the question of the cost of drugs, it being beyond their particular organization's interest, is that there is not very much wrong with what we have lived with up to now; let us ignore the recommendations of the Restrictive Trade Practices commission about abolishing these patents in the field of drugs, and let us even be cautious about the recommendations of the Hall Commission.

Members of the Committee, are not so concerned with the details but, rather what actually happens as a result of the system we have. Are you not aware of the detailed studies that have been made which demonstrated pretty conclusively that in Canada the cost of prescription drugs to the consumer is relatively high when compared not just to a country like Italy in which the patent laws are entirely different, but to countries like France or Britain?

Mr. SMART: Speaking for those of us in the Institute who have been concerned directly with the research that led to the preparation of our brief, I can say that we have been following all of these proceedings to which Mr. Orlikow has referred very closely and with a great deal of interest. We, as members of the Institute to which we belong, are not concerned and are not knowledgeable on the economic aspects of the subject. We are concerned, primarily, with trying to assist this Committee and through it, the legislature, in carrying out what it concludes to be the true public interest concerned with these economic factors with legislation which does not destroy that we consider to be the true public interest expressed in the patent and trade marks legislation, taken as a whole. We have been following the economic reports very closely but we do not feel that we are in a position to make economic recommendations.

Mr. ORLIKOW: I am sure you are aware of the fact that there have been very few, if any, prescription drugs actually developed in Canada?

Mr. SMART: Yes, I think that that is true in the sense that the basic chemical discoveries of the chemicals which are the active ingredients of our prescription drugs, have in most but not in all cases, come from abroad. In that connection there were some very interesting figures given in a number of reports which I did read from other countries, which did seem to indicate that the greatest number of new discoveries in that field, per capita of population, were in the geographical areas where there was a strong patent system.

Mr. ORLIKOW: You have agreed that the basic chemicals have not usually been developed in Canada. Is it not also true that even the prescription items refined from the basic chemicals have usually not been developed in Canada but, rather, in the United States, France or Switzerland?

Mr. SMART: I think that is a fair statement. I might say that you will find there have been some in Canada, and when I say "some" I mean a number which is not out of proportion to our relative population.

Mr. ORLIKOW: When we talk about the patent laws in Canada, you really cannot look at them by themselves because they are part of a general system of patent laws in the western world and also with the exception of Italy, in most if not all of the major industrial countries.

Mr. SMART: Yes. There is an international convention in connection with patents, trade marks and copyrights.

Mr. ORLIKOW: If there is a discovery made in France, Britain, Switzerland or the United States, is it not true that as a result of the international nature of a very large part of the drug industry, the licence or the patent in Canada is held by the subsidiary in Canada or is assigned to a company in Canada, which then has the licence for the manufacture or distribution of this drug in Canada?

• (10.10 a.m.)

Mr. SMART: In my experience, Mr. Orlikow, this takes place in a number of ways. There are a number of situations where the foreign company will have a wholly owned Canadian subsidiary to which it will develop its product in Canada. There are other situations where the foreign innovator of one of these drugs will licence a Canadian manufacturer. There are still others that I have come across in my experience where the foreign company will do its own marketing of such a drug in Canada.

Perhaps I did not understand your question?

Mr. ORLIKOW: We are coming to the precise question in which, I think, the Committee is interested and in which, I think, you should be interested. As long as this system exists—and your are really urging the continuation of the system as we have it—what protection does the Canadian consumer have? I am thinking of a particular illustration which I know very well because I had to face it in my family. One of the earliest tranquillizers was discovered, researched, tested and developed 100 per cent in France. It was put on the market and sold to the consumer in France about ten years ago at a price of about three cents a tablet. The Canadian subsidiary of the same company was selling that tranquillizer in Canada at a price to the consumer six times that of the price of the drug in France, between 18 and 20 cents a tablet. If we maintain our patent laws and our licensing arrangements, which is what you are proposing in your brief, what protection does the consumer have? What choice does he have?

Mr. SMART: If the kind of system were adopted, as recommended in our brief, I do not believe the kind of situation that you have mentioned would be one that would be permitted to exist. If it were shown that the Canadian price of such a drug were unreasonable, that would be grounds for giving relief to an applicant for a compulsory licence or for taking some other more drastic step if that should prove necessary.

We have not recommended that the present legislation in this regard should be maintained as it is. We have recommended that the present section 41 of the Patent Act, which is the section dealing with drugs, be abolished because we think in its present form it serves no useful purpose to anybody, and that it be replaced by a special provision which is directly related to the public interest in this field, which sets out objective standards which must be met by drug patentees and which provides a tribunal which can be effective to consider the questions which we think should be considered when a question of this nature arises.

We say that the present compulsory licensing provision is useless because it does not set out what the objective standards must be. It is completely discretionary, and the nature of the tribunal which administers it is a tribunal which is not one which could normally be expected to be in possession of the economic facts necessary to develop a policy consistent with the public interest.

Mr. ORLIKOW: But the difficulty that we are in and the difficulty which the consumer in the United States is in, is that as a result of patent legislation, and as a result of licensing and cross licensing agreements, the price of very important drugs—drugs which are used every day by the doctor, and once the doctor writes the prescription the consumer has no choice because he cannot go shopping around—have been kept at very high rates.

The Kefauver Committee reported that the drug industry, as a whole, made profits on a net worth of well over 20 per cent, which was twice that of industry as a whole. The first two years after a company like Parke Davis came up with its antibiotics it had a monopoly, and it made as much as 40 per cent and more in one year on its net worth. Now, consumers take a pretty dim view of this. It is all very well to say we have to worry about research. We do have to worry about research, but we have to worry about laws which give the manufacturer a licence, I think, to steal, to hold the public up.

Mr. SMART: Dr. Orlikow, I think we are all familiar with the report in the United States about which you are talking. I think that most of us, speaking for the members of our institute, would agree that some abuses were disclosed by the Kefauver Committee in the United States. I think, at least from my own experience in this connection, that the situation is not quite the same today as is was at the time of the Kefauver hearings and before. There has been a good deal of reform since then in the industries which were directly concerned.

Also, the United States patent system did not provide for any compulsory licensing; their patent philosophy was slightly different than that which is expressed in the Canadian statute. One of Senator Kefauver's objects was to introduce a compulsory licensing system, and in the proposals he made in his draft bill—and he was certainly no friend of the drug industry—he was very careful to set forth very exactly expressed objective tests which the tribunal considering these matters would have to consider. I do not suggest that the particular tests which he set forth there are those which would be apt in this country, but it is the fact that they are there. So the policy carried out and administered by the tribunal corresponds to the public interest expressed and adopted by parliament. That is the thing which is, in our submission, important.

• (10.20 a.m.)

Mr. BRAND: I have a few questions. I rather liked the brief in that you have been rather straightforward in suggesting how you would like section 41 thrown out and what you would have put in its place. I think this Committee needs more suggestions along these lines.

So far as section 41(3) is concerned, I notice on page 18 you make a comment that it discourages that manufacture of patented drugs in Canada. Conversely to that, do you believe that by changing or putting in a new section along the lines suggested by your group, this would encourage the manufacturing of patented drugs. Do you really believe so?

Mr. SMART: We think it would because in order to justify the investment in plant equipment, a person considering making such an investment must be able to forecast that the operation will be sound financially. If the manufacturing that he is going to do is in a field where suddenly he can have a competitor whose costs are bound to be less than his, then I suggest it is much more difficult to

justify the original investment. I have seen a number of instance where the possibility of a compulsory licence, with virtually no royalties, has discouraged the setting up of a Canadian manufacture. I know also of one case, in the days when we did not realize how section 41(3) operated—in other words we felt it would be administered on a fair price basis rather than on a nominal royalty basis—where a drug manufacturer actually did build a plant in Canada on the assumption that the worst competition he could get would be from someone making his product with a royalty which assured him of, essentially, a fair price.

Mr. BRAND: Would it be a fair statement to make that the Patent and Trademark Institute of Canada can claim among its members some of those who have acted for the generic houses as well as for the P.M.A.C.?

Mr. SMART: We have among our members both. Obviously those firms who do a good deal of patent soliciting before the patent office are apt to be, generally speaking, representing patentees, because they would be in no position to act on the other side. But within our membership we have members who are in both positions.

Mr. BRAND: Would you say that this brief, excluding the fellow who is acting for the Committee, would be a fair cross section of opinion among this group.

Mr. SMART: We did everything in our power to ensure that that was so, insofar as was possible. Before our annual meeting this year we circulated a draft of this brief—not exactly in the form in which it is now—together with a notice indicating the various principles which we felt people in the institute would agree to, the principles being the ones that are elaborated really in the brief itself. At the annual meeting we had a very thorough discussion on each of the principles and, in the form in which the draft then was, six out of the ten principles put forward were unanimously adopted by the meeting; of the others, there was a good deal of divided opinion and the brief has since been changed in an attempt to be representative of the position indicated by the membership. Where the membership at the meeting was unable to come to a conclusion, one way or the other, we have not made any recommendateions to this Committee.

Mr. BRAND: In other words, it is a fair statement to make that this is a consensus of both sides of the picture?

Mr. SMART: We think that it represents the almost unanimous views of our members.

Mr. BRAND: This certainly gives more validity to the brief, as such, if this is the case of course.

You use the word "tribunal" quite a bit throughout your brief. Are you familiar with the tribunal system in Great Britain and the granting of compulsory licences?

Mr. SMART: Yes.

Mr. BRAND: In your view, then, if you are familiar with this system, do you think this would have any specific application to the situation in Canada?

Mr. SMART: At the present time, I should think it would be most difficult to apply here because, in effect, what we have is a tribunal. It may be that the person who occupies the seat in the tribunal is an administrative officer, but if

one substituted a judicial officer in the same tribunal with the same frame of reference, I should doubt that it would make any change to the present situation.

The difference in England is the whole tribunal arrangement is in the framework of the whole situation in England and the practices which had developed in similar fields before the present tribunal was set up, were more or less transferred. So the manner of operation of that tribunal is a great deal more conservative in the sense of keeping with traditional practices than one could expect a tribunal with as wide a frame of reference to be in this country. For instance, I understand that in compulsory licence applications on the question of royalties, the tribunal will take into consideration and more or less follow the negotiated fair price which the companies arrive at with the Department of National Health and Welfare people.

Mr. BRAND: Your suggestion here, of course, is to bring in the Department of National Health and Welfare.

Mr. SMART: I think that when you are considering the question of granting a licence to manufacture a drug, it seems to me that one of the most important things is whether that person is duly qualified to do it. The person charged with the responsibility of determining that, it seems to me, would be the Minister of National Health and Welfare through the Food and Drug Branch.

Mr. BRAND: Has it been your experience that most of these compulsory licences end up in the Exchequer Court?

Mr. SMART: My experience has been that the majority of them do, or in the past, have. This is partly due to the wording of the act, which leaves enough room for argument on almost every line of the section to make it impossible to say that there is no chance of success on an appeal. In my view, this is obscure legislation. It is the kind of obscurity I was speaking of in my opening remarks.

Mr. BRAND: I have no more questions for the moment. I would like to thank the Committee, for what I consider is a most reasoned brief and one to which I think we will pay a lot of attention in the future. Thank you.

Mr. MACLEAN (*Queens*): You mentioned on page 6, the international organization with regard to patents. Could you elaborate on this and tell the Committee under what aegis this organization exists, or if there is some branch of the United Nations Organization which concerns itself wth the standardization with regard to patents generally.

• (10.30 a.m.)

Mr. SMART: The principal international agreement is a congress treaty, which is adhered to by Canada and I am not sure how many countries now because so many countries have been coming into the world recently—it was 45, I think, at the last congress—which assures a person who makes an invention and files a patent application in his own country of being able to get—provided he files his application in another country of the union within one year—the equivalent in that country of the rights he would get in his own country. In other words, he would get the benefit of his priority. This is designed to prevent pirating.

Mr. MACLEAN (*Queens*): To clarify our thinking on this whole problem, I would like you to comment on an extreme case. Suppose the whole concept of

patenting were done away with, what, in your judgment, would be the effect of this in any field of endeavour perhaps, but with specific reference to the development of the drug industry?

Mr. SMART: I would have to speak personally on this, Mr. MacLean, because you are speaking now more in the economics sphere and this is more in the field of an economist than of a lawyer. Speaking, personally, from the research that I have done over the years and the practical experience I have had over the years in the patents field, I am perfectly satisfied that without a proper patent system, the incentive to research, to invest in research and the economic development of any economy is hindered.

Mr. MACLEAN (*Queens*): Therefore, it would follow that some sort of protection for the innovator of new drugs or new processes and new inventions generally, is justifiable in the public interest?

Mr. SMART: That is my submission and, of course, again I can speak for the institute on that last question.

Mr. MACLEAN (*Queens*): It seems to me that pharmaceutical drugs, perhaps more than any other type of development, are dependent on world markets. If someone comes up with a useful new drug it is expected to be available almost everywhere in the world. New drug developments are not thought of as being developed for some particular market, as might be the case with automobiles, farm machinery or something of this sort. Is that a reasonable assumption?

Mr. MACLEAN (*Queens*): It seems to me that pharmaceutical drugs, perhaps put in different forms for administration in different countries, but the basic chemicals are certainly universal.

Mr. MACLEAN (*Queens*): No company developing a new antibiotic would expect to cater only to the market of one particular country or to one economic bloc of countries. This is a lifesaving thing and, from a humanitarian point of view, it would be expected to be made available to humanity everywhere.

Mr. SMART: I agree.

Mr. MACLEAN (*Queens*): I believe that this complicates tremendously the question of patents, so far as pharmaceuticals are concerned. If my assumption is right, innovators in the pharmaceutical field who are dependent on world markets should expect the protection they get to be generally available to them throughout the world so that the segment of the cost to the consumer which is due to the patent would be evenly distributed.

Mr. SMART: I think I agree with you. Really that is one of the objects of this International Convention which gives the inventor time to go through the formalities of applying in all of the countries in which he wants to before someone else can pirate from him.

Mr. MACLEAN (*Queens*): If an innovator happens to exist in a large market, even like the United States, where he could recover most of his costs there by a relatively small increase in the market value of his product in his home market, it is still not fair to expect the rest of the world to be free riders on his invention; they should make some contribution to the cost of the development in the form of patents.

Does this not bring forth another economic problem, which I feel is constantly mixed into the general problem of drug costs and the patenting of them; research in pharmaceuticals tends to concentrate in areas where the industry is highly developed and where there is a strong scientific base, like the United States and certain countries in Europe, and so on. Take an extreme case of a very under developed country where most of the population are not even literate; they have no hope in the foreseeable future of getting any economic benefit from the production of drugs. It is highly unlikely that they, in the foreseeable future, would develop some drug which would have an application on world markets. I do not want to mention any particular country but you can imagine some country, say, in Africa and, so far as they are concerned, it is going to be everlastingly along a one way street. They are paying out economically for the benefit of research that is going to be eternally done in other countries. While the humanitarian benefits may be great, from an economic point of view they are always going to have an unfavourable trade balance, so to speak, in this particular field of human endeavour. Is that not one of the problems that confuses us in Canada most of the time, because we are somewhere in between. Perhaps there is the occasional thing in which we can compete but most of the time we are importers, if you like, of the skills and innovations which are made in other countries, and only occasionally can we produce something that has a world application on a world market, so that we can export it either in the form of the product or in the form of patents to other parts of the world.

Mr. SMART: That is certainly one way of looking at it, Mr. MacLean. The one thing that I think should not be overlooked is that even the country such as the one you chose in Africa, may not be in a position to make a primary research contribution, it is, and Canada is, in a position to make a contribution in clinical research. I think that all of us can think of cases where most important clinical research has been done with new drugs in some of the countries which are underdeveloped. Of course, the same is true in Canada; a great deal of clinical research is done here, and I believe this is one of the important prospects. Having read some of the submissions made to this Committee, it seems to me that the clinical testing side of things apparently shows up as a fairly important prospect relative to the basic research factor.

• (10.40 a.m.)

Mr. MACLEAN (*Queens*): I am wondering if it were economically possible to diffuse research which contributes to the cost of drugs, to most countries of the world if the objection to the patent system for pharmaceuticals would be somewhat reduced because from the national point of view it then, would not be detrimental. In this way the country concerned would have the economic benefit of the research being done in that country which, in the perfect state, would balance the extra cost of the drugs sold in that market due to patents, the purpose of which, as I understand it, is to provide the added income to the innovator to balance off his costs of research.

Mr. SMART: I think what you are mentioning is true. In the world today it seems that the over-all compensation is that these countries receive foreign aid from the countries that are highly developed technically and if one looks at the countries that give foreign aid, we would find that they are complex economies in which patents play a part.

Mr. MacLEAN (*Queens*): I agree whole heartedly with the proposition that just because a company is protected by a patent, it should not be allowed to gouge the consumer because it has for a time perhaps, a monopoly and, therefore, charges inflated prices for its products. On the other hand, I think there is a tendency for people to want to have the best of both worlds; they want to pay only the cost of unpatented drugs and yet they want the benefits of research that is being done all over the world to innovate new drugs and lifesaving pharmaceuticals of various kinds. I do not think you can have it both ways. If you were in the position which, happily, Italy is in, you would have a short term benefit but, in the long run and in the wide view of humanity, generally, Italy is contributing little or nothing to the advancement of pharmaceutical science, where as if patents existed in Italy, it would have a great potential to do this.

Mr. SMART: I must agree with you.

Mr. MacLEAN (*Queens*): Section 41(3) of the Patent Act deals with both food and drugs. If there were a proposed revision of the act, do you think it would be advantageous to segregate patent law on pharmaceuticals from other products? Is the situation sometimes obscured because something that might fit well with regard to the production of foods does not really apply to the production of pharmaceuticals and vice versa.

Mr. SMART: Speaking personally, I would say yes. This is a question that I did not put to our meeting as a whole. I have a feeling that most of our members probably would agree with you, that it does produce an unnecessary complication by having foods and drugs lumped together. I think that when one thinks further on it, one sees that the public interest relating to foods is quite a bit different and certainly less highly developed than that relating to drugs. I think the two of them were lumped together in the days when the public generally were thinking that we were eventually all going to live on synthetic chemicals.

Mr. HAYHURST: Yes, I believe there was a difficulty in distinguishing between a food and a drug, too. In some borderline cases, it is hard to know whether it is acting as a food or a drug.

Mr. MACKASEY: Mr. Chairman, I am sorry Mr. Orlikow has left because we have been getting along so well this session. However, there are one or two of his statements to which I would like to take objection, particularly his statement that the drug industry have a licence to steal. It may make great headlines but it is presupposing the recommendations or the findings of this Committee. This is what we have to find out, and I do not know how a member can do his job right if he is biased, or prejudiced toward the outcome of this before we have all the evidence.

Another one of his statements to which I object is that people cannot shop around. One of the good things coming out of this Comimttee is the fact that we are acquainting the public, when we get some coverage in the press, that they can shop around. I am sure most Committee members are sharing the same experience as I am, receiving letters from people all over Canada who are insisting upon a prescription, then taking it and shopping around. They have found tremendous variation in prices between the various drug stores. I think this is one of the healthy by-products of our Committee.

I would now like to get back to your brief. The part that intrigues me, being pragmatic by nature, is section C on page 5, the second paragraph which says: "The first difficulty about abolition resides in the difficulty of identifying a drug patent." Would you like to elaborate a little more on that?

Mr. SMART: Yes. As I am sure members of this Committee are well aware, an innovator may come up with a new compound which he thinks may be a useful drug but before it can be so used and actually become a drug, there is a long process of biological testing in vitro, in vivo and it goes into clinical testing and finally, in Canada at any rate, there is a new drug submission made. What the innovator has done in the usual case, in the first instance, is to have devised a whole new group of compounds, a whole chemical family. It may have thousands of members in it, and he may have been able to satisfy himself and his scientific colleagues that this particular group of chemicals all possess a common property supressing a certain kind of bug. It may turn out that all but a very small number of those eventually pass the clinical tests. The difficulty is that he has to file his patent application as soon as he has made his invention or somebody else will beat him to it. So a great many patent applications are related to substances which may have some physiological properties and may be thought possibly some day useful as drugs but which are not, in fact, drugs, and these same substances may be very useful in some other connection.

Mr. MACKASEY: In answer to Mr. MacLean, you mentioned the international treaty signed by at least 45 countries respecting, I presume, each other's patents. Surely the patent laws of each country are not identical.

Mr. SMART: No; they are different. There is some gradual movement toward the making of more uniform patent laws throughout the world, and this has made some progress in that certain groups of countries tend to have similar systems. At the moment there appears to be under consideration certain changes in the United States and possibly also in this country—I know that there are committees studying it here—which would move the North American patent laws closer, in theory, to the European patent laws.

• (10.50 a.m.)

Mr. MACKASEY: Is there any advantage in international companies selecting one country over another when applying for the original patent?

Mr. SMART: There may be in some technical patent sense. As a Canadian, one would tend to file one's patent application initially in the United States, the most important reason being that one gets a specific technical advantage in the United States by doing it that way—and I do not need to elaborate on that because it is irrelevant to the considerations. Also, the United States have the most elaborate and best equipped patent office in the world and one gets very promptly a very thorough search which enables one to make a decision whether the invention is, in fact, a new one and has a chance of being patented, and of being patented elsewhere.

Mr. MACKASEY: In other words, you can acquire your patent much faster in the United States than in Canada. But having acquired your patent in the United States, is there any undue delay in designating the rights to your Canadian subsidiary to use that patent in Canada?

Mr. SMART: One would file both a Canadian application and a United States one. One must have a patent in each country in which one wishes the patent.

Mr. MACKASEY: Yes.

Mr. SMART: There may be as many as 40 or more countries for some inventions.

Mr. MACKASEY: You mentioned in a rather laudatory tone the growth of clinical research in Canada. Is it true that this has come about because of the food and drug legislation in this country?

Mr. SMART: I think that there was a good deal of clinical research of one kind or another being carried out in Canada before this legislation to which you are referring. I am not qualified to speak for the institute on this but it certainly would be my personal opinion that what you have said is right.

Mr. MACKASEY: Mr. MacLean mentioned, quite properly, that a country would not want to deprive other countries from the benefit of a new antibiotic, but this is not my attitude. However, I do take a dim view of Canadians having to pay more than Americans for the same antibiotic.

Mr. SMART: That is something that I just do not know.

Mr. MACKASEY: No, I would not expect you to comment on that because it is a little outside the field of patents.

Getting back now to page 5 of section C, what that page says, in effect, is that while the Restrictive Trade Practices Commission may recommend the abolition of patents, in your opinion it is practically impossible?

Mr. SMART: It is impractical and undesirable.

Mr. MACKASEY: From a practical point of view it would be very difficult to do? I think you gave excellent reasons for making it retroactive because of the patents which have not expired.

Mr. SMART: Yes.

Mr. MACKASEY: You say in section 3 which I think should be on record: "We would not feel the effect of such legislation for many many years, until all patents had run out."

On page 6 you pose the question: Why should the drug industry be more vulnerable than the fellow making toys?

On page 7 you say:

> "If all countries were to withdraw patent protection for drugs, the primary incentive for private drug research would be gone: who would invest large sums of money on research only to be faced, once the product of his research became available for analysis, with unrestricted competition by those who bore no part of the research costs?"

We have heard this message over and over again. I agree with that principle, as you probably know from following our meetings. Where I disagree with the industry is that more of this research should be done in Canada rather than other countries, I think it is because we do not have legislation forcing them to do it here. Do you have any comment on that?

Mr. SMART: That would be my view, and I know it is the view of many of my colleagues.

Mr. MACKASEY: But we should have laws forcing them to do more research in Canada?

Mr. SMART: I do not think one can force someone to do research.

Mr. MACKASEY: Well, induce or encourage.

Mr. SMART: We should encourage it. One of the strongest encouragements is sound, clear, easily understood and easily administered patent laws, something which is simple enough for the layman to understand and not to put him in the position of having to go to an expensive lawyer to be assured that he really understands what it means and then be faced, as many Canadian companies have been faced, with having their lawyers proved wrong because even the lawyers who were supposed to understand what the statute meant could not arrive at what the construction has turned out to be.

Mr. MACKASEY: You make me feel much better because I spent half the night trying to understand what it meant. I am glad you told me that the learned lawyers themselves do not quite understand the act.

Mr. SMART: When I was first called to the bar, sir, I thought I knew what that meant, but ever since I have been finding out that I know less and less about what it means.

Mr. MACKASEY: It looks like lawyers drafted it in the first place.

Mr. MACLEAN (*Queens*): Could I ask one supplementary here? Mr. Mackasey has suggested that there will not be a large amount of research done in Canada until we induce companies to do so by legislation. I would assume that companies do their research where it is most feasible from an economic point of view, and the presumption would have to be that to do something different would be somewhat more expensive. If that follows, the dispersion of research throughout all the countries in the world—and every other country would want to have its share, the same as Canada—would have an upward pressure on the price of drugs in the long run, it would make their manufactures a little more expensive. I am not objecting to the principle; maybe it is worth it if my assumption is right.

Mr. SMART: I think from a company's point of view, the incentive to make a research investment comes from a number of sources. It comes from income tax allowances and various other economic factors such as a favourable tariff position. It comes from geographic considerations; from considerations of the nearness of other research groups where you can have a cross pollination, as it has been called, one of the important factors—and it is a factor only—is proper, clear and precise patent legislation which assures the investor of the ability to have, at least for a limited time, the fruits of his research, if any.

Mr. MACLEAN (*Queens*): Does he necessarily have to patent his drug, his pharmaceutical or his development first in the country in which the research was done?

• (11.00 a.m.)

Mr. SMART: Not necessarily, although it is a great deal less expensive to do it that way.

Mr. MacLEAN (*Queens*): Would not the tendency be to patent it in Canada if Canada's laws were favourable to the industry? You mentioned clear-cut and precise patent laws.

Mr. SMART: In most countries of the world, as is mentioned in one section of the brief, the inventor has to race to the patent office to beat rivals who may also be racing there with the same invention. The first person to get there and have his application filed is the person entitled to it. So the tendency, in most countries, is to file in the home country first so as to have the benefit of the International Convention.

So far as Canada is concerned, our statute at present, in the general provisions, provides that we can take two years getting to the patent office from the time we make our invention as long as we can prove when we actually made it.

The United States has a similar provision of one year, which applies only to United States residents. A Canadian can wait two years and still preserve his rights as far as Canada is concerned, but he feels obliged to rush to the United States.

Mr. MACKASEY: Yes, because of the year factor. This would be one area where your 45 countries should standardize this procedure.

Mr. SMART: It is very likely that when the general review of the patent laws of the United States and Canada takes place, this will be one area in which more uniformity will be achieved.

Mr. MACKASEY: On page 6 of that same section you mention: "Thirdly we think that abolition of drug patents in Canada would invite the possibility of international repercussions." Would you like to elaborate on that?

Mr. SMART: Yes. It would be contrary to the spirit of the convention and certainly would cause favourable comments in congress that meet from time to time to review the convention. In certain instances, notably countries such as the United States, the laws provide that international concessions to non-residents be bilateral, and this could have the effect of at least certain factions in that country seeking discriminatory legislation against Canadians.

Mr. JOHNSTON: Do you not mean repercussions in areas other than drug manufacture?

Mr. SMART: That would be only speculation. I would think that if there were repercussions in the United States, for instance, of the nature that I have been mentioning, these would be specific, in the same way as there was a lobby in connection with forest products not too long ago, and the importation of natural gas and so on. I think they tend to be specific in the United States.

Mr. MACKASEY: Of course, you are very familiar with the Hall Report, the spirit of which is embodied in your brief.

Mr. SMART: I am familiar with the patent section of it. I have read and studied the report as a whole. There are very many large sections of it which, to me, are in quite a different spirit than those in the patent portions.

Mr. MACKASEY: On page 702 of the Hall Royal Commission Report it says:

> There is one consideration which makes the position of the holder of a Canadian patent less vulnerable than it might appear in comparison with

that of the holder of an American patent. Under Canadian patent law, automatic protection is assured by a process patent which prevents the importation of products made abroad by processes patented in Canada. The theory is that the value of the process patent could be adversely affected if products manufactured by the process could be freely imported.

If this is so, why is there not a greater tendency to take out the patent under Canadian laws instead of American?

Mr. SMART: I am not sure that I fully understand the question, because one normally would have a patent both in Canada and in the United States.

Mr. MACKASEY: I am seeking information. In the United States do they patent the process or do they patent the substance, or both?

Mr. SMART: One can patent both. My understanding of the United States law is that one does not infringe a United States process patent by importing and selling the product of that process in the United States. As the law stands at the present time, in Canada, it appears that if one had a Canadian process patent, a person would infringe that patent by importing the product of that process from abroad and selling it in Canada. This is a point that is not completely settled. It has never been specifically so decided by the Supreme Court of Canada, although there are decisions in our Exchequer Court which indicate this is the law.

Mr. MACKASEY: But in the United States there is no protection for the man who patents the process from imports?

Mr. SMART: There is in the tariff laws.

Mr. MACKASEY: They do not prevent; they just charge more for it.

Mr. SMART: No. There is a specific provision in the United States tariffs, that the holder of a process patent may stop in customs the product of his patented process.

Mr. MACKASEY: Why is it they are unable to stop the importation of drugs from Italy which are using the American process?

Mr. SMART: The difficulty has been in proving the process by which those drugs were made.

Mr. MACKASEY: You make a very good point in your brief, that we must be coming to the end of our chemical process resources, that the real discoveries now are not in the processes but in the substances.

Mr. SMART: This is so. There still are occasions where fundamentally new chemical procedures are discovered, but these are becoming very rare.

Mr. MACKASEY: Except when Joe Greene gets behind the discoveries.

That is all for the moment, Mr. Chairman. I will ask a few other questions later.

The CHAIRMAN: Do you have any questions, Mr. Laidlaw?

Mr. LAIDLAW: Yes, Mr. Chairman. I would like to refer back, merely for elaboration, to Mr. Smart's initial statement. He said that the institute was not really concerned with the economic aspects of patents.

Mr. Smart, have the institute ever considered the economic aspects of patents either with respect to patents as a whole or drug patents, as they affect Canada?

Mr. SMART: I believe that in the submissions made to the Ilsley Commission there was a certain amount of research and material submitted on economic questions, most of which would now be out of date.

Mr. LAIDLAW: I appreciate that. There seems to be some implication in your introduction, and also on page 24 of the brief dealing with trade marks, that the purposes of this type of legislation should not be lessened in any way and that the acts really stand by themselves. On reading your brief, I got the impression that the institute was primarily concerned with promoting patent protection and maintaining the monopoly for various good reasons, all of which you set out in your brief. The reason I bring this up is that the Ilsley Commission, as you probably are aware, quoted with approval a statement in a book on *The Economics of the International Patent System* by a Mrs. Edith T. Penrose who made a thorough research on the international patent system. I am quoting Mrs. Penrose from page 15 of the Report on Patents of Invention by the Ilsley Commission:

> Any country must lose if it grants monopoly privileges in the domestic market which neither improve nor cheapen the goods available, develop its own productive capacity nor obtain for its producers at least equivalent privileges in other markets. No amount of talk about "economic unity of the world" can hide the fact that some countries with little export trade in industrial goods and few, if any inventions for sale, have nothing to gain from granting patents on inventions worked and patented abroad except the avoidance of unpleasant foreign retaliation in other directions. In this category are agricultural countries and countries striving to industrialize but exporting primarily raw materials.

• (11.10 a.m.)

That is the end of the quotation. If there is any value in this comment, I think the Committee should be aware of the actual patent system as it is operating in Canada and in the United States.

Mr. Smart, have you the percentage of drug patents in this country owned by Canadians?

Mr. SMART: I have no figures but before venturing a guess, if that is what you wish me to do, I will have to have a definition of "Canadians". Do you mean Canadian corporations or are you asking me about Canadian inventors?

Mr. LAIDLAW: I am asking about Canadian inventors.

Mr. SMART: Canadian inventions or Canadian inventors?

Mr. LAIDLAW: Yes, Canadian inventions.

Mr. SMART: I would expect that it would be a small percentage. Relatively speaking, there are not very many Canadian inventions in the drug field.

Mr. LAIDLAW: No. The attention of the Committee was drawn the other day to the fact that about 92 per cent of all Canadian patents were owned by

foreigners. I would imagine this would be substantially higher in relation to the drug patents in this country owned by foreigners.

On the other hand, in the United States, by far the greatest majority of the drug patents are owned by Americans. I am pointing this out because I would like to follow Mr. MacLean's suggestion, that in the light of this entirely opposite situation should not the economic aspects of the patent system be studied, particularly in relation to the drug industry? It is a question of balance but, because the patent system certainly did a great deal for the United States, does it automatically follow that it does do the equivalent for other less developed countries?

Mr. SMART: I think what you have brought forward, Mr. Laidlaw, illustrates that the same patent system may not be what is called for in every country. In the United States they have a patent system tailored to a philosophy of patents that suits their particular economy. We have at present in Canada a patent system which in effect, was, tailored to what parliament believed to be the particular needs of the Canadian economy at the time it was adopted. Our brief points out in certain respects in relation to drugs that that philosophy is out of date. The point I make is that the existence of a patent, no matter who owns it, is something which can be made to benefit the economy of the country in which it exists, provided the philospphy of the patent statute is properly conceived.

Mr. LAIDLAW: In other words, you feel that although Canada is not as advanced industrially as the United States, the patent system, as it is now in our statute, will eventually lead us into that position. For that reason, any tampering with the patent system would be bad for development and research?

Mr. SMART: The only principle that is common to all patent systems is that inventions should be encouraged by giving to the inventor some sort of limited monopoly for a certain period, possibly circumscribed with certain conditions in the public interest, one of which universally is early publication to make the technical information available to the public. This is really the common denominator of all patent systems, and this is the basic philosophy—that we support. We say that if the public interest of Canada, in the present state of the Canadian economy, indicates to this Committee and to Parliament that there should be terms and conditions which are up to date attached to this in the peculiarly Canadian context, we say that is fine; but in defining those present day interests, let us do it in such a way that it does not detract from the basic fundamental philosophy. As we say in our brief, we think, that it can be done.

Mr. LAIDLAW: Yes, I appreciate that, Mr. Smart. There are one or two other questions I would like to ask.

Has your Institute ever considered shortening the term of years for patent protection relating to drugs; in other words, attempting to set a limit on the period of monopoly so that all research costs were recovered and proper profits were made but, at the same time, coming to an end when prices would automatically go down once the patent protection disappeared.

Mr. SMART: This question has been considered. It certainly was discussed in our deliberations leading up to the preparation of this brief. There are difficulties about that concept. We felt that the idea of having a set of standards of conduct, if you like, for a drug patentee in relation to the public interest would

be a much more effective and simple way of reaching that objective. If you are thinking in terms of a set standard of what a fair price or a fair scale of distribution is, as long as that is being met, I believe it is more likely that the public will benefit more by the patentee proceeding. On the other hand, if it is not being met, the monopoly as such disappears.

Mr. LAIDLAW: Did you also discuss in your deliberations, if the compulsory licensing provisions were allowed to be retained by this Committee in one form or another, whether an application for a compulsory licence should not be made, say, for three years after the patent issues; in other words, assist the drug manufacturer to take a step—at least for a period of time he would know that a compulsory licence could not be obtained. Have you had any thoughts along these lines?

Mr. SMART: We also discussed that question. We felt that it was most difficult to justify an arbitrary time limit which commences with the granting of the patent. The patent grant may take place shortly after the drug is innovated or it may be several years later. These things may happen through no fault of the patentee. He may be involved in a contest for priority of invention in the patent office, which may delay things for several years. Or he may come against one of the obscurities in the statute which involves a great amount of argument with the patent office as to whether or not he is entitled to a certain patent claim, and he may feel justified in appealing a refusal for it. This may take several years, assuming the best possible intentions on the part of the patentee.

• (11.20 a.m.)

On the other side of that coin, if you have a fixed period, you open the door to abuses of the system by intentional delays. There has to be flexibility in the procedures for granting patents because of the many different situations that arise. If you set a fixed time certain people might well take advantage of that to achieve delays.

Mr. LAIDLAW: I see some of the drug manufacturers here this morning as observers, Mr. Chairman. I think it would be interesting if they made some comments on this particular subject when they appear on Thursday.

Mr. Smart, did your Institute appear before the Restrictive Trade Practices Commission and the Hall Commission?

Mr. SMART: I do not believe that we were invited to appear before either the Restrictive Trade Practices Commission or the Hall Commission.

Mr. LAIDLAW: Then, this is your first brief that is really based on the recommendations of the two commissions?

Mr. SMART: This is our first formal comment on those two commissions.

Mr. LAIDLAW: I just wanted to bring that out.

Going to another problem which has come up several times, Mr. Chairman, if the compulsory licensing provision, or something similar to the one we have now, is brought in by parliament, there is the question of the tribunal that should set the conditions of the licence. I understood you to say, Mr. Smart—and please correct me if I am wrong—that in the United Kingdom this tribunal, in effect, is the comptroller of patents, is he not?

Mr. SMART: Yes, that is right.

Mr. LAIDLAW: Is that particular gentleman equivalent to our Commissioner of Patents?

Mr. SMART: In most respects, yes.

Mr. LAIDLAW: I want to be quite clear about this because a tribunal in the United Kingdom, too, is really administrative. There have been quite a few suggestions, put to the Committee on the compulsory licensing provision one being that the tribunal, to make such important decisions, should be composed probably, of not only the commissioner but also a representative from the Food and Drug Directorate and possibly an economist from the Department of Defence Production or the Department of Trade and Commerce. In other words, so as to have a tribunal that is competent to settle important matters of this kind, apparently in the United Kingdom—I am asking for information because I do not know, myself—although they changed the act in 1949, they still retain an administrative official for setting compulsory licensing terms?

Mr. SMART: That is true. They instituted the patents appeal tribunal, which was essentially a judicial tribunal, to which an appeal could be taken from the commission, with limited powers of appeal from the patents appeal tribunal to courts of appeal.

Mr. LAIDLAW: If this Committee recommended that the Food and Drug Directorate be brought into any decision of this nature, would you agree that this would be an advance perhaps on the United Kingdom provision?

Mr. SMART: Many of us have reservations on the operation of the British system in this area; we think there is room for improvement, particularly in our Canadian context. In our deliberations on this question we were unable to reach any view that could be put forward representing the majority of members of our institute. There were those who believed that it would be simpler to have the application made, in the first instance, to the Exchequer Court with the relevant ministries appearing through counsel. There were those who felt that there should be a special, primarily economic, tribunal, for instance along the lines of the Tariff Board, again, before whom the relevant ministries and parties concerned, would be represented. There were some who felt that if that kind of a tribunal were the one to be used, there should be no appeal; that should be the final decision. There were those who believed that there should be an appeal but only on points of law. There were those who felt that there should be completely unrestricted appeals.

This question of a proper tribunal is a most difficult problem because it involves the cost of this type of proceeding. Obviously, if the cost of it is very high it will not be resorted to except in extreme cases. On the other hand, if the procedure is too summary, the parties are not going to be satisfied that justice has been done by it.

Mr. LAIDLAW: I think the Committee will appreciate receiving those remarks because I believe that this is the first time, since the hearings began this particular aspect has been discussed.

Mr. SMART: Mr. Laidlaw, I might say that one would think from the wording of section 41(3) of the present Patent Act that we have now a very

simple procedure which could be expected to be inexpensive. In fact, this has not proven to be the case in most instances. It is just as expensive for the parties to adduce evidence of the nature required before the Commissioner of Patents as it is to do the same thing before a court such as the Exchequer Court. At present there is an appeal from the commissioner to the Exchequer Court which is, in a sense, a duplication of proceedings, and subsequent to that there is another right of appeal to the Supreme Court of Canada. It very often takes three or four years for a compulsory licence application to be finalized.

Mr. LAIDLAW: I realize the legal profession is the only beneficiary.

Mr. SMART: Unfortunately, this is the case.

Mr. LAIDLAW: Along the same lines, there have been complaints and probably justifiable ones on the pittance of royalties granted by the Commissioner of Patents under the compulsory licensing system. Has your institute any recommendations to make on how an appropriate royalty can be set. The Committee is aware of the fact that the commissioner sets the royalty on the bulk price of the active ingredient, although the drug companies feel that this should be set on the finished dosage form. Would the setting of a royalty have to be fixed statutory procedure?

• (11.30 a.m.)

Mr. SMART: Our view on that is that the statute should enumerate the principles that must be considered in arriving at a fair royalty. As expressed in the brief, we think, the final royalty should be designed in the light of the consideration of certain enumerated principles to assure the patentee a fair return for the use of his invention. The present wording which speaks of rewarding the inventor for the research leading to his invention, really has no meaning in modern day economic terms. The fair return for the use of the invention is a concept that went into the British statute, and that aspect of it has probably been responsible for the tribunal's willingness to look at royalty rates or costs and prices arrived at through negotiation with the National Health Service.

Mr. LAIDLAW: Thank you. Turning to another aspect, which is also of extreme importance—and it follows also from what is set out in your brief—the Ilsley Commission has recommended that section 41(1) be abandoned, as you also have recommended, and that patents on product drugs should be allowed. At the same time the Ilsley Commission recommended an identical provision to the British provision on compulsory licensing. Would you feel that would solve the problem as you see it?

Mr. SMART: No, I do not think so. You must remember that the Ilsley Commission's recommendation was made before section 41(3), as it stands, was interpreted by the courts. As you are aware, the British provision is not too unlike our present section 41(3). I believe that what is needed is a new provision, drafted in the light of the problems which, for instance, have come out in the proceedings before this Committee and the evidence that has been given by those who are able to say what the various factors of cost are and what the economic conditions of the drug market in Canada are.

Mr. LAIDLAW: As I understand it, Mr. Smart, the British provision permits the licensing of imports, and this was one of the recommendations in the Hall

Commission. Is your institute opposed to either the recommendation or the British provision because of that reason?

Mr. SMART: I do not think that the question of importation can be divorced from the other questions that have to be taken into consideration. Under the present legislation, I certainly would expect at least those members of the institute whose background has been on the patentee's side of things, to be very strongly opposed to permitting importation under our present system. If we had a system where the royalty was based on present day economic conditions in the drug market in Canada so as to assure a fair return to the patentee for the use of his invention, I think any controversy over importation or non importation would disappear.

Mr. LAIDLAW: I believe this suggestion also was made by the Consumers Association. The economist who presented that brief to the Committee said that, in his opinion, permitting imports would inject more competition into the industry—not into the industry as among themselves—perhaps making the industry more efficient, resulting in a downgrading in the price of the ultimate drug product. But this is an economic problem.

Mr. SMART: I think that is primarily an economic problem, and perhaps a problem in connection with which the Food and Drug Directorate might have certain things to say, because the more imported finished drugs that are on the Canadian market, the more weight of work falls upon the inspection services of the Food and Drug Directorate. There, again, that is really not our field.

Mr. LAIDLAW: I hvae just one further question to ask Mr. Smart, Mr. Chairman. It relates to page 25 of the brief, where section 30 of the Combines Investigation Act is referred to. There seems to be an implication that section 30(c) of that act, set out in the bottom paragraph of that page, is, perhaps, sufficient to control prices. Has this section ever been used, to your knowledge?

Mr. SMART: I am not aware of any case but I have not made any research effort to find out whether or not it has been.

Mr. LAIDLAW: You would not know whether it has ever been made with respect to patented or trade marked drugs?

Mr. SMART: I have seen it resorted to in private litigation pleadings; I never have seen it actually dealt with by a court in the reported decisions.

Mr. LAIDLAW: Do you feel that the mere existence of this section acts as a threat to patentees to sort of behave themselves in respect of pricing?

Mr. SMART: I think very much so because, on the one hand, whether or not a patentee would feel that a prosecution in which this section was resorted to would result in a conviction, any patentee would be silly to run the risk of having an investigation and a prosecution started because everyone knows, particularly those who come to this country from the United States and has had experience with anti trust investigations, just an investigation throws a manufacturing operation into confusion for months and the defence of the proceedings is a most costly affair.

Mr. LAIDLAW: Thank you, Mr. Smart. That is all I have to say.

Mr. MACKASEY: Mr. Chairman, earlier Mr. Laidlaw made reference to remarks of a Mrs. Edith Penrose which, if you want to find an easier source, are on

page 705 of the Hall Commission Report. I would like my comments on it, Mr. Chairman, to be noted. I will just repeat a very short part of her views:

> Any country must lose if it grants monopoly privileges in the domestic market which neither improve nor cheapen the goods available,...

And the next portion

> ...develop its own productive capacity nor obtain for its producers at least equivalent privileges in other markets.

● (11.40 a.m.)

This was studied by the Restrictive Trade Practices Commission who, I think, unfair to the drug industry, goes on—I am also going to read this little portion, Mr. Chairman—to admit that production in Canada had been increased by patent protection, but then goes on to eliminate it on the conjecture that production might have increased anyway. I will read it:

> The Restrictive Trade Practices Commission concluded:
>
> The evidence collected in this inquiry does not show that patents have either cheapened the drugs available in Canada—

which is one of the criterion outlined by Mrs. Penrose,

> —or improved them in any way.

Another one of her criterion. Then it goes on to say this:

> Productive capacity in Canada has definitely increased,

which is her justification for patents. It then goes on and presumes that possibly productivity in Canada may have increased anyway without the patent protection. I think this is rather unfair of the Hall Commission or of the Restrictive Trade Practices Commission because, at least, they have conclusive evidence that patents, according to their own statement, does increase productivity in the drug industry in Canada, which is one of the criteria which Mrs. Penrose outlines as justifying adequate patent laws.

The Hall Commission then goes on to suggest that we abolish it entirely, quoting the Restrictive Trade Practices Commission, and completely ignoring Mrs. Penrose's statement on which they had put so much emphasis earlier in the paragraph. The Hall Commission then suggests that we do not abolish it for at least five years. It seems to me, Mr. Chairman, that the Hall Commission has recommended this recommendation of the Restrictive Trade Practices Commission because it did not have any other. The wording seems to say: Well, we have to make some recommendation in the brief; we have not come to any conclusion so we might as well accept this particular one.

Mr. Chairman, I am not too sure if the word "tribunal" has the same connotation to me as it does to experts in the field of patents. The reason I had suggested earlier, when one of the witnesses from the industry were here, the establishment of a tribunal was because I was impressed by the Hilliard Committee Report. Although price reduction is an objective of this Committee, so is safety, and I thought that by establishing a tribunal, which to me was at least three people sitting together, that the representative of the Food and Drug Directorate might have the power to overrule even the Commissioner of Patents if, in the opinion of the Food and Drug Directorate, the granting of a compulsory licence at the same time indicated a degree of danger to health because the

applicant could not meet the standards laid down by the Food and Drug Directorate which, I think, is what the Hilliard Committee Report is all about.

When I hear Mr. Laidlaw talking about a tribunal of one person, I am a little confused.

Mr. SMART: Perhaps I could clarify it to this extent. In the brief, and when I have personally spoken of a tribunal I am using it in its broader sense to mean anybody, whether it be a single person or a number of persons, charged with making a decision in pursuance to some statutory authority.

Mr. MACKASEY: Being a layman I am precise; being a lawyer, you are ambiguous.

Mr. SMART: This is quite possibly so.

Mr. MACKASEY: That is the basic difference.

Mr. SMART: If I may just speak for a minute on the question of a tribunal consisting of a number of people as opposed to a single person before whom are brought representatives of the various interests involved, one possibility that was discussed in our deliberations was the possibility that the route to an application for a compulsory licence might well be through the Food and Drug Directorate; in other words, only such people who could satisfy the Food and Drug authorities should be permitted to make application. This would in our view, perhaps have the effect of cutting down a number of undesirable applications.

Mr. MACKASEY: Mr. Chairman, there is another section or two which I have marked off. I think we have not done justice to the section in the brief on trade marks. There is something in that section that intrigues me. In the bottom part of section 8 on page 24, your brief goes on to say:

> If the public interest in the expected lowering of the price of some trade marked drugs by forcing Canadian companies to compete in the Canadian market with their foreign related companies under identical trade marks is considered to be paramount and greater even than the public interest in the integrity of trade marks then it will require a very carefully drafted provision affecting the whole scheme of the Trade Marks Act and not merely Section 20 as suggested in the Hall Report.

Would you elaborate on that, please?

Mr. SMART: If the suggestion in the Hall Report were to be adopted, it would make something which, almost by definition, is an infringement of the trade mark into something which was not. A trake mark is something that has validity because of something that is in the minds of the public in relation to it. It is not because it is in the mind of the trade mark holder; it has value simply because people at large recognize it as meaning something. If you say that by statute in certain instances it is not going to mean that, in a sense you are attempting to legislate a fact out of existence—and we all know that that is impossible. Therefore, what would happen in connection with the trade marks directly affected by such a provision would be that in the course of time they would come to mean nothing and would disappear; in other words, the provision would be repugnant to the philosophy—

Mr. MACKASEY: In any event, in section 9 you emphasize how easy it would be to circumvent this law, which would mean that the law would be useless anyway.

Mr. SMART: Yes, and there are other sections in the Trade Marks Act which would be affected. I did not feel justified in taking the time of the Committee to go into all the complexities of the Trade Marks Act, but there are many other sections which would have to be carefully thought over in relation to such a provision.

Mr. MACKASEY: Earlier I think Mr. MacLean brought up an interesting point dealing with the period of protection to which the inventor should be entitled, and I think Mr. Laidlaw suggested the possibility of shortening this period. Has your international group considered the possiblity of making this period uniform? The reason I ask this is that Mr. MacLean mentioned the recouping of research costs. Suppose in one country the period is three years, in another one it is five and in another one it is seven years. How is research recovered on an equitable basis.

Mr. SMART: There has been a good deal of discussion in international circles on this question. There are two basic systems of counting time. One system counts the time from the date that the application is filed and, in general, the period is approximately 20 years. Others count the time from the actual grant of the patent, and those countries vary from approximately 15 to 18 years. On the average, probably the statutory time is designed to be approximately the same everywhere—but it cannot be because in one case the period of protection commences at a later date than the other.

Mr. MACKASEY: It would be desirable if it were uniform?

Mr. SMART: In common with many other aspects of international patents, it would be desirable if there could be an international uniformity.

Mr. MACKASEY: Mr. Smart, I am a little concerned that those who advocate reducing the period of protection in Canada do so on the premise that after that period is over the cost of drugs would be lower. But there is another fear that bothers me. Suppose an international firm discovers a new product—we will use, say, a three year period in Canada, a five year period in "X" country and a seven year period in "Y" country—the tendency would be for the international company to regain Canada's portion of the international research over a shorter period—over a three year period—which would drive the cost of the drug up considerably, whereas in the country which had three or four times as long, say a 12 year period, the tendency would be to amortize it over a 12 year period.

• (11.50 a.m.)

Mr. SMART: That certainly would be one possible effect of shortening the time unilaterally.

Mr. MACKASEY: He could drive the cost of drugs up for that period?

Mr. SMART: Yes.

Mr. MACKASEY: It may be true that it would hasten the day when it would be no longer valid to charge for research but I think the tendency lately is that after three or four years the drug is obsolete anyway.

Mr. SMART: This seems to be the case in drugs. For instance, if we, abolish drug patents in Canada unilaterally, I think one could expect that the price initially for new drugs would tend to be all the market could possibly bear, to take advantage of the period before the alert competition comes in for purposes of recouping research costs.

Mr. MACKASEY: In other words, this could more than offset the indiscriminate importation of drugs?

Mr. SMART: I think so, because the importation of drugs by and large, in my experience as a person who has been involved in litigation resulting out of it, seems to be largely confined to the drugs that are well established with a large market in Canada and these, generally speaking, do not become available on the international market for a certain period after the actual innovation of the drug.

Mr. MACKASEY: You mentioned that anything done to increase the importation, say, at the cost of manufacturing in Canada, would put an added strain on the Food and Drug Directorate.

Mr. SMART: Yes, because they concern themselves with the conditions under which the drugs are manufactured. And they have resources which enable them to see that drugs that are manufactured in Canada are manufactured under proper conditions, and in certain foreign countries too.

Mr. MACKASEY: Since you mentioned it, you see, and I did not, I wanted you to repeat it so it would give me an opportunity to comment on the Food and Drug Directorate.

Some time ago I ventured an opinion here that many of our foreign sources of importation could not meet the standard of the Food and Drug Directorate—and, of course, I was chastised for divulging confidential information which I obtained from the yellow section of *Macleans* magazine. I have been waiting ever since for representatives from the Food and Drug Directorate to appear before us so I could resume that little battle. I am just warning them; I am like an elephant.

The CHAIRMAN: I have seen that yellow section of *Macleans* and there are some discrepancies. You will be pleased to know that the Food and Drug Directorate will be back before us so that this point may be cleared up.

Mr. MACKASEY: I am looking in anticipation to their appearing here again.

Those are all the questions I have, Mr. Smart. Thank you.

The CHAIRMAN: If there are no other questions, gentlemen, I would like to thank the gentlemen from the Patent and Trademark Institute of Canada for coming before us. We certainly kept Mr. Smart very busy.

At our meeting on Thursday, we will continue our examination of the witnesses on patents. We will have before us representatives of the Pharmaceutical Manufacturers Association, representatives of the Canadian Drug Manufacturers Association, followed by Mr. David Henry, the Director of Investigation and Research, Restrictive Trade Practices Commission.

Mr. MACKASEY: Mr. Chairman, will Mr. Henry be appearing after we have completed our inquiry of the other groups?

The CHAIRMAN: It is my understanding that Mr. Henry will be here during the whole session, but he wishes to make his statement and answer any questions after the other people are finished.

Mr. MACKASEY: I am not on the steering committee. Is it the intention to have the P.M.A.C. and the witnesses from the generic houses appear at the same time? If so, who is going to act as referee, Mr. Chairman?

The CHAIRMAN: The chairman.

Mr. MACKASEY: In all seriousness, what do we hope to accomplish by having them all here at the same time?

The CHAIRMAN: I think it was the feeling of the steering committee that we should have them both here at the same time to give us the answers to the same questions. In other words, one question could be asked and both groups could give their answer. Perhaps they will disagree with this procedure, but it was the feeling that they both should be here at the same time to answer the same questions.

Mr. MACKASEY: Could we televise this?

The CHAIRMAN: No. The meeting is adjourned.

APPENDIX "A"

SUBMISSION TO THE SPECIAL COMMITTEE ON DRUG COSTS AND PRICES BY THE PATENT AND TRADEMARK INSTITUTE OF CANADA

Introduction

1. As members of a professional association we are deeply concerned with the laws governing the subject matter of our profession, namely patents and trade marks. We are, therefore, concerned when, in the course of an enquiry such as the one being conducted by this Committee, changes are proposed in patent and trade mark legislation as a means of serving some economic interest which, however desirable and however much in the public interest is really not directly related to the purposes of that legislation.

2. Such concern impels us to present to this Committee our views on such proposals and our recommendations as to the kind of legislation which in our view would best serve the present-day public interest. While we do not deal directly with drug costs and prices we feel that in relation to our object of promoting clear legislation which is easy to understand and administer we are, in relation to patented and trade marked drugs at least, dealing with a factor of cost. Obscure or needlessly complex legislation in this field leads to higher patent costs and is an invitation to a most expensive kind of litigation. All of this expense is part of the cost overhead of the drug patent owner—as well as the drug patent infringer, and must be borne out of the sale price of the products of both protagonists. Uncertainty as to the legal position or a bias of the legal position against the drug manufacturer is a drag on enterprise and often leads to marketing conditions where manufacturers are led into taking a short term view when introducing new products, whereby they seek to recover their initial marketing expense and research development expense in a shorter rather than a longer period. The result, of course, is higher prices.

3. Thus, while our submission is mainly directed to the state of the law, it is not wholly without relevance to the subject of costs and prices.

(A) *THE PATENT AND TRADE MARK INSTITUTE OF CANADA*
(referred to herein as "The Institute")

1. The Institute was founded 40 years ago as the Canadian Institute of Patent Solicitors. It is a non-profit organization and was incorporated as such in 1935 under Federal Charter as a part II Company without share capital under the name "The Patent Institute of Canada". In 1958 the name was changed to the present name.

2. The objects of The Institute as set out in its letters of incorporation are as follows:—

(a) To form a united and representative group of persons specializing in matters pertaining to patents, trade marks, copyright and industrial designs;

(b) To study the laws and practice relating to patents, trade marks, industrial designs and copyright in Canada and to promote the efficient administration and development of the same for the protection of industrial and intellectual property in Canada;

(c) To promote and maintain high standards of training and ethics among the members;

(d) To disseminate to the public useful knowledge relating to the protection of industrial and intellectual property;

(e) To facilitate the acquirements of professional knowledge and information affecting practice and to promote the interchange thereof among its members.

3. The Institute consists of Fellows who constitute the voting membership, Honorary Members, both Resident and Non-resident Associates and Affiliates who are entitled to attend meetings and other activities of The Institute but who have no vote in its affairs. The qualifications required of members in all categories are set forth in Appendix "A". All members in all categories must, as a condition of admission to membership, undertake to abide by the by-laws of The Institute and the Code of Ethics of The Institute (Appendix "B"). A complete list of the membership of The Institute as of the 1965 Annual Meeting is attached as Appendix "C".

4. The Fellows of The Institute are either barristers and solicitors, trade mark agents, or patent agents or may have two or all three of these qualifications. Practically all active practitioners before the Canadian Patent Office are members of The Institute as are the most active of those practicing before the Trade Marks Office. The Fellows generally represent the more experienced of these persons.

5. By virtue of its objects and membership it is self-evident that The Institute has a special interest in patent and trade mark legislation. It represents a vast majority of those who practice pursuant to such legislation and who are daily called upon to interpret it to members of the public and to advise members of the public as to their rights and duties in relation thereto.

(B) *THE PURPOSE OF THIS SUBMISSION*

1. The Institute has two traditional interests in patent and trade mark legislation; (a) To promote legislation which improves the patent system and the trade marks system so that each system becomes more effective to perform its basic function; (b) To promote legislation that can be easily understood, which is practical to administer and provides for effective judicial review of ministerial decisions affecting the rights of the public, inventors and trade mark owners.

2. This Committee has before it submissions as to changes both in the Patent Act and in the Trade Marks Act and has had referred to it the various recommendations as to changes in patent and trade mark legislation pertaining to drugs in the Report of the Royal Commission on Patents, Copyright and Industrial Designs (Ilsley Commission), in the Restrictive Trade Practices Commission Report and in the Report of the Royal Commission on Health Services, (Hall Report). Whether some or any of these suggestions should be followed depends upon whether or not, in the opinion of this Parliamentary Committee

and subsequently Parliament, they are best calculated to serve the public interest of Canada. The facts and figures of the drug industry and the needs of the public in relation to the availability, safety and cost of drugs have been comprehensively laid before this Committee from both government, medical and industrial sources as a basis upon which it can deduce the direction in which the true public interest lies. We conceive it to be our duty to lay before the Committee our views concerning the public interest, which exists in the field under examination, in legislation which, while conforming to the basic principles which are the foundation of patent and trade mark law, expresses the special public interest peculiar to the drug field in clear and precise terms which can be interpreted and followed with confidence by those concerned.

3. We also conceive it to be our duty to put at the disposal of the Committee the experience of our membership in respect to the framing of legislation in the patent and trade mark field and in the interpretation and practical working of existing legislation. During the past quarter century members of The Institute have had a hand in the preparation of the statutory provisions involved in every important legislative change which has been made in the law of patents and of trade marks. The Institute was officially represented on the drafting committees which prepared the 1932 amendment, the 1935 complete revision and 1947 amendment of the Patent Act, on the Trade Mark Law Revision Committee which produced the draft bill for the present Trade Marks Act which was enacted in 1953 and proclaimed in 1954 completely revamping Canadian trade mark law, and presented a very substantial brief to the Ilsley Commission. We hope that we may be called upon in a similar capacity in connection with any changes in the Patent or Trade Marks Acts which this committee sees fit to recommend.

(C) *PATENTS*

1. The Restrictive Trade Practices Commission recommended the abolition of patents on drugs. More recently, the Hall Report disagreed with that recommendation and suggested that any proposal to abolish drug patents should be deferred for at least five years on the ground that such a drastic step might not prove necessary to accomplish the objects intended in view of other steps which could be taken and that voluntary restraint on the part of drug patent holders should be given a chance to operate.

2. The first difficulty about abolition resides in the difficulty of identifying a drug patent. In a great many cases patents covering new chemical substances are granted well before the time that such substances have been accepted for use as medicine (more will be said on this subject in our discussion of present Section 41(1) of the Patent Act).

3. The second and, in our view, formidable difficulty about abolition is that unless the proposed legislation to abolish drug patents were made retroactive the effects of it would not be felt for many years to come. Large numbers of pending applications in the field will not have been granted for several years and many of the most important granted patents still have many years to run. Consequently, the effect of abolition and the assessment of that effect would remain in the realm of speculation for many years to come. The alternative, that of making the legislation retroactive, would give rise to difficulty of compensation to the patent

holders and applicants whose rights were legislated out of existence posing almost insurmountable problems of assessment and valuation or the imposition of what would effectively be legislative confiscation without compensation. Such legislative confiscation would be discrimination of the most repugnant kind since those patentees who have done most to further the public policy expressed in the Patent Act (that new inventions should be reduced to practice in Canada as quickly as possible) and have built up new businesses in Canada based on the patents concerned would be the hardest hit, while those who have maintained their Canadian establishments and Canadian labour at a minimum and satisfied the Canadian demand by importation (which under the provisions of the present Patent Act would constitute an abuse of the patent for which remedies up to and including revocation of the patent concerned are provided) would be the least affected. The man who runs a toy factory would escape scot-free while his neighbour across the street busy producing life and health preserving drug preparations would have the foundation of his business suddenly removed —not because his products have been superseded or have lost out in the struggle for marginal utility in the Canadian market place, but solely because he happened to be in the drug business.

4. Thirdly we think that abolition of drug patents in Canada would invite the possibility of international repercussions. Such a measure would be contrary to the spirit of the international convention* and might well lead to unilateral reprisal action by foreign countries against Canadian applicants for patents in foreign countries.

5. Since the proposal does have international implications it is fair to ask how such mesure would affect Canada's image abroad. We doubt if Canada's image will be improved by a measure which appears to invite the pirating of drug inventions in Canada.

6. It must be kept constantly in mind that the principal function of the patent system is the encouragement of research and investment. This encouragement has resulted in the discovery of new drugs that have saved literally millions of lives; it is no appeal to sentimentality to assert that most of us have close friends or relatives who would not be alive today but for modern drugs that were discovered as a result of the large and expensive research programs of drug companies. If all countries were to withdraw patent protection for drugs, the primary incentive for private drug research would be gone: who would invest large sums of money on research only to be faced, once the product of his research became available for analysis, with unrestricted competition by those who bore no part of the research costs? If such research is socially desirable Canada should do its part to support and encourage it.

7. For the foregoing reasons we think that the proposal to abolish drug patents is one which would create at least as many problems as it might be considered to solve. It would, in our view, inevitably result in confusion and uncertainty not only in the pharmaceutical industry but in the whole chemical industry owing to the difficulty of determining what is and what is not a drug patent. We are furthermore convinced that the public interest involved can be served by legislation which is not inconsistent with the general philosophy of patents involving only relatively minor amendment to the present Patent Act.

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*International Convention for the protection of Industrial Property.

8. We, therefore, recommend that no action be taken on the proposal to abolish patents in this field.

(D) *THE PATENT ACT*

1. The only section of the Patent Act which deals specifically with medicines is Section 41 which reads as follows:—

(1) In the case of inventions relating to substances prepared or produced by chemical processes and intended for food or medicine, the specification shall not include claims for the substance itself, except when prepared or produced by the methods or processes of manufacture particularly described and claimed or by their obvious chemical equivalents.

(2) In an action for infringement of a patent where the invention relates to the production of a new substance, any substance of the same chemical composition and constitution shall, in the absence of proof to the contrary, be deemed to have been produced by the patented process.

(3) In the case of any patent for an invention intended for or capable of being used for the preparation or production of food or medicine, the Commissioner shall, unless he sees good reason to the contrary, grant to any person applying for the same, a license limited to the use of the invention for the purposes of the preparation or production or food or medicine but not otherwise; and in settling the terms of such licence and fixing the amount of royalty or other consideration payable the Commissioner shall have regard to the desirability of making the food or medicine available to the public at the lowest possible price consistent with giving to the inventor due reward for the research leading to the invention.

(4) Any decision of the Commissioner under this section is subject to appeal to the Exchequer Court.

(5) This section applies only to patents granted after the 13th day of June, 1923.

We do not think that this Section of the Patent Act serves the present day public interest of Canada and we shall attempt to explain why we hold this view and to suggest alternatives which in our view would represent an improvement. In doing so, we shall deal with the section, sub-section by sub-section.

2. There are, we think, two main reasons why Section 41 in part fails to perform anything useful in relation to the present public interest and in part is ineffective, namely:—

(1) The science of chemistry has expanded so enormously since 1923 when the forerunner of the present section, based on an English precedent of 1919, was introduced into Canada that the philosophy behind the section is no longer valid.

(2) The precise meaning of words, especially those having to do with technical subject matter has so changed as the scientific context against which they are applied has changed and expanded that words which in 1923 in the then scientific context may have been reasonably clear and precise have become subject to a variety of plausible interpretations which could not possibly have been foreseeable when the words were first adopted.

(E) *SECTION 41(1)*

1. To illustrate the above two points, this sub-section came up for consideration by the Court in the case of *Winthrop* v. *Commissioner of Patents** in the year 1948 approximately 25 years after the section became law. The case involved a technical point of Patent Office practice. The Commissioner of Patents contended that the sub-section meant that there must be a separate claim with respect to the process by reference to which a separate claim in respect to the product must be limited. The appeallant, who had a very large number of accrued patent applications which would have to be amended at considerable expense if the Commissioner's view were right, contended that the wording of the sub-section was met if it had in a single claim a claim to the product when made by a particular process set forth in the same claim. The scope of the patent would have been the same in either case. The President of the Exchequer Court in a detailed judgment** agreed with the appellant, and reversed the Commissioner. The Supreme Court concluded that the Commissioner's view was right and reversed the Exchequer Court. Thus, some 20 years ago the difficulty of construing Section 41 (1) was such that it enabled two courts to come to different conclusions as to the meaning of its language. Fourteen years later in the case of *Bœhringer* v. *Bell-Craig**** the Exchequer Court concluded that not only must the process be separately claimed but the product claim which referred to it for purposes of limitation could be valid only if the process claim was itself valid even though the reason for the invalidity of the process claim might have had no bearing whatever on the scope of patent protection included within the language of the product claim. The Supreme Court of Canada***** supported that view and affirmed the Exchequer Court specifically on that point thus establishing an additional ground for the invalidity of patents to which Section 41(1) applies over and above the usual grounds of invalidity to which claims to subject matter not within Section 41(1) are subject. In the Exchequer Court a number of additional grounds of invalidity arising solely from the wording of Section 41(1) were adopted by the Court and since these were not dealt with by the Supreme Court of Canada, they must be taken as representing the present state of the law. As a practical matter in most cases it would be virtually impossible for an applicant for a drug patent to have any confidence that he has avoided all these grounds of invalidity.

2. The reason for this is that the inventor of a new chemical compound which is intended as a drug (usually a chemist) has completed his task as soon as he has made the new compound and had it confirmed in tests that it (and usually a group of chemically related compounds) possesses unusual and potentially valuable properties. Before that compound or any of its related compounds can be accepted as a useful drug there must be extensive biological tests, *in vitro* first, and then in test animals and finally extensive clinical testing in humans. This may take several years. The patent system, however, requires the inventor to file his patent application as soon as he has made his invention or run the risk of being forestalled by a rival inventor******. When he files his application he has

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* (1948) S.C.R. 46
** (1947) Ex.C.R. 36
*** (1962) Ex.C.R. 201
****(1963) S.C.R. 410
*****In all countries except Canada (and with respect to domestic inventors only, the United States) the person who first files a patent application is the person who is entitled to the patent.

no basis for predicting confidently which particular one of his group of new compounds will turn out to be the drug of choice, or what the preferred salt, dosage form and method of production will be. However, among the grounds of invalidity adopted by the Exchequer Court in the decision above referred to is failure in the specification to particularly describe these things.

3. Thus not only does the interpretation of Section 41(1) give difficulty, but the current judicial interpretation of it shows it to be booby-trapped with special requirements for validity which are frequently impossible to meet.

4. Back in 1919 and indeed well into the 30's it was a widely held view that the value of chemical science lay primarily in the devising of new processes by which substances already known or to be found in nature could be synthesized or could be more cheaply produced. It was also a widely held view that chemical compounds *per se* were intrinsic to nature and that therefore, no chemical compound *per se* could be held to have that element of novelty necessary to make it a patentable invention. That view has now changed notably in the following respects:—

(a) Synthetic chemistry has expanded beyond anything that was foreseen in those days until we have reached the stage where it is taken for granted that chemical substances not found in nature can be synthesized and chemical research is devoted almost entirely to the preparation and investigation of the properties of chemical compounds which have never before been in existence. These are theoretically as unlimited in number as the stars in the universe.

(b) The fundamental laws of chemistry have been ascertained to the extent where a fundamentally new chemical method is a great rarity. Where a chemist conceives a chemical formula for a previously unknown compound, he is able to predict with reasonable certainty a number of known chemical methods by which such new compound can be prepared, thus putting it out of the power of any subsequent chemist to claim any originality of thought in the mere preparation of such new substance by any of the methods which have already become conventional chemistry. Thus, today we have had it pronounced by the Supreme Court of Canada* that the inventive merit in a case involving an important drug resides in the discovery of the useful properties of the product rather than in any particular method of producing it.

5. This would seem to make it clear that a section such as Section 41(1) which was designed to restrict the reward to the inventor of a new substance to the aspect of his invention involving what was then (in 1923) regarded as the inventive merit, namely the process, is out of place in a later day and age which regards the discovered intrinsic properties of the product as the seat of inventive merit.

6. Nor is the foregoing the only anomaly to be found in respect to Section 41(1). If it is intended (as we think it must be presumed to be) to make special provisions in the public interest in respect to food and medicine, then it seems to us to be clear on its face that it falls far short of that objective.

7. As it stands, Section 41(1) prohibits the patenting of new compounds *per se* only when such compounds are produced by chemical processes and intended for food or medicine. It does not prevent the patenting *per se* of foods or

**Hoechst v. Gilbert* (1965 S.C.R.)

medicines which are not produced by chemical processes and it does not prevent the patenting *per se* of new compounds which are produced by chemical processes and later turn out to be useful foods or medicines unless at the time of the filing of the patent application the compounds concerned were *intended* as food or medicine. Thus the sub-section is not directed generally to all patents having to do with foods or drugs but only to those patents on foods or drugs where the substances concerned are produced by chemical processes and which were known to be sufficiently useful as foods or medicines at the time of the application as to be intended for food or medicine. Thus, a particular new chemical might be intended for medicine but might never pass the clinical testing required by the Food and Drug administration before it could be used as such and so might never actually be a medicine. Yet the sub-section under consideration would clearly apply to it and deprive the inventor of the right to a patent on it even though it might be a very useful compound from points of view other than use in medicine and a most useful contribution to the scientific arts. On the other hand, a patent on a new compound which was not intended as a medicine can create a perfectly valid monopoly on a medicinal substance *per se* as long as the inventor did not know it was useful as a medicine at the time he filed his patent application. In our submission, this situation is nothing short of ridiculous. In the present state of scientific knowledge and government control of foods and drugs we can see no justification for putting the patentability of substances *per se* in the food and drug field on any different basis than that of compounds *per se* in any other field such as dyestuffs, plastics, etc.

8. If Section 41(1) were to be repealed the position in respect to patents on foods and drugs would then accord with the general philosophy of the public interest in the patent system which is the encouragement of the advancement of the useful arts by giving to inventors and their legal representatives a limited period of exclusive use of this invention in return for a public disclosure. In our submission the force of this philosophy is, if anything, greater in relation to the medical arts than it is relation to the other useful scientific arts.

9. We agree with the Ilsley Commission Report (pp 93,94) that Section 41(1) should be repealed both for the reasons there given and for the reasons outlined above. The corresponding provision in the British Patents Act was in fact repealed in 1949 as recommended by the Swan Report.*

(F) *SECTION 41(2)*

1. If Section 41(1) is repealed it does not appear to us that Section 41(2) has much meaning.

(G) *SECTION 41(3)*

1. The special public interest in the field of foods and drugs does not necessarily require a departure from the general philosophy of the patent system and indeed such public interest is capable of full legislative expression which reinforces rather than detracts from this philosophy.

2. The deficiencies of Section 41(3) as a definition of this special public interest were well explained in the brief to the special committee by the

*Report on "Patents and Designs Acts" presented to the Parliament of Great Britain by the President of the Board and Trade—September, 1947.

Pharmaceutical Manufacturers Association of Canada (Section 11). In short, the intent of this section as interpreted by the courts is to take from the patentee and give to anyone who makes application the right to, for practical purposes, a virtual free ride on the patentee's coat-tails unless the Commissioner of Patents sees some as yet undefined "reason to the contrary".

3. Concern for some possible resulting effects was well articulated before the House of Commons in the Hilliard Report which also suggested a number of criteria in relation to the protection of the interests of the public.

4. It seems to be an accepted idea that in respect of patents relating to drugs, more is expected of the patentee than mere disclosure of his invention in order to justify the continuance of his exclusive privileges. What this "more" is has certainly not been objectively defined in Section 41(3). In our submission, if the public interest is to be properly served it must be objectively defined by statute. This is the business of Parliament, and in our submission should not be abdicated to an administrative official or the judiciary.

5. We think that what is needed is a statutory provision setting forth what is to be expected of the owner of a patent covering a drug; an objective test against which the patentee's conduct can be measured. We think that the justice of the situation demands that there be no penalty against the patentee who fulfills the objective test and that the public interest peculiar to drugs demands that if the patentee does not meet the test, others should be encouraged to try to do so. The most satisfactory tribunal for the determination of such matters is a tribunal particularly qualified to make the economic enquiry which is called for, from which there is a right of appeal at least as to matters of law. Such a tribunal can only function satisfactorily, however, and satisfy those coming before it of its objectivity if the statute provides it with a clear frame of reference as to the questions it must consider, and a clear direction of principle upon each question to be considered.

6. Such legislation should, in our view, set out precisely the obligation of the drug patentee in relation

(a) satisfying the demand at a reasonable price

(b) required marketing practices.

It should provide a means whereby the Food and Drug directorate automatically is involved in all compulsory license proceedings, e.g. by requiring that proceedings be served on the Minister of National Health and Welfare. Most importantly it should specify in detail the basis upon which royalties payable under a compulsory licence are to be calculated.

7. Section 41(3) as presently framed is, in our view, further deficient in that it discourages the manufacturing of patented drugs in Canada. The establishing of manufacturing facilities in Canada to supply the Canadian demand has been held not to be a defence and seems to be regarded as irrelevant to an application for compulsory license and this encourages foreign-based Canadian drug manufacturers to import the active ingredients which can be more economically manufactured abroad where a bigger market is available. It is to be noted that this is in direct opposition to the declared object of Section 67 (a general provision of the Patent Act in respect to compulsory licenses) that "patents for new inventions are granted not only to encourage invention but to secure that

new inventions shall, so far as possible, be worked on a commercial scale in Canada without undue delay". Under Section 67 the patentee who can show that he has, within three years of the granting of the patent, worked the invention within Canada on a commercial scale to meet the demand to an adequate extent and on reasonable terms may urge this as a defence to an application for a compulsory license and can thus justify his investment in Canadian plant and equipment to supply the Canadian demand.

(H) *SECTION 41(4)*

1. This sub-section which provides an appeal should obviously stand or fall along with the rest of the Section.

(I) *SECTION 41(5)*

1. This sub-section which is transitional in nature has no further application owing to the passage of time and should be repealed.

(J) *TRADE MARKS*

1. A trade mark is a badge for the wares on which it appears of
   (a) their origin
   (b) their character or quality
   (c) the conditions of their manufacture

2. The primary public interest in trade marks is that the badge remain a *bona fide* true badge and does not mislead the public. When a trade mark is used as a badge of origin and simultaneously appears on wares from more than one origin the public is misled and the meaning of the badge is destroyed. This is the fundamental principle of trade mark law.

3. A trade mark's meaning as a badge of origin is also destroyed when it is so used by its owner as to become the generic name of the wares on which it appears.

4. When a particular drug comes to be known only by a particular trade mark that trade mark becomes public property as part of the common language and any registration of it can have no validity. Any right of the person who has been using it to prevent others from using it ceases to exist.

5. The present Trade Marks Act provides for the removal of such trade marks from the Register by application to the Exchequer Court of Canada by the Registrar of Trade Marks or by any person interested pursuant to Section 56 of the Trade Marks Act. There is no reason why such applications cannot in the existing legislation be brought by the Attorney General on the information of the Minister of National Health and Welfare.

6. If therefore, there are abuses of trade mark rights in accordance with which certain drug manufacturers assert, contrary to the public interest, practical monopolies over the only names by which certain drugs are known to the public, the remedy lies not in the creation of new legislation but in the use of the remedies provided by the present Trade Marks Act.

7. The Hall Report, Page 711, suggested that the Trade Marks Act should be amended "to make it clear that no infringement could be claimed where the drugs in question are manufactured by a related company. Section 2(r) of the

Trade Marks Act designates related companies as "companies that are members of a group of two or more companies, one of which, directly or indirectly, own or controls a majority of the isued voting stock of the others". The purpose of this recommentation is said to be to enable Canadian importers to purchase trade marked wares of the related companies in foreign countries where the foreign price happens to be lower than the price charged by the Canadian company which has the exclusive right to the use of the mark in Canada. As the law presently stands in cases where the Canadian company is the owner of the trade mark registration the selling and offering for sale in Canada of the wares of the related companies marked with the same trade mark would appear to be an infringement of the trade mark registration. If however, the Canadian company does not own the trade mark registration but merely uses the mark as a "registered user" thereof (the trade mark being actually owned by the foreign related company) such sale of the trade marked wares imported from the foreign related companies would not constitute an infringement of the registration.

8. We feel bound to call attention to the danger of making isolated piecemeal changes in legislation like the Trade Marks Act especially where the purpose of the change *qua* trade mark law runs contrary to the underlying purpose of the Act as a whole which is to avoid confusion and make registered trade marks an honest badge of origin. The public interest in the integrity of trade marks is great and we doubt if it is greater in relation to any class of wares than it is in relation to drugs. If the public interest in the expected lowering of the price of some trade marked drugs by forcing Canadian companies to compete in the Canadian market with their foreign related companies under identical trade marks is considered to be paramount and greater even than the public interest in the integrity of trade marks then it will require a very carefully drafted provision affecting the whole scheme of the Trade Marks Act and not merely Section 20 as suggested in the Hall Report.

9. The second difficulty that we see with this proposal is that it is to be expected that any international company which found that its Canadian subsidiary was being adversely affected by importation of identically marked wares from its related companies would adopt the policy of employing a different trade mark for the wares of its Canadian company than for the same wares manufactured by its other subsidiaries in other countries. A number of companies already do this because of the greater suitability of one trade mark over another for related companies in countries of different ethnic background and language.

10. Thirdly we think that a provision such as that suggested is unnecessary to accomplish the desired purpose since there is nothing in the Trade Marks Act which prevents a Canadian importer from purchasing finished drugs abroad from the related company of the Canadian company concerned and selling them in Canada under his own label with proper reference to the name of the manufacturer.

11. We especially doubt the need for any special provision in the Trade Marks Act in view of the special remedies provided in Section 30 of the Combines Investigation Act which reads as follows:

> 30. In any case where use has been made of the exclusive rights and privileges conferred by one or more patents for invention or by one or more trade marks so as

(a) Unduly to limit the facilities for transporting, producing, manufacturing, supplying, storing or dealing in any article or commodity which may be a subject of trade or commerce; or

(b) Unduly to restrain or injure trade or commerce in relation to any such article or commodity; or

(c) Unduly to prevent, limit or lessen the manufacture or production of any such article or commodity or unreasonably to enhance the price thereof; or

(d) Unduly to prevent or lessen competition in the production, manufacture, purchase, barter sale, transportation or supply of any such article or commodity;

the Exchequer Court of Canada, on an information exhibited by the Attorney General of Canada, may for the purpose of preventing any use in the manner defined above of the exclusive rights and privileges conferred by any patents or trade marks relating to or affecting the manufacture, use or sale of such article or commodity make one or more of the following orders:

(i) declaring void, in whole or in part, any agreement, arrangement or licence relating to such use;

(ii) restraining any person from carrying out or exercising any or all of the terms or provisions of such agreement, arrangement or licence;

(iii) directing the grant of licences under any such patent to such persons and on such terms and conditions as the court may deem proper, or, if such grant and other remedies under this section would appear insufficient to prevent such use, revoking such patent;

(iv) directing that the registration of a trade mark in the register of trade marks be expunged or amended; and

(v) directing that such other acts be done or omitted as the Court may deem necessary to prevent any such use;

but no order shall be made under this section which is at variance with any treaty, convention, arrangement or engagement respecting patents or trade marks with any other country to which Canada is a party.

(K) *SUMMARY*

1. We recommend that:—

(a) Section 41 of the Patent Act be repealed in its entirety;

(b) The compulsory licence provisions now existing as 41(3) be replaced by a provision defining objectively the obligations to the public of the holder of a drug patent, and the basis upon which such drug patent holder is to be remunerated for the use of his invention upon grant of a compulsory licence;

(c) No change be made in the trade marks act which would put trade marks associated with drugs on a special footing.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 21

THURSDAY, NOVEMBER 24, 1966

WITNESSES:

Representing the Pharmaceutical Manufacturers Association of Canada: Dr. Wm. W. Wigle, President; Mr. Gordon Henderson, Q.C., Patent Advisor, both of Ottawa, and Dr. Brian Stewart of Pointe-Claire, Quebec, Director of Pharma-Research Canada Limited.

Representing the Canadian Drug Manufacturers: Mr. Leslie L. Dan, of Scarborough, Ont., Chairman, and Dr. George F. Wright, of Toronto, Research Consultant.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1966

25291—1

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

MINUTES OF PROCEEDINGS

THURSDAY, November 24, 1966.
(30)

The Special Committee on Drug Costs and Prices met this day at 9.55 a.m. The Chairman, Mr. Harry C. Harley, presided.

Members present: Messrs. Brand, Enns, Harley, Howe (*Hamilton South*), Hymmen, Isabelle, Mackasey, Rynard.

In attendance: *Representing the Pharmaceutical Manufacturers Association of Canada*: Dr. Wm. W. Wigle, President; Mr. Gordon Henderson, Q.C., Patent Advisor, both of Ottawa, and Dr. Brian Stewart of Pointe-Claire, Quebec, Director of Pharma-Research Canada Limited.

Representing the Canadian Drug Manufacturers: Mr. Leslie L. Dan, of Scarborough, Ontario, Chairman, and Dr. George F. Wright, of Toronto, Research Consultant.

Mr. David Henry, Chairman of the Restrictive Trade Practices Commission, Department of Justice.

Also in attendance: Mr. A. M. Laidlaw, Q.C., of Ottawa, Legal Counsel for the Committee.

The Committee resumed consideration of the subject of patents in relation to the price of drugs.

At the request of Mr. Dan, the Chairman requested that a correction be brought to testimony given before the Committee on July 7, *Issue No. 8* (*See this day's evidence*)

The Chairman called on Mr. Dan who read a prepared statement and tabled numerous documents, among which was the Code of Ethics of the members of the Canadian Drug Manufacturers and the CDM Rules of Practice.

Agreed,—That the briefs presented today, being one by The Canadian Drug Manufacturers and one by Dr. George F. Wright, be printed as appendices to this day's proceedings. (*See Appendices "A" and "B"*)

The Chairman called on Dr. Wigle to introduce the members of his group.

Dr. Wigle, Dr. Stewart and Mr. Henderson read statements into the record.

Mr. Dan and the representatives of PMAC were questioned.

The Chairman called on Dr. Wright who commented on his brief.

The Committee resumed questioning of the witnesses.

At 12.45 p.m. the Committee adjourned to 3.30 p.m.

25291—1½

AFTERNOON SITTING

(31)

The Committee reconvened at 3.50 p.m., the Chairman, Mr. Harry C. Harley presiding.

Members present: Messrs. Asselin, Brand, Harley, Howe (*Hamilton South*), Hymmen, Tardif and Yanakis.

In attendance: Same as at the morning sitting.

Mr. Laidlaw questioned the witnesses about the exact meaning of the words "Innovator" and "Copier", and about related matters.

At the closing of the questioning, the witnesses were invited to make their final comments.

The Chairman thanked the representatives of both groups for their co-operation and at 5.15 p.m. the Committee adjourned to 9.30 a.m., Tuesday, November 29.

Gabrielle Savard,
Clerk of the Committee.

EVIDENCE

(Recorded by Electronic Apparatus)

THURSDAY, November 24, 1966.

The CHAIRMAN: Gentlemen, I think we might start the meeting.

I anticipated that today's meetings might be rather lengthy and for that reason we have sent out notices to the members to be here this afternoon also; but this will be dependent on whether we actually finish this morning or have to continue in the afternoon.

First of all, Mr. Dan on his previous appearance gave some testimony which he wishes to correct, and perhaps I should correct it in the records. There was some discussion of various drug companies and their ownership, and Mr. Dan has noted that the companies Mowat and Moore and Canada Duphar are still under Canadian control. The evidence was to the contrary on his last appearance.

We have with us this morning, to continue our discussion and examination of patents, representatives of the P.M.A.C. and representatives from Canadian Drug Manufacturing Association.

In attendance also is Mr. David Henry from the Restrictive Trade Practices Commission. It is our hope that if we get through with our witnesses Mr. Henry will appear later on today, also to discuss patents.

There has been some question about the format of the meeting today. The meeting was set up in this way at the request of the Committee so that the Committee members could ask both of these organizations various questions about patents. It was not set up to create a confrontation, if I may put it that way. For that reason I would request, of course, that any questions come through the Chair and that there be no cross-questioning of, or comment on, the witnesses.

First of all, I will call on Mr. Dan who is going to present a statement on behalf of his group.

Mr. Leslie L. DAN (*Chairman, Canadian Drug Manufacturers*): Mr. Chairman, since our last appearance here early in July, about four months ago, considerable water has flowed down our rivers and many important things have happened. I made several promises to your Committee with regard to our Group, which, in the meantime, have been fulfilled. I am now handing over to you, Mr. Chairman, our Code of Ethics which our members agreed to implement in their daily practice, and also a statement of our combined financial earnings which is about 9 per cent before taxes. I should hasten to point out that the submission of these figures was done on a voluntary basis—after all, we are not public companies—and therefore not all the members turned in their figures. Nevertheless, we are of the impression that the CDM members and probably those of AFQPP do have net earnings (before taxes) of about 9-12 per cent.

Mr. HOWE (*Hamilton South*): Excuse me, Mr. Chairman, may I make an interjection at this point. When you say 9 per cent, Mr. Dan, do you mean 9 per cent of the gross income, or 9 per cent of the money involved.

Mr. DAN: Nine per cent of sales. I am also turning over to you the most recent list of our members and you will quickly notice that several companies have been removed temporarily, or permanently, because they did not seem to conform to the Standards we are advocating. I wish to point out to you that our members are anxious and eager to maintain high standards in their pharmaceutical manufacturing, as evidenced by their desire to accept the principles embodied in our Code of Ethics and Rules of Practice. It is conceivable that several other pharmaceutical companies exist, or may appear in the future, and may have questionable standards. These firms, however, are not connected with our group, nor have they adopted our standards and therefore they should not cast any shadow upon us.

Mr. Chairman, I would like to tell you that our group also has responded to the changing times and influenced by the present Hearing, is now considering a radical reorganization in our operations. I predict that in a very short time, several of our member firms will merge and several million dollars will be poured into this project, probably with a substantial public participation. I envisage that our new group in about five years, or even earlier, will be a strong and noticeable factor in the pharmaceutical industry.

I also predict that very shortly our members will introduce new drugs on the Canadian Market, as a result of the international link-up with medium-sized firms, the arrangements for which are now in process.

I might add, Mr. Chairman, that this venture is not unique in Canada, except for timing—since a similar merger was done with great success by a dynamic group of French-Canadians who call themselves Sogena Inc. I knew little about them, and likely many of you are still not aware of them—however, the records are here, they are a public company, and they do shine in achievements. I quickly discovered that the principals and officers of this company enjoy the highest reputation in our financial and business community. I also learned that they are enterprising and dynamic French-Canadians, who merged successfully three pharmaceutical companies—Desberges, Nadeau and Canada Drug.

Mr. Chairman, you might also be interested to learn that another French-Canadian group—Octo-Analco Laboratories, are now in the process of forming a marketing group with Nordic Biologicals, all located in Montreal, and again they too were probably stimulated greatly by our changing times and the present Hearings.

I hope that I have not taken up too much of your time with these matters, but I felt that this information and news would lilely be of interest to you, and significant in your future deliberations.

Now—let us consider Patents Affecting Pharmaceuticals.

Our Association is fortunate to have as our technical consultant on Patents—Dr. Wright, a Professor of Chemistry at the University of Toronto. He is a noted authority in organic chemistry, which is undoubtedly his main field.

As for myself, I admit that I am neither an organic chemist nor a lawyer, merely a pharmacist, and therefore I felt somewhat at a disadvantage dealing

with this highly complex and technical problem. Therefore, I had to do some investigations of my own, and discuss the patent matters with patent lawyers and our members. I also made certain to attend the recent Hearings when Hoffmann-LaRoche appeared as a witness, since somehow I felt that they would deal with the patent problem thoroughly. I think that they made an excellent presentation—much to the credit of their highly able and intelligent company officials—and submitted to this Committee probably the best and most lucidly written brief. I somehow felt that they made quite an impression on the Committee members and the audience, including myself.

However, after I read their Brief on the plane on my way home, some of their arguments just did not seem to add up. I suddenly became very restless and inquisitive in my mind. I quickly decided to fly over to Europe for a few days to consult European Patent authorities on pharmaceutical patents and learn more about the background of the patent laws in the various countries.

It did not take too long to discover that the basis of the patent laws for most Western countries has been the famous Paris Convention, which was held in about 1890 when the fundamental points of patent laws were spelled out and accepted by all participants, including Canada, to be used as the basis of their patent laws.

It is a matter of some interest that recently, even Russia agreed to adhere to the pharmaceutical patent laws because she also realized that inventors, including those of pharmaceuticals, needed some protection. I was further told that the major points in these patent laws were unlikely to be changed, only the minor ones, unless the entire system of patent laws was changed. Some minor variations in the different countries may exist, such as in Canada where the food and pharmaceutical products receive a special consideration as expressed in section 41, 3 under Compulsory Licensing which says, and I quote "They should be made available to the public at the lowest possible price consistent with giving the inventor due reward for the research leading to the invention." It appeared to me that our Canadian law makers were very wise indeed when they recognized that both food and pharmaceuticals enjoy a special status, being important and essential commodities in our lives. Our Association, the CDM agrees with this fundamental principle, as most Canadians will likely do. Now, what surprised me during the discussion with the European attorney was that the same, or similar patent clauses have different interpretations in various countries. For example, in Germany, where no pharmaceutical patent laws exist on substance, only on process—as in Canada—yet the courts interpret the process laws so strictly as if laws on substance did exist.

It appeared to me that from the viewpoint of the pharmaceutical manufacturers who carry on business on an international scale, the interpretation of pharmaceutical patents can be classified into Primary Markets, Secondary Markets and Tertiary Markets. Primary Markets undoubtedly are very important to the manufacturer since a substantial volume of his overall sales are derived from these markets and probably his basic revenues come from there and major policies are determined on the conditions existing there. In the major markets pharmaceutical manufacturers usually carry out the important pharmaceutical activities, that is to say, they conduct pharmaceutical research, manufacture most of the raw materials, do physical manufacturing in dosage forms, and also engage in exports. Such key markets would undoubtedly be the United

States, Germany or Britain, where, under such conditions, pharmaceutical manufacturers are certainly entitled to a greater protection because they carry out full-line activities. Hoffman-LaRoche Co. in their written Brief explained the different interpretation of Section 43, 3 of the Patent Laws on Compulsory Licenses in England in contrast to those by the Canadian Courts. They did not, however, explain sufficiently that in England, several companies have their important research centres located and engage in major export activities, doing a volume about 50 per cent of their own home consumption. Expressed in dollars, for example, in 1958 about 100 million dollars worth of pharmaceuticals were exported from England, while about 200 million dollars were consumed in their home market. Of course, the pharmaceutical industry deserves a better protection.

In the Secondary Markets, the pharmaceutical manufacturer does NOT carry out the complete phases of their operation, for usually they do very little, if any, pharmaceutical research, produce only a small percentage of the raw materials, carry out little or no exports, however they may do physical manufacturing in dosage forms. The sales volume of their products in those countries is usually small compared to the overall international sales volume, such as in the case of Canada, it may represent only about 3-5 per cent of the total market. Of course, major international policy decisions are unlikely to be based on conditions existing in the Secondary market. Manufacturers nevertheless will do their best to get as much out of the Secondary Markets as possible. Since the pharmaceutical activities carried out in those markets are usually limited, the manufacturer should not be entitled to as great a protection in the Secondary Market as he would be in the Primary Market, for obvious reasons. Canada certainly can be considered a Secondary Market by the international pharmaceutical houses.

A Tertiary Pharmaceutical Market is one where sound pharmaceutical patent laws do not exist, such as in most countries of Africa or the Middle East or if laws do exist, they are not enforceable such as in most countries in South America. They are probably the gravy markets of the international pharmaceutical houses, since they try to sell there as much as they can, probably at the best prices possible, they wheel and deal as well as they can and they may not be overly concerned about patent protections for the moment.

Considering the characteristics of the above three markets, the passionate pleadings for greater patent protection in Canada by Hoffman-LaRoche Co. and the other companies, just melt away and become less convincing. Of course, a sound business man will always try for the most and we certainly cannot blame them for that.

However, the interpretation of the pharmaceutical patents by our lawmakers and the Restrictive Trade Practices Commission, the profound and accurate analysis of the Royal Commission all make sense, once we understand the basic operational pattern of the large international pharmaceutical houses and examine the particular economic environment that exists in Canada today.

Last year, in 1965, the large international drug houses had quite a healthy sales increase of 15 per cent—and, I might add, that the value of their shares also increased 15 per cent. There is little doubt in our minds that with their vast organization they are quite capable of looking after their own interests. If any pharmaceutical group needs assistance today, it is the Canadian-owned members

of the CDM and AFQPP, for they represent the balancing force in the pharmaceutical industry and act as an effective instrument to lower the costs of medicines to the public.

I might add, Mr. Chairman, that since the preparation of our submission to your Committee, several provocative and thought-provoking articles appeared in the newspapers across the country in a spontaneous manner. René Lévesque, the former Minister of Resources of the Province of Quebec published a major article in the "Dimanche Matin"; D. H. Fullerton wrote in the Toronto *Daily Star*; and also the *Financial Post*—an influential and restrained, yet astute observer of our nation's economy—in an editorial assessed very accurately the position of the pharmaceutical industry in Canada. All these articles had one thing in common, they all were highly critical of certain aspects and the performance of the pharmaceutical industry. Although we speak here only on our behalf, yet we—a few Canadian-owned Drug Houses—are of the impression that we have a *very strong public opinion* behind us, probably supporting most of our ideas.

Therefore, our Association, the CDM, strongly urges this Committee to recommend to our Parliament that they endorse the viewpoints taken by our Judiciary and the various investigating commissions, and to relax our Patent Laws on pharmaceuticals even more, as described in our Brief, for only this makes sense to the Canadian people.

Thank you, Mr. Chairman.

The CHAIRMAN: Thank you, Mr. Dan. Before we go any further, gentlemen, is it agreed that we should have all of today's briefs as an appendix to today's proceedings?

Some hon. MEMBERS: Agreed.

The CHAIRMAN: I will call now on Dr. Wigle.

I should remind members that the original submission by P.M.A.C., the red book that we have all had in our possession for many months, also does contain a section on research and on patents. This statement by Dr. Wigle is a supplement to that, and is really in no way an answer to what Mr. Dan has said. It is a separate statement.

Dr. W. W. WIGLE (*President of Pharmaceutical Manufacturers Association of Canada*): Thank you, Mr. Chairman. That was our understanding, that we were coming back to talk to the Committee on the completion of our brief.

Mr. Chairman, I would first like to introduce the representatives of our Association, who have come today to provide expert testimony on pharmaceutical patents and research. On my right is Mr. Gordon Henderson, Q.C., P.M.A.C.'s patent adviser and one of Canada's leading patent counsel. Next to him is Dr. Brian Stewart, a director of Pharma-Research Canada Limited.

We would like to remind the Committee that P.M.A.C., as pointed out in our submission to you on June 16th, represents 58 pharmaceutical manufacturers that account for more than 85 per cent of the prescription drugs made and sold in Canada. In other words, Mr. Chairman, our Association speaks for by far the greater part of the industry, certainly for the innovators and originators of new drugs within the industry, and it seeks through its charter to foster self-regulation among the great majority of responsible companies within the industry.

We welcome the opportunity to come before the Committee today to testify on the matter of pharmaceutical patents and their relationship to Canadian and international drug research.

We have not prepared a supplementary brief on patents for the obvious reason that our original submission to the Committee states our case as succinctly as we are able to state it.

It is our conviction that patents and the economic incentive they provide are essential to the discovery and continuing flow of health-restoring and lifesaving pharmaceuticals.

From a therapeutic point of view, the abolition of patents would be a medical catastrophe in that the search for new cures would be seriously arrested. From an economic point of view it would destroy a growing industry and reduce it to nothing more than a collection of import houses and imitators. The Patent and Trademark Institute appeared before this Committee two days ago and submitted a thoughtful brief that probed this subject of patents in depth. Our Association fully endorses the recommendations made by the Patent and Trademark Institute.

As you can well imagine, we have followed the proceedings of this Committee with great interest during the time that has elapsed since our last appearance. I want, at this point, Mr. Chairman, to commend this body on the scope of the present enquiry. The diversity of interested groups, associations, companies and individuals is evidence of your wish to get all the facts and of the fairness and impartiality of these hearings.

Some of the witnesses who have appeared before you have made statements with which we find ourselves in disagreement. Although it is not our intention to systematically rebut every piece of evidence that is contrary to our stated position, some statements and allegations that are based on groundless assumptions, outdated information, or misstatements of fact, can not be allowed to stand on the record unchallenged. To cite simply one example, the brief of the Consumers' Association of Canada adduces evidence from the Kefauver hearings that was shown to be untrue by the U.S. Commissioner of Patents. We plan to send you a letter setting forth the facts and we would ask that it be entered into the record. If it is the Committee's wish, we would be pleased to follow this course with other statements and briefs that call for challenge.

You have heard much testimony from various witnesses on the subject of medical information. I would like, therefore, to comment briefly on P.M.A.C.'s advertising controls. The P.M.A.C. code of marketing practice, which is Appendix C of the P.M.A.C. brief, has been in effect for nearly a year. All advertising in Canadian medical journals by P.M.A.C. companies is now screened by an expert committee at our office in Ottawa to ensure conformity with our standards governing advertisements to the medical profession. This code has received the approval of the Canadian Medical Association and the Food and Drug Directorate has recognized it as a realistic standard.

A company which issues an advertisement that does not comply with the code is immediately warned of the infraction and requested to take corrective action. Repeated infractions will be considered a breach of our code of ethics and can result in expulsion from P.M.A.C.

We would like, in passing, to thank the Food and Drug Directorate for its excellent co-operation in helping us to establish and administer this code. We are, by the way, developing a similar screening process for direct mail to doctors.

Finally, I want to establish a point in answer to those who state that patents contribute to the so-called high cost of drugs, and indeed, Mr. Chairman, to anyone who will claim that the cost of pharmaceuticals is today unnecessarily high, and that is this fact: the prescription drug index, compiled by the Dominion Bureau of Statistics with prices for 1949 providing a base of 100, has declined over the years to a low this year of 97.4. This actual decline in the drug price index occurred during a time when the general cost of living index for all items rose to 143.2 and the index for total health and personal care rose to 179.2. I think we must bear in mind that the price of virtually every single commodity and service we buy today has been on the rise, with a few exceptions, for example, drugs.

This Dominion Bureau of Statistics figure is an eloquent response to a question raised by one of the Committee members last summer when he questioned the terms of reference of the Committee, asking if they did not in fact contain an implicit assumption that drug costs were too high before the Committee had an opportunity to determine that fact.

Now, Mr. Chairman, I would like to ask Dr. Stewart to comment on the research situation in relation to our industry, and, following Dr. Stewart's remarks, Mr. Henderson will speak specifically on pharmaceutical patents; and after that we would be very pleased to receive questions from the Committee.

Dr. Brian STEWART (*Director, Pharma-Research Canada Limited*): Mr. Chairman, I would like to ask and attempt to answer briefly three questions about industrial research.

(1) *What constitutes research in the pharmaceutical industry?*

Put simply it is all the steps involved starting with the synthesis or discovery of a new chemical entity to its successful introduction as a new drug into medical practice.

The sequence is outlined in our brief, Section 7.4 and Appendix H, and I would refer you to it It does not make sense to grade pharmaceutical research into first, second or third class or to divide it into fundamental, basic or applied. All the steps outlined in our brief are essential if our objective is to be achieved. There are considerable skills necessary at every level.

Also as a matter of philosophy it should be stated that pharmaceutical research is not in competition with academic or government institutions. Our skills are geared to translating new ideas into practical reality. As we stated in our original brief, "Man benefits from the fruits of new knowledge only as industry can devise means to make it available."

(2) *What contributions has pharmaceutical research made in the development of drugs?*

This question in my opinion was answered in a carefully documented lecture delivered by Professor E. B. Chain entitled "Academic and Industrial Contributions to Drug Research." I have copies of this lecture and would respectfully

request, Mr. Chairman, that it be included as part of the record. It is a complete review of the subject and I would commend those interested to read it.

Professor Chain summarizes his opinion of the research contribution made by the pharmaceutical industry as follows:

Perhaps I should digress for a minute to say that, as you are probably aware, Professor Chain is a Nobel Prize Winner. He was a co-winner with Florey and Fleming for his contribution in the discovery and application of penicillin.

I quote from Professor Chain's article:

> "I cannot visualize how the industrial pharmaceutical research laboratory could adequately be replaced by any other non-industrial structure, and those who wish to abolish it by nationalization for theoretical reasons, or impede notably its freedom of action, must know that in taking such steps they are conjuring up a major health hazard, much more dangerous than a virulent epidemic. No pharmaceutical industry—no new drugs; this, in a nutshell, is the situation. It is of course theoretically conceivable to create a state-controlled organization for drug research on the lines of the present private industry; but before tampering with the present system which we know produces results, though maybe imperfectly, let us first make sure and doubly sure that the new system will really function as well as the present one, which it is designed to replace. Theoretical arguments are not sufficient; the only decisive criterion for the acceptability of a new system for drug research is the acid test whether it produces in practice new drugs in satisfactory numbers or not."

and he ends with the following plea:

> "Let us then stop the sterile and futile quibble as to which type of laboratory has made contributions of greater value towards the promotion of the subject, let us put an end to prejudiced, irresponsible and tendentious denigration of the pharmaceutical industry and let us work quite intentionally and consciously towards creating an atmosphere which destroys distrust and promotes understanding and which ensures opportunities for still closer and more intensified contacts and collaboration between academic and industrial scientists. Let us be sure to deploy all our resources, intellectual and material, in the most expedient manner so that we can give the scientists concerned with drug research, both in the universities and in industry, the most favourable conditions in which they can advance more speedily and with the least impediment towards their one great aim, to which they devote their lives and in which all of us have the highest stakes: to combat and conquer pain and an ever-increasing range of diseases through the discovery of new and more efficacious drugs."

My last question is: *What is the cost of pharmaceutical research?*

This is perhaps the hardest to answer because it is the most difficult to estimate. It would be easier if the total sequence of research was done in one place but this hardly or never occurs. It seems a general pattern that some steps at least are done in different countries.

I will try and divide the cost estimate into two parts:—

(1) *The total cost of developing a single new drug.* The best estimates originate from the United States where the size of the country allows almost the ideal of doing all the research in one central place. The average cost of a new drug now is stated to be $5,000,000. These costs include the toxicology and clinical trials necessary to satisfy government agencies in addition to the laboratory costs.

(2) *We can look at it as the actual amount spent on research.* I cannot speak for other countries but would like to confine my remarks to Canada where we do have our own figures.

In our brief, Section 7.9, we stated according to the figures available when it was written that the expenditure on research and development rose from $2,-500,000 in 1959 to an estimated $6,500,000. The latest figures just compiled by our Association on the same 37 reporting companies shows a further increase to $9,500,000 this year.

In addition—I have just been handed some later figures—there are 9 member companies of P.M.A.C. doing laboratory research as well as other types of research as outlined in our brief. These people employ 442 scientists and technicians. Their yearly budget is $7.5 million and their investment in research in Canada is now $12.5 million.

I would like to state in conclusion that research by the pharmaceutical industry has made a major contribution to medical care. It is encouraging to us in industrial research to see that the Canadian contribution is developing and increasing and it is our hope and aim that the efforts on the part of government to further encourage this program will include the incentive of strong patent protection.

I am a scientist, Mr. Chairman, and I see the industry from this angle. My experience is that members of our Association are dedicated and committed to foster development of new drugs. I would like to see us in Canada continue our active part in this. Thank you.

Mr. Gordon F. HENDERSON (*Patent Advisor, Pharmaceutical Manufacturers Association of Canada*): Mr. Chairman and gentlemen, the submission of the Pharmaceutical Manufacturers Association of Canada relating to patents is made against the background of evidence that has been submitted by this Association and by certain member companies. It is based upon the following factual situation, the evidence relating to which has previously been submitted:

(1) that within the last 20 years, new drugs have effectively transformed the treatment of human diseases. By way of example, tremendous advances have been made in the area of infectious and communicable diseases as well as nervous disorders.

(2) that the new drugs that have constituted major advances in the therapeutic art have been achieved by private enterprise through planned research by trained personnel of the major pharmaceutical companies. Apart from penicillin and perhaps some of the sulfa drugs, all new drugs have been achieved through corporate research. No major drug is known to have been innovated and marketed in Russia through state activity.

(3) a company achieves a major breakthrough in a ten year span. It is through a major breakthrough that a company is able to support its research and general drug activity.

A major breakthrough is, therefore, the instrument to enable the company to recover its cost of research, pharmacological and toxicological testing and medical information. It is through a major breakthrough that a company is able to recover its costs either by the price it is able to charge or through the royalty received from a licensee.

The functions performed by an innovator company dependent upon research include:

(1) the function of research. This function results in a chemical which at that state of its history is not capable of human use. It is only a chemical curiosity which may have a utility as a safe drug.

(2) pharmacological and toxicological testing to establish the safety of the drug for use for human consumption. This includes not only testing on animals but the establishment of the safety of the drug to the satisfaction of the department of government concerned.

(3) medical information. Unless a doctor has confidence in the safety of the drug, he will not prescribe it. Confidence arises not only from the reputation and stability of the manufacturer but through the continuing information relating to the efficacy of the drug for particular uses and the risks relating to it received from the manufacturer. This information arises in a two-way relationship in that information received throughout the world by the manufacturer from other doctors is passed on to doctors throughout the world in relation to the drug. Moreover medical information has continuing activity in that the risks incident to continuous or long-term use can only be obtained after the drug has been on the market for a period of time.

It is submitted that the evidence given to this Committee establishes that each of the above functions is a necessary function. The cost of such functions is a necessary cost. One may differ in terms of the amount that ought to be expended in respect of each function but a new drug cannot be safely and successfully put on the commercial market unless the manufacturer is prepared to undertake the necessary cost to successfully carry out each function. It is essential for the continuance of new drugs through private enterprise that these necessary costs plus a reasonable profit be recovered. It is therefore submitted to the Committee that a study relating to the price of drugs should take into consideration the cost applicable to such necessary functions.

Similarly any consideration as to the role of patents in relation to prices should be related to a consideration of a patent as an instrument enabling the drug company which has innovated a new drug to recover such necessary costs plus a reasonable profit whether by way of the price which it charges or the royalty which it recovers.

Section 41 of the Canadian Patent Act as now being interpreted by the Canadian courts does not enable a company which has made a major breakthrough to recover its necessary costs in that the scope of protection afforded to a drug invention made by chemical processes is limited. In other words, you cannot have a claim and get protection in that sphere unless you have invented a

process; and compulsory licences are granted under Section 41, subsection (3) almost as a matter of right, with a royalty that has been characterised, by the tribunal fixing the amount, as a pittance.

Any consideration of the role of patents in relation to any product, drugs or whatever products, should reflect the basic purpose or philosophy behind the patent grant. A patent constitutes an incentive. The purpose of the Canadian Patent Act is reflected in Section 67(3). The section reads as follows:

> "67.(3) It is declared with relation to every paragraph of subsection (2)"—

and I may say this is the ordinary compulsory licence provision—

> "that, for the purpose of determining whether there has been any abuse of the exclusive rights under a patent, it shall be taken that patents for new inventions are granted not only to encourage invention"—

so that is one incentive to encourage invention—"but to secure that new inventions shall so far as possible be worked on a commercial scale in Canada without undue delay."—or as an incentive to investment for productive purposes in Canada.

A patent not only encourages invention through research but constitutes an incentive to production of the subject matter of the invention in Canada. In the absence of a temporary monopoly granted by a patent, there is no incentive to make large-scale investments in this country to produce. Any diminution of the patent right diminishes the incentive to invest in the establishment of a producing entity in this country. The abolition of patents would lead to the Canadian market becoming dependent upon foreign producers and with the risks that the necessary drugs might become unavailable in times of great need and consequent scarcity.

Section 41(1) of the Canadian Patent Act deprives an innovator of a new drug produced by chemical process of any protection unless there is invention in the process. Section 41(3) as presently interpreted by the Commissioner of Patents and the Courts has resulted in a grant of compulsory licences almost as of right with a minimal payment that does not cover the necessary costs to the extent that drug patents on major breakthroughs have lost any real significance in this country.

It is submitted that by including in Subsection 41(3) the concept that a licence should not be granted where the Commissioner sees good reason to the contrary that is the brake that now appears in the subsection, which has been judicially, in my submission, interpreted out of the section—the legislature did not comtemplate a licence as of right. What we are urging here is that that concept be now made effective.

However, it is difficult to find a situation today where the Commissioner will see good reason to the contrary. The difficulties with the compulsory licence provisions as they now appear are as follows:

(1) There is no objective standard against which a patentee can protect himself.

(2) The Commissioner and the Courts do not consider the economic problem from an economic standpoint but tend to look at the matter legalistically.

(3) Licences have been granted where there is no oral presentation or cross-examination of the statement made by an applicant.

(4) The most recent licence has been granted where the patentee produced the product in Canada, carried out research in Canada, supplied an export market from Canada and is prepared to justify its Canadian price in relation to its costs.

In the light of that situation, nonetheless, without a hearing—that is a formal oral hearing—a compulsory licence was granted this year. That is in the case of Micro Chemical versus Smith, Kline, and French for Stelazine, the details of which have been given to the Committee earlier.

The Pharmaceutical Manufacturers Association of Canada urges that Section 41(3) in its present form be abolished and that a tribunal be created which will examine the question of compulsory licence having regard to fixed objective standards which would include elements of price and safety; that the composition of any tribunal to investigate compulsory licences relating to food and drugs should include persons with an economic background, as we submit that this is an economic question which should be determined by a tribunal that is trained in economics.

The royalty in respect of any licence should be of such a magnitude as will enable a patentee to recover real costs in relation to the real functions, which that tribunal will determine.

Section 41(1) is so restrictive in relation to the protection which a drug patentee can obtain that companies which consider they may not meet the stringent conditions of the Hilliard Committee recommendations will avoid pursuing a compulsory licence under Section 41(3) and seek to invalidate a patent under Section 41(1). Since the courts are reluctant to grant interlocutory injunctions in relation to patent matters, the small Canadian company will run the risk of producing and selling the patented drug until the patent action has been finally determined. Therefore, in effect, they take their own compulsory licence.

It is submitted that Section 41(1) should be abolished. The abolition of this subsection was recommended by the Ilsley Commission which studied patents a few years ago in Canada. It was abolished in England following a similar recommendation by the Swan Committee in that country.

It is difficult to consider what the Commissioner of Patents will find to fall within the phrase "good reason to the contrary" against a grant of a compulsory licence; but I can say this to you, and it is said in our brief, that the matter of safety goes by default. The Commissioner is not obliged to consider the matter of safety, and the courts have so stated. As recently as last year, in a case in the Exchequer Court, the Court held as follows: In particular, there is no statutory requirement that he—being the applicant—prove that he is competent. There is no requirement that the applicant prove that he is competent to produce the food or medicine, or that he is possessed of the equipment, know-how and resources to do so. Then the Court went on to say that the Commissioner may consider this; but he is not obliged to. In other words, there are no objective standards against which the Commissioner may make a determination of a compulsory licence.

The Commissioner is, in effect, almost free to legislate, and the courts, although appeal has been provided, will not second-guess, if you will, the

Commissioner. They will not reconsider the matter of what should be considered within the phrase "good reason to the contrary". The result is that the Commissioner, who is well trained in chemical matters and in the administration of the Patent Office, determines an economic question legalistically without any standards at all, and the courts accept what he has done without any reconsideration. The result is that at the moment licences are being granted without an oral presentation, without cross-examination of the applicant's statement, in the circumstances that I have outlined and with a royalty that I suggest to the Committee bears no real relation to the costs which must be borne by an innovator company.

It is in the light of that background that we urge that section 41 be eliminated and that there be enacted a section which would enable a realistic determination to be made by an economic tribunal which would consider both price and safety.

The CHAIRMAN: Thank you, Mr. Henderson.

Mr. MACKASEY: Mr. Chairman, I have one observation to make. Since I have come in late, for which I apologize—I am on another committee across the hall—I have been handed five additional pieces of information. I do not have the mental capacity to absorb them at a sitting such as this one. I admit my weaknesses in this respect. I am honest, which is more than some of the briefs are!

Mr. Chairman, the point is that much of the information in most of these additional documents is very pertinent to what is before us. The information contained is in addition to the original briefs which Mr. Dan was kind enough to forward and which P.M.A.C. forwarded some time ago. How are we expected to do justice to these particular supplementary briefs that have just been placed at our disposal without having some time to study them?

The CHAIRMAN: I am not sure what five documents you are really referring to, but most of them were copies of statements that have just been made orally.

Mr. MACKASEY: That is right; they have just been made now, the point is that nobody in this room has absorbed all these statements, or is capable of absorbing them all, and the gentlemen have been kind enough to give us written copies of what they have said. We have not had an opportunity to study them or look at them

It may be funny to some of the members, Mr. Chairman, but it is serious to me, because I treat this Committee seriously. I have things to do other than to look at the statements. I have not had an opportunity to examine these statements from the point of view of my own interpretation of what was said, and based on my own conclusions of what the witnesses have said. This is what I am objecting to.

You asked me what are the five. There is the opening statement of Dr. Wigle; there is a statement of Dr. Stewart; there is the "Academic and Industrial Contributions to Research" by a gentleman named Chain; there is certainly a very strong submission by Mr. Dan, which supplements his brief and which introduces completely new areas which need to be substantiated or clarified, because I appreciate many of the points and he has answered many of the questions that I wanted answered. This is just an observation.

The CHAIRMAN: Your observation is well taken. I agree that forty minutes of our time this morning was spent on what was perhaps new material that has not been before the Committee for study, but under the circumstances there is no way that we can proceed other than with any questions that might occur to us.

Mr. HOWE (*Hamilton South*): Mr. Chairman, I am sure that the rest of the members of this Committee also take it seriously. Secondly, while we are on the matter of not receiving briefs soon enough, I think that many of the briefs arrive even too late for proper study before we have a meeting. Some of them arrive the day before, and this does not give adequate chance for study, with all the other work that has to be done in other Committees that many members are on.

I think we should receive our briefs far enough ahead that we have time to properly study them and organize a series of questions that are going to be useful, rather than spontaneously, at the time that they are given out, or the morning after, to try to organize something that is going to teach us anyhing. I think that we get them too late to be able to accomplish this, and I agree with Mr. Mackasey.

The CHAIRMAN: Yes. It was the hope of the Committee that they would be here at least one week prior to their presentation, but this has not always been so, unfortunately.

Mr. HOWE (*Hamilton South*): Yes; the bigger they are, the later they come.

The CHAIRMAN: It takes them longer to do, I suppose. I would remind you that it is quite possible that there will be an afternoon session, if anybody wants to study at lunch time.

The meeting is open for questioning.

(*Translation*)

Mr. ISABELLE: Mr. Chairman, I would like to make a comment. There is nothing new about being flooded with all kinds of briefs in this Committee. With all this scientific evidence before us, we really should be able to reduce the price of drugs one of these days. Those are our terms of reference. This morning I was reading in a magazine, that drug costs are shrinking, according to U.S. Manufacturers and the U. S. Pharmaceutical Manufacturers Association says that drug costs may take a smaller part of the health care dollar than ever before, and, of every dollar spent on medical care, only 14 cents goes to retail outlets for drugs compared to 17.5 cents in 1946; and prescription drugs account for 9.8 cents of the medical dollar. I hope that you are going to follow the United States in this regard and that the price would go down in this country.

Could I ask questions? Mr. Dan, last July when you came here, you talked about the standards of your new Association. Have these standards now been laid down?

(*English*)

Mr. DAN: Dr. Isabelle, they have been laid down and copies have been handed over to the chairman, so that it is probable that he will distribute them.

Mr. ISABELLE: They have been established.

Mr. DAN: That is right. Of course, standards always have to be revised and they will be tightened up.

The CHAIRMAN: There are a few copies available.

Do you have some more questions, Dr. Isabelle?

Mr. ISABELLE: No, not at this time.

Mr. RYNARD: Mr. Chairman, I certainly agree with my friend, Bryce Mackasey, in what he had to say about our not having had too much time to study this brief.

There is a question I would like to ask Mr. Dan. If I understood him correctly, he said that they propose that they were going to bring in more and more of the smaller companies and form a great big company, and were going to have public subscription on it. I am wondering how he is going to have public subscription if this figure of 9½ per cent is correct on his return before taxes. What was the return after taxes and where is he going to get public subscription for that?

Mr. DAN: Dr. Rynard, I indicated in my brief that there was a very strong tendency on the part of the smaller firms, shall I say, first, to co-operate, second, to merge in certain activities, and third, to merge structurally. I am not an expert in financing but my understanding is that before you float a company you have to have certain sales which I would consider to be about $1.5 million to $2 million; you have to have a certain profit picture, either immediately or in the near future; and you have to have an expanding phase in the industry, which happens to be in the pharmaceuticals, and one of my points which I brought out to you during the previous hearings is that we see something unprecedented in the pharmaceutical industry—a termendous expansion. This is something that surprised people in the industry.

Just a couple of weeks ago there was an article in the *Financial Post* on the Swedish pharmaceutical industry and it explained to the public that the industry in a period of ten years expanded about three times. Since the industry is expanding, in my judgment that is the right move. I am not making any secret of it; and this is not at all new. I can go back thirty years, when in 1930 I understand economic conditions were worse. Today, we are in the affluent society, but at that time there was a severe depression, and if I understand correctly, in those years several firms in Britain merged and formed a company called British Drug Houses, out of necessity, not out of convenience. Today they are one of the largest companies. That is the trend. We have to do that, because if we do not follow the pattern, interpret economic trends and act accordingly, then I would say we will amount to nothing.

That is what I was referring to, and my prediction, if I understand the trends correctly, is that mergers of this kind must take place. I have cited two examples that already have taken place. This particular company, Sogena, has a public record. It is available to anyone. I deposited the record with your Chairman. You can go over it. I respectfully submit that in the near future there will be other similar types of mergers.

Mr. RYNARD: Mr. Chairman, I would just like to pursue that a little further.

This, of course, is in the hypothetical stage, whether you do go on with this or not. The proposals are not very definite but one of the things that we are

dependent on—and I think I would like to point this out to Mr. Dan—is research, and we Canadians, today, are far behind in research spending. When you consider that we spend less than one tenth per capita of what United States does surely there is a great field that must be filled by private enterprise doing some of this research that we need so badly and which is not being done in Canada. In other words, you are not going to keep the trained people in Canada unless you do this research. Therefore, this research has to be protected, and I am concerned when you say. "Well, we will protect this for a few years," because how are you going to know and who is going to decide, when that time comes, or when you set an arbitrary scale of five to six, or four or five years of protection, or whatever the case may be, how are you going to know that that research cost has been fully recovered? I could name a lot of drugs on which they have not recovered it in that period of time. Not only that, how are they going to carry on the other research that is being carried on, when out of many, many research experiments only one comes through?

I think we have to be fair about this, and I do not think we are fair when we say that we can make a cut-off in four or five years. This is begging the point. We cannot do it; you do not know how long it is going to take to recover it. You are going to have people not going into research, and manufacturing a lot of very useful drugs for which there is not a big demand.

Mr. DAN: Dr. Rynard, I share your sentiments about research. Nevertheless I would like to point out respectfully to you that for some reason or other research has been a little bit over-emphasized.

You have to look at the hard facts of life. The facts of life are that the major companies do not do research in Canada, and they intimated during the hearings—and it is in Hansard—that they are not prepared to do it, with a very few exceptions. Therefore, immediately we have to differentiate between those of the 57 companies who are prepared to do research—and I can mention only six or seven at the most—and the ones who are not prepared to do research, and have said so, except berhaps too clinical research which today is almost mandatory under the present laws. I believe the very few who are prepared to do research should be helped. How? Perhaps by special rates of taxation, or perhaps by special grants. There are ways and means whereby these companies could be helped.

I fully agree with you that I do not like to see my classmates going to the United States or any other country, because they have more position there—and I do not mean that as derogatory of other countries. But you have to look at the facts of life, and you cannot make a judgement without first understanding the structure of the particular industry which in this case is pharmaceuticals. That is what I have tried to do in my written and oral submissions —to put that industry into the economic fabric of our country. The fact is that today, as I pointed out in the brief, we are a secondary market.

I respectfully submit to you, sir, that you may have to re-examine the entire industry in four of five years, to see just what these companies have done in four or five years. If you find five years hence that out of the 57 companies you have 25 doing research, and in major areas, then I would say, sir, that you are absolutely right, and that these companies have to be protected; but the facts are that today they are not doing it, so why should they deserve special canside ration—I am thinking of the 50 companies—for things they do not do? That is why

I pointed out that in England the situation is entirely different, where they do considerably greater research, and I feel that they are entitled to protection.

Mr. RYNARD: Well, Mr. Chairman, I agree in part with what Mr. Dan has said, that we have a small infant, but are we going to starve this infant and make Canada a completely secondary country in the buying of those goods? What we hope to do is keep on building up this research industry. We have a lot to do, I agree. Perhaps drug-research should be given more incentive in Canada than it is getting; but, for goodness' sake, this does not substantiate your argument that we forget all about it. Surely we should encourage the research that we have so that things will go on and build up, rather than destroy what we have?

Mr. DAN: With all due respect, I do not believe I said that we should forget about it. I merely said that we should interpret it realistically, which means support the ones who want to do research, and give them every opportunity and every chance. But I do not see why 50 other companies, which state quite clearly that they do not have any intention of doing any basic research over and above what is mandatory today by law, should benefit from the activities of the other seven. That is why I say that you may have to convene again in four or five years to re-examine and adjust your laws accordingly; but, today, with the conditions as they exist, I feel that our interpretation is realistic.

Mr. MACKASEY: Mr. Chairman, would Dr. Rynard permit me to ask a supplementary question? I might just forget it later on.

Mr. Dan, what you are saying, as I understand it, is that in five years' time we could sit down and pick out those companies who are deserving of some form of protection, or bonus, if you want to put it that way, because they have proven over this five year period between now and, we will say, 1971 that they have done research in Canada. Is that what you are saying? You recognize the principle that there is a correlation between research and patent protection.

Mr. DAN: Absolutely; and also the other activities.

Mr. MACKASEY: All right. I am not trying to harass you. I want to get this clear in my mind.

What is your attitude towards those firms in Canada who can prove conclusively that they are doing research at the moment?

Mr. DAN: They should be supported. In fact, if I have read the reports correctly, some of the principals who have appeared on behalf of companies have admitted that one of the reasons why they came to Canada was because the government created a favourable atmosphere, with such things as grants and incentives. This was the main reason.

Mr. MACKASEY: I want to be fair to Dr. Rynard.

The point I am making is that you mentioned earlier—and I think it is an excellent suggestion—that we sit down after a five-year period and see what has been the increase in research facilities. This is the point that I have been stressing all the time on the Committee. Your principle is that those firms which, as good Canadian corporate citizens, are doing research in Canada should be rewarded in some tangible fashion, and you are suggesting that this take the form of increased patent protection. Therefore, we are simply going to recognize the universal principle that they should have the right to the fruits of their labour. But what about the firms that we were speaking of, that are spending the

$12 million in Canada today? Why should they have to wait five years for this type of reward—and not in the form of cash grants, but in the form of suitable patent protection?

Mr. DAN: Mr. Mackasey, can you name a product which was discovered by these firms in the last two or three years? Between now and five years hence, there will be some products. Can you add the name of one original product that was discovered in the last two or three years?

Mr. MACKASEY: Do you mind, Dr. Rynard, if I follow this up?

Mr. RYNARD: Go ahead.

Mr. MACKASEY: Mr. Dan, from what little knowledge I have of the pharmaceutical industry—and what I have is just from working at it—proof of research dollars spent in research is not necessarily reflected in what you have discovered, because, unfortunately, from what I can gather from scientists and chemists and people working in lonely attics, they can work for 20 years on research and never have the good fortune of recovering—if they want to recover it—the expense of their research in discovering a drug. You cannot, in all fairness, say that you can gauge what research is being done by whether or not a substance is discovered. The one discovery that I have noted is Joe Green's well-publicized discovery, in the Department of Agriculture, which may have been the result of somebody removing a manure heap; I do not know. The point I am getting at is this: If you are going to use that criterion, then the Department of Agriculture is spending time and money and effort in research on a firm that may have been working for ten years and been unfortunate enough not to have discovered something.

Mr. DAN: Mr. Mackasey, the point is that today research is not the general rule; it is the exception.

Mr. MACKASEY: Yes. I am agreeing with you.

Mr. DAN: Therefore, the government should find ways and means to assist those who wish to do research.

Mr. MACKASEY: I apologize to Dr. Rynard. We will pursue this little debate later when my turn comes up. Thank you, Dr. Rynard.

Mr. RYNARD: Mr. Chairman, there is just one conclusion that can be reached after this long conversation and it is simply this—and I think Mr. Dan would agree with this—that more research should be done in Canada by the drug firms, and more incentives should be granted to encourage them to carry on this research and to build our industry and to protect it.

Mr. DAN: I agree with you, Dr. Rynard.

The CHAIRMAN: Dr. Howe, have you any comments you would like to make on this?

Mr. HOWE (*Hamilton South*): I have a couple of questions, because I have to leave in a few moments. I am in the unfortunate position of knowing the name of everybody here except that of the gentleman I want to ask the question of.

The CHAIRMAN: Mr. Henderson.

Mr. HOWE (*Hamilton South*): Mr. Henderson, do you think that it takes 17 years of monopoly sales to accomplish the return of investment or the research done to discover this drug.

Mr. HENDERSON: There is no magic in numbers. One cannot categorically say that it takes two years, three years, or seventeen years. In my view, it depends entirely on the particular product. It may in some instances be 17 years; it may in some instances be four or five.

What I am urging is that there be an opportunity to establish what the right number of years may be in relation to a particular drug. In other words, I think that is a matter which the tribunal may well consider. One cannot be arbitrary, that it will be five or that it will be three or that it will be seven.

Mr. HOWE (*Hamilton South*): Apparently the law has been arbitrary in the selection of this length of time.

Mr. HENDERSON: Yes, there must be a cut-off at some point, and it has been 17 for a long number of years in a large number of countries. This has been the history. But I have to say to you that that is dependent upon the particular product that is being considered and is a matter that ought to be considered by the tribunal in determining any application made to it for a license.

Mr. HOWE (*Hamilton South*): So that the cost of a drug that has been discovered is determined largely, then, by the amount of research that has gone into it, and the return of this investment being sufficient to get this research money back and, of course, to acquire more money for more research in the hope that another break-through will eventually come.

Mr. HENDERSON: I want to make it clear that research, in our view, is only one of the elements of cost that must be recovered; but the answer to your question, in terms of research as an element of cost, is yes.

Mr. HOWE (*Hamilton South*): Well, you have the work that is done that is researched, or proved to the Food and Drug Administration to be safe and efficient and that it will do what is claimed, and so on. Therefore, you have this expense, as well, that is involved in any new drug that comes on the market.

Mr. HENDERSON: That is correct. And, Dr. Howe, I am sure I do not have to tell you that medical information knows no period of time. This is a continuing thing, because the indications of any particular drug may enlarge or narrow, depending upon usage over a long period of time in a particular person, or in a given number of people, and medical information is a cost and it is a continuing cost. It is another cost that has to be taken into consideration.

Mr. HOWE (*Hamilton South*): I was leading up to this question: What about a drug that is imported from the United States as a new drug in Canada, that comes up with all the research information, that comes up with all its quality control, that is sufficient in itself to pass on to the Food and Drug administration for being granted a licence or permission to be sold in Canada, that is free of costs in Canada, and yet will sell at the same price as though it had been discovered in Canada, or at the same price at which it is being sold in the States?

Mr. HENDERSON: With respect, I would suggest to you that one cannot isolate costs to a country. The cost must be related to the world-wide activity of the sale, because an invention knows no territorial boundary. A drug knows no

territorial boundary. A patent does know a territorial boundary, but not an invention. The costs relating to that particular invention, that particular drug, must be related to the world-wide activities of the particular company selling the drug. So I would suggest to you that any consideration of cost isolated particularly to a particular country is an academic exercise, not a real one.

Mr. HOWE (*Hamilton South*): But does this not really put the Canadian subsidiary company in the same position as any other copying company?

Mr. HENDERSON: The destination of the funds of the Canadian subsidiary is part of the innovator company; whereas the destination of the funds of the copier is in a very different place. It does not put it in the same position, because it is a part of a world-wide organization.

Mr. HOWE (*Hamilton South*): In other words, the profit on these drugs, then, returns to the States, to the parent company, to help pay for this research cost that was incurred?

Mr. HENDERSON: Which will result in a new drug, to the betterment of the health of the Canadian people.

Mr. HOWE (*Hamilton South*): Yes; but is this profit sent down there to compensate for the research costs, or is simply a royalty paid for the licence that is granted to manufacture the drug in Canada?

Mr. HENDERSON: I am sorry, I missed your point. I did not quite follow.

Mr. HOWE (*Hamilton South*): My point is that if a drug is discovered in the States by a parent company and is later manufactured here in Canada or distributed, or bottled, labelled and distributed in Canada by a subsidiary company, how is this compensated for by the parent company? Does it receive a profit to compensate for the research work that the parent company has done, or is a royalty paid, such as any copying company would do when they got a compulsory licence to manufacture this drug?

Mr. HENDERSON: It may be paid in several ways but two logical ways would be by way of a component of royalty or by way of dividend. It could be paid either way, but the effect of the patent is to encourage that company to produce that drug in Canada.

Mr. HOWE (*Hamilton South*): Even though it has not discovered this drug through its own research.

Mr. HENDERSON: I do not care where it is discovered, but the patent laws are designed to encourage the production of that drug in this country, and our laws do provide protection; apart from section 41 of the Canadian Patent Act, which is the burden of our submission here, we have protection in this country to ensure that there is an incentive to produce the drug in Canada. That is what our patent laws are designed to do. Now, we are not seeking to avoid that obligation.

Mr. HOWE (*Hamilton South*): This is not the actual company that discovered the drug so, therefore, any company could manufacture that drug under a compulsory licence or a voluntary licence and accomplish the same end.

Mr. HENDERSON: Well, perhaps I do not see the end you are seeking to accomplish.

Mr. HOWE (*Hamilton South*): You say the patent laws are to protect the sale and distribution of this drug by that company. You know that this particular subsidiary company did not actually acquire the patent originally by discovering the drug.

Mr. HENDERSON: I do not recall saying that.

Mr. HOWE (*Hamilton South*): I perhaps misunderstood you.

Mr. HENDERSON: I think we are talking at cross purposes because that is not what I intended to say. What I intend to say is this. That the patent laws encourage; they first create the incentive against which people will innovate. That is incentive number one. Incentive to innovate. But besides that it gives you a climate in which you are prepared to invest. I suggest to you that there would not have been a plant in Kingston producing terylene if there had not been a patent which ensured them, the company that built the plant, the opportunity of recovering its costs over a given period of time.

Now, the same thing applies in drugs. The patent encourages the production in this country. It enables the company to obtain its return over a given period of time. It can make that recovery of its costs incident to that investment either by way of the price which it charges if it pursues the monopoly position that it has under the Patent Act, or it may choose to obtain that recovery through a licence. But whichever route it chooses it must obtain sufficient funds to enable the recovery to be made.

Mr. HOWE (*Hamilton South*): What recovery does this Canadian company have to make if they are simply a distributor of an American invented drug?

Mr. HENDERSON: Well, it must make some recovery relating to the over-all cost of the parent company. It must bear its proportion of relationship.

Mr. HOWE (*Hamilton South*): But some of these companies do not research and do not do actual manufacturing within this country, and yet they are protected by this patent law when they are not actually partaking in this research.

Mr. HENDERSON: With respect, there is another provision which we are not asking to be changed which comes then into play, and they then are not protected by the patent law. That is the point I am making. Section 67 of the Canadian Patent Act enables any company, any interested person, to make an application for compulsory licence if there is not manufacture of the subject matter of the patent in this country. That is independent completely of section 41, so that there is protection in our patent laws to prevent the abuse that you speak of, and what we are urging is the abolition of section 41 (3) which is the granting of a compulsory licence as of right, apart from abuse. We are not urging that we be excepted from the general principle of compulsory licence where there would be abuse and failure to manufacture in this country.

Mr. HOWE (*Hamilton South*): This is of any class of kind, is it not?

Mr. HENDERSON: No, it is any product at all. Any product. This is not of any class or kind. Class or kind has no relationship to the patent laws. Class or kind is purely an incident of 7½ per cent duty as opposed to 22½ under the Customs Act. It has nothing to do with the Patent Act.

Mr. HOWE (*Hamilton South*): I see.

Dr. W. W. WIGLE (*President, Pharmaceutical Manufacturers Association of Canada*): Mr. Chairman, may I suggest that on the first part of Dr. Howe's question, where he related the cost of the specific drug to the research for that drug, Dr. Brian Stewart, with your permission, might have something to say.

The CHAIRMAN: Would you like to say something, Dr. Stewart?

Dr. STEWART: I think that what Dr. Howe was getting at is that the total research operation of the company has to be considered when you are talking of recovering research costs. We submitted in our brief under Professor Briant's heading the actual rayalties paid to drug companies outside Canada. I would like to make two points. One, that it is our experience, on the average, in asking around that it is seven to ten years after the discovery of a new drug by research laboratories before it starts to be marketed to earn money. So whatever length of protection we get under the Patent Act is not operative in drugs at the present time for at least seven to ten years after the patent is applied for.

Secondly, coming down to research in Canada, research is a long-term investment and I would like to underline this. You cannot suddenly have a research department tomorrow because qualified people are not available. It is a question of training them and getting them to work together and it is a specialized field compared to university. Everything has small beginnings. We hear now that research is the exception. Let me respectfully submit that five years ago it was an even greater exception. The growth of research in Canada in the last five years has, in my opinion, been spectacular. We are in the phase now when we are getting the people. When do we get the results? This is a very useful question you are asking.

Well, Mr. Mackasey's point here is well taken. We cannot guarantee results here. The more people there are working on it, the more likely we are to get results in Canada and contribute then to the international pharmaceutical drug field. So I think that it is not meaningful to me as a scientist to try and say we will give this to this country and that to this country. I am looking at it as a total effort. I have tried to outline in the brief that different countries are doing different tasks of research necessary to discover a new drug, and I am proud to feel Canada is doing more and more as time goes by, and I just respectfully ask that this be encouraged in the deliberations of this Committee.

Dr. WIGLE: Mr. Chairman, I had hoped that what Dr. Brian Stewart was going to point out was that it is my understanding that in a continuing research operation a single discovery has not likely been cost accounted day by day throughout the years so that that particular pill can then be said to have cost exactly that much in the operation and therefore, when it has made that much we can write it off and start to look for a new one. The whole operation goes ahead, and probably expands because of the process.

Mr. HOWE (*Hamilton South*): One simply applies the research to the overall cost of that company's total operation.

Mr. ENNS: Well, after the discussion on research and following up Mr. Dan's brief for the relaxation of patent laws although I do have sympathy for the breakdown of market as Mr. Dan spelled it out in his brief, the first, second and tertiary market, putting Canada in the secondary position where not enough research is done, I am wondering whether the aim can be best achieved by tax

incentives or bonus or subsidies to companies rather than on patents. I have a real quarrel in my own mind here with the position that has been posed to us this morning and at earlier hearings. I have an inclination to believe that the patent system might be the more equitable system because we might get into the position of doing research for the sake of research or just for the sake of the subsidy, and this, of course, would only add to the cost of drugs. If is fine to say we must have more research but if this means duplicating research in other countries, I question again the validity of this aim as an end in itself. I wonder if I might not take issue with Mr. Dan even though I say to him I feel strongly that Canada should not probably be in the primary position where research is not really done to the extent that it might be. I am just bringing this thought to the Committee because I feel we are in this position. We have to decide between these two approaches respecting giving incentive to research.

Mr. DAN: I believe the kernel of the entire analysis is timing. It is our contention that today, at this particular stage, as the industry is today, the answer is patent relaxation, because they do not do the research that they should do, although they faithfully promise that they will, and I have reason to believe they might. They do not do any export at all, very little to speak of. They discourage export, in fact. They do not make the raw materials. They have a minimum input with a maximum take out. The few who express the willingness to do research I think really should be encouraged. At the same time, we have 50 other companies who are riding on their coat tails while the public is paying the high cost of medicines. Perhaps in five years, or at a certain time when you see that these activities are carried out in a full-line fashion, then the answer perhaps will be a greater patent protection. I have examined all the records; I have examined the industry, and the economy and I came to the conclusion that today that is the right answer.

Mr. ENNS: Well, in which way, Mr. Dan, do the 50 other companies ride on the coat tails of the others?

Mr. DAN: Well, you see it very clearly that they are not doing any research. They do not intend to locate their research centres here. They do not intend to carry out the other activities.

Mr. ENNS: Well, are you suggesting that the price of their manufactured product is as if they were doing this research?

Mr. DAN: Yes, exactly. That is the point. You have to look at the parent company. The parent companies are doing quite well. I do not think that anyone would get the impression that the drug industry is depressed. It certainly is not. It is probably one of the healthiest industries if not the healthiest industry, and the parent companies are no doubt deriving the benefits which is good business. I am not against this. But I wish to interpret the conditions and activities that exist here in Canada and make recommendations accordingly. That is why I am firmly of the opinion and our association is of the opinion too, that today the answer is to relax. Tomorrow it might be tightening I do not know. We have to live until tomorrow.

The CHAIRMAN: Gentlemen, first of all, I apologize to the Committee and also to the gentleman who is also here as witness, the Chair had misplaced his brief. But as you all know, when Dr. Wright was before us he said he would

return to talk about Canadian drug patents. You already have his brief and I think it has been in your hands for perhaps a week. Dr. Wright, would you like to make a comment on patents.

Mr. MACKASEY: There are a lot of questions I want to ask Mr. Dan. Is this the opportune time?

The CHAIRMAN: Well, perhaps to be fair to Dr. Wright, he might comment on patents and then we will carry on with the questioning. I have Dr. Brand next and then Mr. Mackasey.

Mr. GEORGE F. WRIGHT (*Counsel, Canadian Drug Manufacturers*): Thank you, Mr. Chairman. The brief that I am submitting as of today is in a sense supplementary to the brief that I submitted last July 8, in which I tried to consider pharmaceutical research from the standpoint of the patent situation.

Of course, as I have expressed it in these briefs, I do not look at research with the same awe perhaps that some others do here. Research seems to take on the sanctity of the famous sacred cow. Well, I have been milking this research cow for about 30 years and I can tell you I do not think she is sacred.

An hon. MEMBER: Is she still giving milk?

Mr. WRIGHT: She is still giving milk. As I pointed out in my earlier brief, the term research, sacred or not, covers a lot of divisions which none of us, even Dr. Chain, has successfully classified. We are still trying to classify it. For at least we can roughly consider the division between pure and development research. There is very little pure research that I have found that is done by the pharmaceutical companies. This is perhaps proper that it should be divided as it is divided. For the most part they do the developmental work and while this developmental work needs to be done, it needs to be supported and promoted for the future. It does not deserve the high support in so far as it is self-supporting that it would if it were a pure search into the unknown, and in a sense it is its own reward. I have seen very little research, as I think I mentioned here once before, that somehow or other, whether or not the project is successful in its original aim, does not result in some profits.

I think of a fiber that appeared on the market that was in prospect a few years ago, and a lot of money, many millions of dollars, went into this fibre, and it turned out to be a failure simply because it would not stand up in shop windows. That would seem to be a complete loss, but out of that, one year later, with the technology that had been developed, there came a fibre which has been inherently successful. I think this is typical; that you cannot pick up your hand to do research without giving some benefit both to the world and to yourself.

On the other hand, looking at it from the other point of view, I think that research is being used in this attitude as a promotional device, as a way of advancing the product, which has no relationship to its actual significance. In part of this I agree entirely with Mr. Henderson, that section 41(1) is inadequate to give us a proper future in the pharmaceutical patent field. It ties the requirement to a process which almost always is school boy chemistry and has no originality and which explains the fact that many times another process can be worked out. I would quite agree that section 41(1) should be revised in this respect.

The only thing that I would suggest is that if one revises it in this respect, one must not leave a vacuum. One must patent that which ought to be patented, that is to say, the new drug. But this means, and this is a very vexing situation indeed, that this drug must be examined with respect to its usefulness. It is not enough to put the drug out, to use the expressions being used in the States recently, as a sort of hunting license, to find a use for it. This patent should be granted for an authenticated use and if this were the way in which the law was written I would fully approve of it.

With respect to section 41(3), I feel that in this case, too, although I think that the Commissioner has interpreted the law very carefully and very closely, even in respect of the section requiring—how does it read, Mr. Henderson?

Mr. HENDERSON: "The reasons to the contrary".

Mr. WRIGHT: "The reasons to the contrary". I think that this has been done in most cases, but I too, would think that it would be wise to subject this to a tribunal which would have more ability to readjust than exists now.

I think this is all I care to say on it. I have covered the points I have made in here, except to point out, as I did in the latter part of this report, that many of the non-patented drugs sold in Canada seem to be riding on the coat tails of the patented drugs, and I mentioned one incident here in the case of the drug penta-erythritol tetranitrate which enjoys a large pricing differential between one class of company versus the other but it is completely unpatentable. Thank you, Mr. Chairman.

The CHAIRMAN: Thank you, Dr. Wright.

Mr. BRAND: I must join the chorus of voices who talked about being overcome by the paper work we have before us. However, I would like to ask Mr. Dan a few questions.

On page 10 of his brief he says that little or no original pharmaceutical research is done in Canada, presently amounting to about 3 per cent based on sales. I wonder if he could enlarge on that a little bit. We have had a lot of evidence before us on the amount of research which is done in this country and the figures seem to be a little different from those Mr. Dan is proposing.

Mr. DAN: Dr. Brand, it is conceivable that you have more up to date figures than the ones I have. I merely had to go by what I had in my possession, that was the P.M.A.C. submission which is lengthy but I think it is a very exhaustive and informative submission. I believe that the research dollars spent in Canada was about $6 million, or in that vicinity. I am not concerned with research dollars which have been taken out of the country—what do you call it—royalty, increased profits, call it anything you wish. Assuming that the Canadian market is 3 to 5 per cent of the total international market; in all fairness, the 3 or 5 per cent will not influence their research activities in the primary market at their major base. If they sell products in the tertiary market they could not care less today, I say, whether or not they will recoup any funds of research.

Mr. BRAND: You are basing this on manufacturing sales, are you, in your statement here?

Mr. DAN: That is right.

Mr. BRAND: It is low then, according to the figures we have, both in the P.M.A.C. brief and I was thinking particularly of Ayerst, McKenna and Harrison, which was somewhere around 9 per cent. That is quite a different figure.

Mr. DAN: Yes, Ayerst, McKenna and Harrison is a unique situation in Canada. I personally would like to see many companies with similar operations, and I would say that if we had many companies like theirs, our entire orientation would be different.

Mr. BRAND: You have quoted extensively in your brief from the Hall Commission report and others. At page 12 in the Appendix you quote from page 708 of the Royal Commission on Health Services:

> The main Canadian research contributions have come from non-commercial activities of organizations like the Connaught Laboratories. Patents therefore cannot be a *sine qua non* of major advances in the drug field.

That is part of it. Do you subscribe to this completely?

Mr. DAN: Bear in mind that this was written in 1964, presumably, on studies done prior to the date.

Mr. BRAND: I think the intent of that, would you not agree, is that since the Connaught Laboratories is a non-commercial laboratory, you might say, they do not have patents. Is that not the impression you get from that?

Mr. DAN: I would say so.

Mr. BRAND: I go back to an article that appeared in the magazine *Applied Therapeutics* in May of 1963, written by Dr. A. M. Fisher, Assistant Director of the Connaught Medical Research Laboratories. In this article, and I will read just part of it, he says, referring to insulin from the Connaught Laboratories.

> The licenses provided for the payment of royalty to the university.

So royalties were indeed paid. I continue:

> In the case of licenses under patents in countries other than Canada and the United States the university assigned the patents without fee to the local national committees. Since the University of Toronto could not render testing and control services effectively over the great distances involved, it was considered that in so far as the University was concerned, royalties would be waived. However, in the case of licenses in the United States, testing and other services were continued and royalties were paid by the licensees... Although the royalty rate was reduced from time to time, substantial sums were paid to the insulin committee. These funds provided the costs of the insulin committee in maintaining the testing laboratory but all of the remainder—and I think this is most important—the major portion of the total sum received—was designated for medical research in four Canadian universities.

It goes on in the same vein which would seem to be at variance with the statement made in the Hall Commission report, would you not agree?

Mr. DAN: There are two considerations here. First, Connaught Laboratories readily issued licenses almost to any bona fide applicant; and second, the royalties were very small. Of course, if you have royalties you use it for research and

my understanding is that Connaught is very substantially research oriented. Bear one point in mind, that the prices charged today by Connaught are very modest and they have no resemblance at all to the prices charged by the major houses. In short, I am not disputing the fact that you need funds to carry out research. I merely say that you take toll at both gates when you take toll at research and also at the price of the medicine.

Mr. BRAND: I think you are missing the point, Mr. Dan, are you not? The point here was that royalties were very useful to the so-called non-commercial activities of this company, and therefore, it mitigates against the argument you have advanced in your brief that it is perhaps not royalties in some ways. This confuses me a bit when, on one hand, you say that patents are terrible things and, on the other hand, you say they are necessary. I find this difficult to equate. But I could read on a little bit. You say it is a small amount of moneys and what Dr. Fisher said and I quote:

> It will be appreciated that money as a direct result of the patenting of insulin and subsequent modifications thereof, provided at a time when research did not receive the support accorded to it today by government—

And it is pretty small I might add, by government.

> —was of great value in establishing and supporting in a major way medical research in some Canadian universities. In the case of insulin Canadian patents whether owned in Canada or abroad had had a favourable affect upon research and the distribution of insulin in Canada. The Patent Act in Canada and in various other countries has provided freedom for the governors of the university to conclude agreements relating to the exchange of information and technical know-how. New insulin preparations, themselves the subject of patents, have been developed and these have been made available in Canada. Quality has been improved and maintained through frequent discussion of research development.

All as a result, I would presume, of the patents which were granted for the original insulin when it was discovered. Would you agree that this is a fair statement?

Mr. DAN: I would say so.

Mr. BRAND: So this supports, I would think, and I would trust you agree, then the idea that patents are useful in promoting research.

Mr. DAN: Provided you do research but, bear in mind, you must examine the impact of patents on (a) the research and (b) the cost of drugs. Up until now we have been concentrating on the question of research and we made certain comments which are pretty clear. The second aspect is the impact of patents on the cost of drugs, and there is probably room for arguing and there probably I may have my session with Mr. Mackasey or with some others. Patents have a very definite affect upon the cost of drugs.

Mr. BRAND: How do you equate these two positions we have here today. I think, you state on page 3 that inventors should be given complete protection for a period of about from 3 to 5 years from the drug notification date. We have had a statement today by Dr. Stewart, I believe, that from the time they notify or apply for the patent it is sometimes from seven to eight years. Is that correct?

Mr. DAN: There is a point of information here. Drug notification, if I understand it correctly, means that whenever you release a product for sale, within a month you have to file a notification. In short, regardless of when you discovered it, if you do not sell it, it has no commercial value but if you sell it today from the notification date on you are engaged in the sale of the product. As to the 3 years protection, whether our laws can be changed to reflect this point, I am not certain. I merely wish to give recognition to the fact that if there is an original product, a new product, it should receive protection for a period of time, because five years or four years are long enough to become established in the market for the major supplier or call it the innovator—

Mr. BRAND: You are referring to one particular drug; how about these many other drugs for which money is paid out and there is never any commercial benefit. How would you equate the cost of these?

Mr. DAN: The drugs that are not sold on the market have no value as a patent.

Mr. BRAND: But they cost money to produce, though, do they not?

Mr. DAN: That is the reason why the so-called winners should pay for the losers and in a period of five years the innovator has enough time to become established in the market and to pay the research costs. Now what is happening when you examine the cost aspect of the patents? When the so-called innovator,—I put this in parenthesis,—has a patent, he will definitely not lower the price until he is forced to do so although he recouped his investment, although he can operate profitably he will make no concession at all until he reaches a particular point. This is a matter of economics and this is the way they just seem to land on their feet.

Mr. BRAND: The whole business is a matter of economics, is it not?

Mr. DAN: That is true. That is my point. In economics you have to have balance, and the entire consideration of the effect, or the impact of patents on costs, is based on balance. Our government is based on balance, you have opposing sides, as opposed to having just one political party. For the proper functioning of our economy you need competition. You must have several types of suppliers because if there is only a particular firm, or two, or three firms supplying all at the same price, and they are all supplying at practically the same price, there is a tendency, because of human nature, that they will follow a particular path which benefits only them and will not benefit the rest of the people.

Mr. BRAND: You are suggesting, if I can summarize something you said, that the one price of the one drug that is patented should be so high as to pay for all these other developments; is this correct?

Mr. DAN: This is what is happening. It not only pays but it pays over again. You need only to look at the operating statements.

Mr. BRAND: Are you not in favour of this?

Mr. DAN: I am in favour of it but my point is that without competition the price of drugs will not come down by themselves.

Mr. BRAND: That is evading the issue a little bit. You are going on to another feature which may be valid but I do not think it is valid for what we are talking

about. What I am trying to get out of you is how do you propose that you recover the other costs of research for drugs which do not give a commercial return, when they turn out to be "dead wood" in the industry, or whatever you want to call it.

Mr. DAN: I assume that you have done research in Canada, or shall I assume that the research was done elsewhere?

Mr. BRAND: Regardless of where it is done. The fact remains that research is an international affair. There is an interchange. I think we explained that even with the Connaught Laboratory, which was in the statement by Dr. Fisher, that the moneys allowed interchange of ideas in the international field which has benefited people all over the world. To go back to what Dr. Howe was pointing out when he was referring to what happens to the drugs that are in the United States and coming into Canada, it is a two-way street. What about insulin which was developed in Canada and has gone to other countries. Surely this has benefited other countries and we in Canada are receiving the benefit from this, and from the royalties in other countries.

Mr. DAN: That is why I made the point—that there should be sufficient protection for them to become established and recover their expenses, but not for 17 years,—five years I feel are sufficient. Even under compulsory licensing, the so-called innovator still has the major share of the market. As pointed out before, when there is no patent protection the innovator still has a major share of the market because of the superiority of his marketing organization.

Mr. BRAND: But you would agree that despite the fact that you would like to see this compulsory licensing loosened considerably,—that is correct?

Mr. DAN: Beyond a certain time, not in the beginning; beyond a certain time.

Mr. BRAND: And it is also true, is it not, that if the Commissioner of Patents allows a compulsory license, despite the fact that the person from whom you are obtaining this license may disagree with you and may take it to the court, but all the time while the litigation is going on, for the several years that this may go on, you are still producing this drug. Is this not correct?

Mr. DAN: On what grounds the Commissioner of Patents allows a license is something which is within his jurisdiction.

Mr. BRAND: That is not the point. The point is that you can produce, manufacture and sell this drug while all this litigation is going on. There are no interlocutory decrees which prevent the manufacture of this drug while litigation is going on. Is this not correct?

Mr. DAN: Apparently that is the case in Canada.

Mr. BRAND: I am being confused by facts here again but I notice you left out the Ilsley Commission report on page 1 of your brief. I wonder why you did not mention that. You mentioned the Director of Investigation and Research in 1961, I have it before me. I have the report of the Restrictive Trade Practices Commission before me as well. I have not got number three. I have not found it yet, but you did leave out the report of the Ilsley Commission. I wonder why?

Mr. DAN: The Ilsley Commission report was dealt with I believe—the Royal Commission report. It is right here. It should have been added, I admit. However it was covered by the Royal Commission report.

Mr. BRAND: Could you summarize for me what you believe the Ilsley Commission proposes?

Mr. DAN: If I understand correctly, the Ilsley Commission proposed (1) patents on substance, (2) it proposed a greater ease in getting compulsory licensing and also proposed, (3) to speed up the proceedings under compulsory licensing.

Mr. BRAND: But you do agree that they did say on page 95 of their report that royalties from the standpoint of the patentee were to be fixed with reference to reasonable advantage to the patentee instead of due reward for research.

Mr. DAN: That is what he said, but I am not an authority on that.

Mr. BRAND: He did propose a patent protection by permitting product patents on substance intended for food or medicine. That is right, is it not?

Mr. DAN: That was his proposition.

Mr. BRAND: Why did you leave that out of page 1? That seems to be in contradistinction to some of the others.

Mr. DAN: It was covered by the Royal Commission report but as I said before, it should be added.

Mr. MACKASEY: Mr. Chairman, in all fairness to Mr. Dan, it is not right to imply that he left it out purposely. I am sure that is not the case.

Mr. BRAND: I thought he had. That was the question.

Mr. MACKASEY: Did you leave it out on purpose, Mr Dan?

Mr. DAN: No. I might add I did not mention the report of your own province, Dr. Brand. I believe that the province of Saskatchewan has done a survey on the cost of drugs. I did notice it later. I should have added it, too. In short, you have to draw a line. There are so many reports to enclose but in view of the fact that you come from Saskatoon I think I should have it enclosed it, too.

Mr. BRAND: I did not know they had. Are you referring to the one that was done in 1946 or 1948?

Mr. DAN: I think it was mentioned in the provision and distribution costs of drugs. There was a report prepared by the Saskatchewan government. There has to be a line drawn in enclosing reports.

Mr. BRAND: I must say we are learning lots of things here today. I did not know that Joe Green had made a discovery. I am indebted to Mr. Mackasey. While we are mentioning Saskatchewan may I point out—

Mr. MACKASEY: You missed Mr. Greene's publicity.

Mr. BRAND: I just wanted to get it on the record that the drug to which Mr. Mackasey was referring was done in the University of Saskatchewan School of Agriculture, not by Joe Greene, of course.

Mr. MACKASEY: I was only referring to Mr. Greene's press releases. I presume they are authentic.

Mr. BRAND: I do not read them, you see.

The CHAIRMAN: I think the free advertising should cease and we should come back to the meeting.

Mr. BRAND: Well, I think it is very important, Mr. Chairman, to mention that this was brought out in university research, that one drug. Universities, of course, are not under the control of the federal government, yet.

Mr. DAN: I think this was the point made by Dr. Wright. There is considerable research that comes from the university.

Mr. BRAND: Just before I let somebody else go on I want to say one brief thing. The Drug Institute for Canada as proposed by Dr. Wright seems to have a great deal of merit, I might add, as I look through it. I would like to study it a bit more but I think the idea behind it is a very good one. We will go into that later, if somebody else would like to speak now.

Mr. MACKASEY: Mr. Chairman, I must congratulate you on the format of the meeting. A lot of people were apprehensive yesterday about the format.

The CHAIRMAN: Well, the Committee members are conservative, Mr. Mackasey.

Mr. MACKASEY: Well, I mean witnesses were a little apprehensive. What struck me in listening to the very pertinent and I think objective questions that have been asked today and the answers of all witnesses, without exception is, Mr. Chairman, that there seems to be a greater area of agreement in the answers than I had anticipated from getting these briefs separately. I want you to understand, Mr. Dan, in case some of my questions may create an opposite impression, that I believe there is a place in the Canadian economic system for generic firms. I think it is time we stopped trying to create the impression beyond a justifiable degree that generic drugs are necessarily unfair and unsafe. From the questions and the answers I have been getting from you and other briefs my opinion is that you people do have to live up to the standards outlined by the Food and Drug Directorate. Am I right in that statement?

Mr. DAN: Absolutely.

Mr. MACKASEY: So, basically therefore, you do have a place and you are regulated by Canadian laws just like anybody else. Now, Mr. Dan, to tick you off a little and I intended to tick the P.M.A.C. off perhaps in what I said, because they are equally guilty in using this as an unfair weapon. The only part that I perhaps take issue with you for is in trying to segregate yourselves from the industry in general. I think you are part of the Canadian pharmaceutical industry in Canada and when you start in the first part of your brief and underline quite heavily that you are Canadian-owned companies, then again, I suggest that this is an appeal to emotionalism that has no place in this type of proceedings because we are interested in the hard facts, for the moment. Earlier in your brief you mention that you will be working in very close co-operation with other firms. I would like to find this so I will not be quoting incorrectly. I am sure you could help me out and show me just where it is. What I really wanted to ask you was, were these other firms international or were they American or European?

Mr. DAN: This refers probably to the medium-sized companies located abroad.

Mr. MACKASEY: What page is that, Mr. Dan?

Mr. DAN: I think it is in our oral submission, page 2.

Mr. MACKASEY: Well, I feel better because obviously it is one of the areas—on page 2. In other words, your great emphasis on the fact that you are Canadian-owned does not prevent you from entering into healthy business relationships with firms outside of Canada.

Mr. DAN: Yes, that is true. Let me make my point very clear. I did not underline it *per se* because I wish to stress the fact that we are still around. Do not lose hopes. I underline it, more or less, because some parts of our brief are instinctively underlined, not because I like to take what you might say is undue advantage; far be it from that. If I am to express my views, you must have a certain balance.

Mr. MACKASEY: The point I am really trying to get at, Mr. Dan, is that I hope that one of the side effects—you see I am already brainwashed by your industry—I was going to say, by-products, of the Committee hearings is that we come to the realization that you are all part of a pharmaceutical industry. Instead of being at each others throats through the medium of your brief, there should be a greater degree of co-operation between the generic firms, or as you call them, Canadian-owned firms, and the members of the P.M.A.C. I think my feeling is strengthened today by the fact, as I mentioned, that your opinions are not diametrically opposed but the differences seem to be in a matter of degrees.

For instance, Dr. Wright in his very excellent opening remarks, and I am wandering around here a little because I am trying to remember them, stated I think that it is ridiculous any longer to issue patents on processes but it is time that we start issuing patents on the substance. Am I right in that statement, Dr. Wright?

Mr. WRIGHT: That is correct.

Mr. MACKASEY: It seems to me that this is an argument that the P.M.A.C. firms have also advanced periodically. Am I right in that, Dr. Stewart?

Mr. STEWART: Yes.

Mr. MACKASEY: So there is one major area that we may have presumed before today's hearing that you would be diametrically opposed, but you are not.

Mr. HENDERSON: Before you go further, I would like a chance to answer fully. The answer is not quite the way you put it because you put it negatively in terms of process. And certainly, if you invent a process you should not be deprived of that invention, and I do not think Dr. Wright would disagree with me when I say that. But what he has said is that the way the act now reads it must be a process before you can get any protection at all. This is unreal.

Mr. MACKASEY: But, Mr. Henderson, you would agree that almost every day the possibility of finding new methods is diminishing. Would you not agree? I think I read that in one of the reports of the P.M.A.C.

Mr. HENDERSON: I find new ones all the time. I must say that I would not eliminate them. All I am saying is that I would not eliminate the likelihood of an inventive process. I did not want to put it any higher than that, but I think with that reservation I would agree with what you said.

Mr. MACKASEY: As I understand from your remarks today, Mr. Dan, you are not in favour of abolishing patents?

Mr. DAN: Correct.

Mr. MACKASEY: Correct, that you are or you are not?

Mr. DAN: We are not in favour of abolishing patents. We are in favour of the patent system but we have to modify it to the particular economy and position that exists here today.

Mr. MACKASEY: In other words, everybody is agreed that we should not eliminate patents. This is fine.

Earlier, in answer to Dr. Rynard, you did suggest that the individual firms who are doing research in Canada are entitled to some reward.

Mr. DAN: They are entitled to reward and consideration.

Mr. MACKASEY: For the work they are doing. You mentioned tax incentives but I am sure you are familiar with the fact that there has been great progress in that respect, for instance, 150 per cent write off.

Mr. DAN: There are ways in which the government can reward each sector if they decide to.

Mr. MACKASEY: Are there any circumstances you would care to enumerate which would in your opinion justify strengthening the patent laws? Are there any set of circumstances that you could suggest that would justify this?

Mr. DAN: I think I mentioned in my brief very clearly that if we would find in Canada among the 57 companies, 24 have research centres here, their exports would be 50 per cent, as it is in England.

Mr. MACKASEY: Excuse me a moment. I want to put this down—24 firms out of 50—about half of them.

Mr. DAN: About half of them would have research centres. Secondly, at least half of our production would be exported, or we might say 50 per cent of the home consumption market.

Mr. MACKASEY: And 50 per cent for exports.

Mr. DAN: And I suggest our raw material industry would be anywhere from 40 to 50 per cent. In short, a great many lives and jobs are dependent on the proper functioning of the industry.

Mr. MACKASEY: Now, you set down three criteria which you would suggest, if met, would justify strengthening of the patent laws.

Mr. DAN: That is right.

Mr. MACKASEY: Actually the percentage is something that—I am being unfair to you—you have had to pick out of your experience but you perhaps could modify, even in price—

Mr. DAN: It would have to be a large enough percentage—

Mr. MACKASEY: Basically, what you are saying is that, if the pharmaceutical industry in Canada, and I do not make the distinction between your firm and Smith, Kline & French, to me you are all part of the Canadian pharmaceutical industry, if sufficient numbers of these firms are doing a satisfactory amount of research in Canada, by whatever standard we decide, the Department of Industry, shall we say, might use as a yardstick, whether it is dollars or results—

Mr. DAN: That is right.

Mr. MACKASEY: —secondly, that it can be shown substantially that this research is leading to increased exports—

Mr. DAN: That is right.

Mr. MACKASEY: —and thirdly, that it would warrant the manufacture in Canada of the raw materials, such as I think Merck tried in Valleyfield, and this would justify an increase in patent protection.

Mr. DAN: Yes.

Mr. MACKASEY: This, Mr. Chairman is the point I have been trying to make for two years, and I agree wholeheartedly with you, Mr. Dan, on exactly what you are saying. This is exactly the challenge I throw out perhaps to Dr. Wigle, to Dr. Stewart or to Mr. Henderson. Why can we not expect this from your firms, particularly in view of the fact that you have constantly justified on the stand the cost of drugs because you are doing research in Canada? Therefore, you should be able to meet the first criteria, and secondly, certain members of P.M.A.C. are doing substantial amounts of export. Why should you not be able to meet these three criteria, Mr. Dan, and then let us find ways and means of strengthening the Patent Act.

Mr. HENDERSON: Let me suggest to you that research, and I am not denigrating it at all, is perhaps not the basic criterion. I suggest to you that the basic criterion is production in this country. You have to walk before you run. Let us concentrate, I suggest to you, on encouraging production in this country. Research will follow.

May I also suggest to you that if you adopt a policy of research in every country in which a patent is held you are not going to decrease prices. I merely say to you that I recommend you focus your attention on what the Patent Act now focuses attention upon and that is, an incentive to produce in Canada. If we do not produce in Canada, then a compulsory licence under the ordinary laws can be obtained. We accept that. Research is being done on an increasing scale in this country. It will follow, I suggest, as production increases. The incentive is to production and we are not saying we will not do research. On the contrary, we said to you that $2,500,000 in 1959 went to $6,500,000 in 1964 and went to $9,500,000 in 1965. We are meeting this.

Mr. MACKASEY: Mr. Henderson, excuse me for interrupting you because we are always working against the clock. Once again, it is a question of semantics because obviously we are all agreeing, Mr. Dan, myself and Mr. Henderson. Mr. Drury will be very pleased to find out that the industry hopes to increase production in this country because, again, this is the reason for his existence and the Department of Industry.

A question that either one of you gentlemen might like to answer and maybe I would ask you first, Mr. Dan, is this. Do you not think it is a question here of the chicken and the egg? What you are saying is that the industry, first of all, has to increase research; secondly, increase exports; thirdly, start producing raw material and as Mr. Henderson mentioned, start increasing production. Do you not think that to accomplish these four laudable objectives, perhaps we could first of all start with an increase in the patent protection for the industry in general, with perhaps a stipulation that these four criteria be met over a period of three, five or ten years, and if they are not met, then we reverse the trend.

Mr. DAN: Mr. Mackasey, they had about 50 years up until now to get into these areas and they have been not concentrating their efforts in the direction up to this date when you ask for them.

Mr. MACKASEY: Mr. Dan, I appreciate your answer but at the same time, not your pessimism, because this country that you and I happen to appreciate has taken 99 years to recognize the French fact but it is not preventing us from finally doing something about it. Perhaps the government had to take a hand and try and introduce tolerance through legislation. All I am saying is that perhaps here the government has finally got to step in, stop the warring factions within the generics and the P.M.A.C. boys and through imaginative legislation bring about what we want, namely, more research, more production, more exports, and more jobs for Canadians and help our balance of payments. When you say that went on for 50 years, obviously you are 100 per cent right, and you will adopt the same bad habits as the big firms when your generic firm grows as I am sure it will. You will then become respectable and you will be admitted to the club. In the meantime, Mr. Dan, I am interested in finding more jobs for Canadians and stimulating research and I am just asking you bluntly why would you not go along with my suggestion that we turn around and make the patent laws more conducive to the growth of the pharmaceutical industry in Canada and put a time limit on when these four desirable effects must be met, or it must be shown that we are working to these objectives at which time we could reverse the trend and abolish patents completely.

Mr. DAN: I wonder, Mr. Mackasey, are you prepared in the meantime to pay the price, meaning that if you have very strong patent laws it is beyond doubt the price of drugs is higher.

Mr. MACKASEY: Mr. Dan, are you willing to pay the price? Are you willing, as a generic firm, to try to find other ways and means of making something to sell until you can take advantage of the legislation? Are you willing to pay the price? Are you willing to make it even more difficult for your own particular firm to—I use pirate—to steal their ideas or borrow their ideas through clauses in the Patent Act, in return for what—

Mr. DAN: I will give you two answers, the second will be a point of clarification.

The first answer is that whatever legislation you recommend it should be such that in all fairness it favours both sides.

Mr. MACKASEY: Exactly.

Mr. DAN: If it favours only P.M.A.C., shall I say, and overlooks the Canadian sector, I do not think it is fair legislation.

Mr. MACKASEY: No, exactly.

Mr. DAN: Or conversely, if it favours us but depresses their activities which they promised to get into, I do not think it is right either.

On the point of clarification, I might say this. The clarification is this that for some reason or other you get the impression that the firms which are engaged here are generic firms. Most of them are not, and I wish to point out that practically all the firms in Quebec are not generic firms. Perhaps they might be

called copy houses but when you use the term copy houses, I am completely at a loss because copying is quite prevalent in our industry where you see major houses marketing products which were developed by other companies. The minute you do not develop that particular product you are not an innovater. Today, meprobaramate, a very well known product is sold by three of four major houses. They have not developed meprobaramate. They are not innovators, to me they are copy houses but shall I say they are more polished. They are accepted in a better fashion. I feel that this term should be clarified.

Mr. MACKASEY: Were you going to ask me something, Mr. Chairman?

The CHAIRMAN: No, I was going to tell you something.

Mr. DAN: My other point is that finally, the compulsory licensing is sought not by our members at the present time. But I respectfully submit that with the so-called medium size firms and some of them may just find themselves in the very association that represents them here today, there is a far greater chance that with a strong or stronger marketing arm, they will take a hit at a large company than shall I say the smaller firms which are still as you said in their infancy or at the walking stage.

The CHAIRMAN: A moment or so ago, there was an implication in your remarks that I am sure was not intended, and I just say in clarification that I do not think respectability has any relationship to size.

Mr. MACKASEY: Of course, not. I was probably being facetious. The point I am getting at, Mr. Chairman, is that I just happen to think that for the good of the industry in Canada, the industry itself should not segregate themselves into the "in" boys and the "out" boys. They, more than anybody else, should remember their own formative days when they were not so big and they operated out of a bathtub and made cough syrup. I am not generalizing.

Dr. WIGLE: Mr. Chairman, on a point of privilege—

Mr. MACKASEY: I should have said good cough syrup.

Dr. WIGLE: I might, however, Mr. Chairman, just toss in one comment here relative to this bantering about of the word Canadian, on which I feel very strongly, having seven generations behind me. I would just like to have it on the record that not long ago the members of our association were highly commended by some representatives of the government for demonstrating their good corporate Canadian citizenship in the fact that they are participating in Expo '67. Thank you.

Mr. MACKASEY: I am sure you did not get any inference from my remarks that you are not good corporate citizens. I am sure Bob Winters has sent you one of his scrolls. The point I am trying to get at, Mr. Chairman, is that I do not see any distinction, or there should not be any distinction, we should all be trying to make the Canadian climate more conducive to the four objectives, the fourth one being added by Mr. Henderson.

Mr. Dan, I am just going through your brief. I know that Mr. Laidlaw has some good questions. I am not particularly struck by your argument on page 6, section 5 about the tribunal and the fact that it is reminiscent of the troika system which the Russians proposed in order to replace the head of the United Nations. Here you are using a false syllogism if I may say so. The idea of the

tribunal, as I understood it, was that the three people on the committee would have different areas of jurisdiction. One would represent the Food and Drug committee, making certain that the recommendations of the Hilliard committee are one of the criteria. The second would be one from the field of economics who would make certain that royalty was fair. I think you mentioned earlier that you think this is logical that royalties should be fair. The third, of course, would be a representative of the patent commission or the Patent Commissioner.

Mr. DAN: There are two reasons for that. First, as the patent law stands we have a Patent Commissioner. Why is the pharmaceutical industry different from the metallurgical industry? Why do we have three advisers and they do not have ten?

Mr. MACKASEY: For the same reason—Oh, I am sorry, I thought you were asking me a question.

Mr. DAN: This may be a point of law. I am not a lawyer, but it was explained to me. Therefore, you cannot have different commissions or different tribunals for every industry because every industry is a special industry. Right across the room we have the food industry having a session. You have to have one man who has the power. Now this man in turn has to use judgment and judiciousness, to use the proper advisers. I know a little about the Commissioner of Patents and how he works and my understanding is that he is continually consulting, and if the Food and Drug directorate would make a contrary recommendation he probably would heed it. I am not against the idea of him consulting two or three or four groups of people but I am against the idea of making a law out of this. He may consult whatever people he feels he should and if from the three people, two say, no, and one says, yes, then let him use his own judgment. After all, we entrust him with the office. We entrust the Prime Minister with an office.

Mr. MACKASEY: What you are saying is that the Patent Commissioner should certainly consult the Food and Drug committee as recommended by the Hilliard report.

Mr. DAN: Yes, but it is not part of the law. The difference is a big thing.

Mr. MACKASEY: All right, leave it out of the law, but you agree that there is a principle involved.

Mr. DAN: He is doing it already.

Mr. MACKASEY: On page 7, scetion 3, you rather contradict some of the statements you made about cartels, or some of the implications; you have some rather strong implications. You ask questions but do not supply answers, which always infuriates me. In section 3, you go on to mention about the P.M.A.C. speaking on behalf of 57 pharmaceutical manufacturers who submitted a lengthy proposal—again, requesting stronger patent protection and less compulsory licensing. Now, all the way through your brief, this has been the implication of this cartel, the closed corporation, and the closed club, but then you go on to say;

> We do no quarrel with the views, but like to point out to them that some of their own members just finished patent fights against each other, or are still involved in them.

This rather contradicts the general presumption that is being created in the press and in the Committee that there is no difference of opinion among the 57 members; that they sit around and help each other.

Mr. DAN: My impression is that there is in some instances a difference of opinion because you can go through the patent cases, some of them are just finished, and you find a second strata of the so-called copy house within their group. It is just bound to happen.

Mr. MACKASEY: But in other words, there is healthy competition and difference of opinion within their industry.

Mr. DAN: To a degree, but to a lesser degree.

Mr. MACKASEY: To a degree which is what I said earlier.

Mr. DAN: To a degree, there is always in business.

Mr. MACKASEY: Now, you have asked a lot of questions at the bottom of page 8 which I think you should answer since you have asked the questions. Would you like to read it and answer it yourself, or would you just care to leave it as it is?

Mr. DAN: Perhaps it is better if you ask the questions and I will answer.

Mr. MACKASEY: Well, I will read it anyway. You go on to say, and I will start with paragraph 5:

> If one company, however, was admitted to the "Club" and obtained a "voluntary" license, suddenly the tarnish of a "copy house" disappeared—although the company did not invent the medication, merely acquired it by a private arrangement. Now the erstwhile "copy house" becomes and "inventor" and the entire play has a "happy ending".
>
> Not quite—for strangely enough—to the amazement of most of us—the "licensed" house rarely, if ever, undersells his benefactor... why?

Mr. DAN: I wonder myself, why.

Mr. MACKASEY: You do not know why they do not undersell?

Mr. DAN: I do not know. I have not seen the arrangement or agreement that they have made with each other. Let me ask the question. Why is that today tolbutamides still sit very firmly at the high level?

Mr. MACKASEY: Do you not think, Mr. Dan, as one who is representing the industry, or part of an industry, that you are leaving a lot of unfair implications here if you do not know.

Mr. DAN: They are not unfair implications. I am observing just as a journalist observes a phenomenon without knowing the exact answer. To know the exact answer I would have to see the contract arrangements—

Mr. MACKASEY: You are not prepared—

Mr. DAN: I have not seen them but I find it very strange that certain products catalogue a price and they do not move, and there are reasons why they should move. They should go down for some reason, yet they stand very firm, and this is precisely what I wish to point out that strong patents do affect the

price and eventually our government will pay the price. The very first thing they will throw at you is, how can it be so high? Here are the very reasons that they are high because of certain protective measures.

Mr. MACKASEY: Well, there is nothing I can do with that, Mr. Chairman.

Let us go back to your other brief which I have tried to read. On page 5—I have forgotten why I have underlined it—you talk about some consultation you had in Europe, and you say:

> What surprised me during the discussion with the European attorney was that the same, or similar patent clauses have different interpretations in various countries. For example, in Germany, where no pharmaceutical patent laws exist on substance, only on process—as in Canada—yet the courts interpret the process laws so strictly as if laws on substance did exist.

Do you think this is desirable or undesirable?

Mr. DAN: In Germany, yes, because they have a very strong pharmaceutical industry and chemical industry.

Mr. MACKASEY: But you do not think it is desirable in Canada?

Mr. DAN: Not yet, because we do not have the chemical industry, the raw material industry does not exist here.

Mr. MACKASEY: Now, primary markets, secondary markets, and tertiary markets, and you have been kind enough to consider Canada a secondary market and not a tertiary market, so we are not quite that weak as yet.

Mr. DAN: I am not criticizing but this is the fact that exists today. I am observing it. Today we are not a major power in the military world. We accept it as a fact. We do not try to be what we are not. The idea of our entire existence is to be what you are not to be what you are not.

Mr. MACKASEY: Well, Mr. Dan, I am not much of a philosopher but you do admit on page 6 that if you are fortunate enough to get into the number one bracket, then it justifies—you say, "pharmaceutical manufacturers are certainly entitled to a great protection because they carry on full-line activities".

Mr. DAN: I agree.

Mr. MACKASEY: Which comes back to my whole original premise here that the pharmaceutical industry in Canada should meet these four criteria; where you and I may differ is whether they should meet them first before they get patent protection or second, whether a revision of our patent laws could bring about these effects faster. Perhaps Dr. Wigle might answer that.

Mr. DAN: Excuse me for a moment. You and I fully agree on this point but as I mentioned before the kernel of my entire argument is timing. In short, today you need a little relaxation on one hand, yet you give them support on the other hand if they wish to develop. In four of five years you have to take a closer look at it.

Mr. MACKASEY: But relaxation to help whom? To help the copiers?

Mr. DAN: No, no, competition. If you have very strong patent laws, for instance, and for 10 or 15 years there is no competitor on the market you pay the price.

Mr. MACKASEY: Yes, Mr. Dan, but could I not get an opposite interpretation by re-reading your article tomorrow or your testimony, if I was not here. Suppose I am someone in Vancouver, I might say this Mr. Dan is a very good advocate of his association. What he is saying, in effect, is let us loosen the laws of the land for five years and during those five years, they will then have an opportunity to get well settled and then tighten them up so nobody can come along and do what Mr. Dan did during that five-year period.

Mr. DAN: Let me point out that the patent laws as they are today are fundamentally sound with a few minor adjustments. That is my point.

Mr. MACKASEY: What minor adjustments would you recommend?

Mr. DAN: I have already recommended the relaxation of compulsory license; that you can get a compulsory license more readily. Secondly, the tribunal should be set up in such a fashion that you still back the authority of the one man but he is not obliged, however he is well advised, to listen to the recommendation of the so-called tribunal; and thirdly, you must meet competition in the industry by the two sectors. I would say the most unfortunate thing that could happen to so-called large companies is that they have no competitors because then really the entire economy stands in their way.

Let me give a simple example. In Toronto, on the corner of Queen and Yonge streets there are two major department stores, Eaton's and Simpson's both thrive together. Whenever a major shopping centre opens up you rarely see one department store going in, always a second. That is fundamental to our economy. You have to have balancing forces. Now they already have 90 per cent of the market. I do not think they can ask for any more. They virtually have the market, yet they thrive better if there is competition.

Mr. MACKASEY: Mr. Dan, I do not think we are getting anywhere because there are 57 companies, at least, plus many others outside the 57. You showed us a brochure here of certain well established firms that I am familiar with in Quebec, so you cannot say there is no competition.

Mr. DAN: I am not going to argue.

Mr. MACKASEY: But there is competition, and legitimate competition in the pharmaceutical industry. There might not be the degree that you seem to think is necessary and perhaps I think is necessary but there is competition, so your analogy of the department store is not accurate. There is a point I had in mind to make when I came over here this morning and you keep harping about the high cost of drugs, we will say, because of monopoly and lack of competition, and yet it has been brought out here quite forcibly that there are in Canada substitutes for the brand name in certain areas that are well accepted, have been proven to be safe, and fit well within the Food and Drug Directorate restrictions, and so forth. They still justify being sold at this high price despite the availability of the lower priced. Are you going to blame the manufacturer for that or are you going to blame the doctor for that?

Mr. DAN: The reason is obvious, because we have a greater and better marketing organization but you as John Q. Public or, shall I say, the prescribing doctor, has an opportunity of choosing, if he wishes to choose and buy their brand products, fine, I have no objection whatsoever, but if he should choose

from another one again, there is no objection whatsoever, but he has an opportunity to choose. On the other hand, if there are only two or three houses marketing a particular drug for a long period of time and there is no other company getting into the field the doctor has no alternative.

Mr. MACKASEY: But I feel there is an alternative, Mr. Dan, because there is at least one generic equivalent to the brand name. He does have—

Mr. DAN: As long as there is, yes. But if the laws are very tight, then there may not be.

Mr. MACKASEY: But I know of dozens of cases where there are. Why? I discuss it with brand companies and they say our price is $20 for so many tablets because according to our books when we add the cost of research and we add the cost of marketing and we add our safety factors beyond the law and we add the cost of our detailman and our reference library and our 24 hour a day facilities for side effects, etc, this is the price we have to sell our product for and make it worth while selling. You have to admire them for that and then in the next breath they will tell you "yes, it is available on the market under a generic name at $7. We understand it. The generic firm can sell it at $7 because they do not have all these additional frills including the cost of research which", is a debatable area. Why then do not the doctors prescribe the $7 item?

The CHAIRMAN: You cannot ask Mr. Dan to answer for the medical profession.

Mr. MACKASEY: No, but it must concern him. He must have analyzed it.

Mr. DAN: My point is this. As long as both products are available on the market, and as long as doctors have the free choice to take and pick whatever they wish or reject, your present system is satisfactory; but if the patent laws are tightened to that extent that there is no new product coming in, or shall I say, if you use the word generic product or if you use the words less expensive brand products, then the system is not good. You should always maintain a flow of both types of products. Let the doctors prescribe whatever they wish.

Mr. MACKASEY: I am sorry I am concentrating on you, Mr. Dan, but I am trying to get information. What you are saying is that the present system is satisfactory provided there is no tightening up of the patent law. This is not what you said in your first trip. On your first trip here you found a lot wrong.

Mr. DAN: Minor adjustments; there have been a few minor tightenings. Well, if firms intend to do research here, they should be given concessions, but that belongs to the pharmaceutical industry and should be handled at industry level and not at patent law level.

Mr. MACKASEY: Now, Mr. Dan, when you were first here you made a very strong and I thought impressive pitch, if I may use that word, for the—perhaps it was Dr. Wright, I apologize,—for the increased use of generic terminology in prescriptions. Am I right in that?

Mr. DAN: Yes.

Mr. MACKASEY: Yet, when I look through the products from one of your member firms—

Mr. DAN: It is not our member. It belongs to the A.F.Q.P.P. Mr. Mackasey.

Mr. MACKASEY: Well, you have used them in the brief as an ideal example of what can—

Mr. DAN: They are not one of our members but I mentioned them.

Mr. MACKASEY: But you used them as an ideal example of what you would like to accomplish in the area outside of the province of Quebec. You are patterning yourselves after them according to your brief. Yet, looking at their lables, just about every label I read is a brand label. There is not a generic label on any of these.

Mr. DAN: They choose to sell under a brand name but their products are less expensive.

Mr. MACKASEY: Ah! But not because they are selling under a generic label. That is all for the moment, Mr. Chairman.

Mr. ISABELLE: Mr. Chairman, I think I begin to see why the prices of drugs are so high in Canada.

Mr. Dan, I have a few questions but they will be very short. I know that you are a great believer in the crystal ball because you have been making many predictions this morning. You say that most of what we call Canadian companies are American-owned companies; am I right?

Mr. DAN: That the companies which were previously owned by Canadians, today have fallen into shall I say, other hands. This is what has happened.

Mr. ISABELLE: Yes. They are the only ones who are doing research or practically the only ones. They are practically the only ones who are doing research along patent lines? Am I right?

Mr. DAN: Yes.

Mr. ISABELLE: And the Canadian-owned companies are not doing any research or practically no research at all?

Mr. DAN: Not yet. You see, not yet.

Mr. ISABELLE: So, who is going to do the research eventually, if the American-owned companies in Canada decide not to do any research, and the Canadian-owned companies decide to do no research, because they are not doing any? Who is going to do the research?

Mr. DAN: Dr. Isabelle, without looking into the crystal ball I can tell you that at the first stage you will get new products by the linking up of medium sized good firms abroad. There are a few excellent companies and you work under arrangements whereby they agree to market their good and successful products in the Canadian market. I can mention examples. This happened when Elliott-Marion took on one of the products which was marketed in Sweden, and this trend will take place. This would be the first step.

The second step is that the company will grow. The companies merge. They get public money. Sooner or later they have to and then they outline research programs.

Mr. ISABELLE: Well, that is the crystal ball. It is not a fact yet. It is something that is going to be.

Mr. DAN: The fact is that you link up with large houses. This is something that is happening today at this very moment and in two to five years, there will be something coming out perhaps from our own group.

Mr. ISABELLE: It seems to me, knowing all those facts, that the problem today with the drug industry is, even P.M.A.C. and you, the generic companies, that you are interested only in profit because it is not an industry. It is run as an ordinary business, and it is not an ordinary business because it deals with the health of the people. I am very sure that if on the balance sheet at the end of the year a company does not show an increase in profit, they will tough it for a year but they will not tough it for three or four years so what is going to happen. Either they increase the price of drugs or they fire the whole executive. It should not be, in my view, I do not know, but it appears to me as if you are dealing with an industry which does not belong to this industrial field. It is a special business and something should be done. I do not know exactly what should be done but it should not be run as a soap company, and as a matter of fact today it is run as a soap company because it is dealing with the health of the Canadian people. This is a right. Health is a right.

Mr. DAN: Dr. Isabelle, I am absolutely delighted to see that you are subscribing to one of our main beliefs that is so amply pointed out in the Royal Commission and I read from page 2:

> Although we accept that the manufacture and distribution of drugs in this country is a private enterprise venture, we have no hesitation in stating that public interest is dominant—

I would like to underline the word "dominant". Of course, if you are in business you have to have a healthy organization, you have to produce profits, you have to expand. That is normal and no one questions it, but then there are considerations, whether it furthers your own company or furthers the public, then I would say you should first look at the public and second at your own company. Now the opposite could perhaps be the cosmetic industry where the men do not have to buy the makeup if they do not desire to buy, or they do not choose to buy. You are a hundred per cent correct, sir.

Mr. ISABELLE: I am coming to what you said, Mr. Dan. This is why I said previously that 50 per cent of all the small companies should not exist. There is no place for them in Canada. Why is it that they have all come into existence in the last ten years? Is it because they were health conscious or because they want to—I imagine it was for a bit of profit.

Mr. DAN: Dr. Isabelle, as long as you live in a country where free enterprise is practised, such as in Canada as opposed to a totalitarian country, you cannot stop people from getting into any business, regardless of what it is. Inevitably, a small percentage of them will get into every business, including the pharmaceutical business, which I agree with you should not perhaps be because sooner or later these people will disappear and I will tell you why. These people cause more trouble for all of us than it is worth. However, you will find, if you temporarily overlook these few companies or firms or individuals, that the rest of the people wish to go take a certain line of action, and I am very glad that Mr. Mackasey pointed out that there are some similarities, although differences, too, between our group and, shall I say, the larger firms. Yet, we do not wish to go on this certain way and fulfil our economic function, because if we do not fulfil our economic function we have no justification to exist.

Mr. ISABELLE: That is why you should join P.M.A.C. Thank you.

Mr. MACKASEY: Mr. Dan, coming out of your answers to Dr. Isabelle, there are not just two categories now, there are three categories. There is P.M.A.C. and you referred to people who caused trouble. What category do they fit in?

Mr. DAN: I will not name them but you will find that in every—

Mr. MACKASEY: I do not want to know names but you are stating that there are others.

Mr. DAN: Perhaps operators, opportunists, people who today you find in one business, tomorrow they go out and operate hot dog stands or car lots. You will find these people in our economy and sometimes they are successful in a particular phase. I am not criticizing them I just recognize that these people are there.

Mr. A. M. LAIDLAW (*Counsel*): Are you continuing this afternoon, Mr. Chairman?

The CHAIRMAN: It is up to the Committee.

Mr. HENDERSON: In view of what Mr. Mackasey has said and some comments that have been made, I would like to make this further comment, if I may, Mr. Mackasey, before Mr. Laidlaw gets into specific patent matters, and that is, as you have pointed out, a patent does not give any therapeutic monopoly. There are several medicines to treat heart disease. A patent relates to a specific process to produce a specific drug, and the Patent Act should be designed in our submission to encourage improvement, not to encourage the copier, and that if you are looking to criteria, the criteria should be safety, price, production; research will follow.

Mr. MACKASEY: Yes, but I would like to see research follow because of legislation and not because of good will because good will has not worked out as much as we want. I keep coming back to that point, and I do not understand the resistance and the stubbornness of the P.M.A.C. witnesses, not to come out and say, yes, if you do this and this and this, we will spend so much in research and we will expand research and instead of spending $5 million in 1969 in Australia or Timbuktu we will spend it in Canada. This is what I am hoping one day someone on the staff of P.M.A.C. is going to say before it is too late and legislation will tell them what to do. That is the point I have been trying to make for three weeks.

Mr. BRAND: I think in all fairness, the point was made, Mr. Chairman, one day when Mr. Mackasey was not here.

Mr. MACKASEY: By whom, Dr. Brand?

Mr. BRAND: I have forgotten offhand, but I know I asked that specific question and it was answered.

Mr. DAN: On a point of privilege, I wish to point out that I can well understand the sympathies and the feelings of Mr. Henderson. But I do feel that the system should be left as is because there is need for, shall I use the word, regulated copy houses, although I am completely at a loss to know what the term copy house means. In my paper I explained the whole term of copy houses as completely farcical because after all there is only one innovator, but for some

strange reason there are ten copy houses of which half are legitimate or half are illegitimate, call it any way you wish, because if you give strong support to one factor invariably the economy will pay the price.

The CHAIRMAN: Do you wish the Committee to carry on and try to conclude?

Mr. BRAND: May I say, Mr. Chairman, that I stopped some of my questions early to allow others to have an opportunity. I am sure there are quite a few more questions. We have not much of a quorum, I may point out.

The CHAIRMAN: No. I would suggest that the meeting adjourn. I know that the witnesses all came with the understanding that it would probably go into the afternoon and I suggest we adjourn now and reconvene after Orders of the Day which will probably be about 3.30 p.m.

Mr. BRAND: You are an optimist.

The CHAIRMAN: The meeting is adjourned.

AFTERNOON SITTING

The CHAIRMAN: Gentlemen, I think we might carry on with the meeting. Dr. Brand, do you wish to carry on with your questioning?

Mr. BRAND: Since we were exposed to pharmaceutical philosophy for a few hours this morning I wonder if we could keep the answers as brief as possible in order to shorten the hearing. I am referring, particularly to some of the statements that were made this morning. They were very good but, as Mr. Mackasey pointed out, philosophy is not my forte, and certainly most of the briefs I have been reading are replete with it.

I would like to go back to your brief, Mr. Dan and to what I referred to this morning. You seem to be presenting two different views here. The reason I say that is that on page 1 you refer to these five different reports, to whose answers you subscribe, according to your brief. Is that correct?

Mr. DAN: Yes.

Mr. BRAND: I looked up one of these, the (Director of Investigation and Research) 1961, and I note that under Part VI of the recommendations, if I may quote, it says:

> The Commission recommends that patents with respect to drugs be abolished.

This hardly seems in keeping with the rest of the brief which seems to point out on page 3 that inventors should be given complete protection.

Mr. DAN: I think you raised a good point. I do not believe that any of my papers or my previous discussions indicated that patents should be abolished. I referred to these four or five papers, which were prepared after considerable studies by learned people, all of whom came to the same conclusions, in essence, and I quote:

> It is the conclusion of this Commission that the control over drugs exercised through patents in Canada is disadvantageous to the users of drugs in this country by enabling the suppliers of such drugs to charge such high prices in relation to the cost of production and distribution of medicine.

Mr. BRAND: So, in effect, you support some of the views expressed by them, not as you say on page 3:

> Our Association therefore endorses the views expressed in the above list of reports and refers the reader to them for details.

I took your advice; I went to them for details, and that is why I found these other things.

Mr. DAN: May I just answer my question fully. I have not completed it.

Mr. BRAND: Certainly.

Mr. DAN: All these books do not cover one another one hundred per cent. If they did, there would be no purpose of issuing another report. Therefore, the subsequent report usually corrected or modified the observations of the first report. Let me make my point clear. The Royal Commission report which came out in 1964 came after the Restrictive Trade Practices Commission report. They dealt with patents in two fashions: (1) the first and second editions, to abolish patents, and (2) not to abolish patents but to have compulsory licensing, and to make compulsory licenses more easily available. If I remember correctly, they felt that at that time the better course of action would be to make compulsory licenses more readily available rather than abolish patents. I further strengthen their recommendations for patent protection. We are not in favour of abolishing patents.

Mr. BRAND: You held up a copy there I believe, of Volume I of the Royal Commission on Health Services. I trust you are aware of the obvious discrepancies in this report with regard to some of the findings. I would refer you to the Minutes of Proceedings on page 12587 in which Mr. Justice Hall, the chairman of this Commission, referring to drug patents, compulsory license and other features in the Patent Act, pointed out, and I quote:

> These are matters of extreme importance, as we know, but there is this situation that the field has already been canvassed by one royal commission. It has made its report. Parliament has not acted upon that report, and we could not upon our terms of reference, broad as they are, ever assume the right to sit and review on another royal commission.

And then they proceed to go right ahead and sit and review on another royal commission, which seems to me to be somewhat at conflict with some of the views expressed by the chairman. I just wanted the Committee to be aware of this.

Mr. DAN: I would say that you will detect minor differences but, in essence—

Mr. BRAND: This is a rather major discrepancy in my view, Mr. Dan. I would like you to summarize the feelings of the Canadian drug manufacturers as to what they would like to see done. Could you summarize those in a few brief terms.

Mr. DAN: Yes. I would like to see patent protection for a period of, say, three to five years.

Mr. BRAND: To clarify that one point, do you mean after the drug has been put on the market for commercial value?

Mr. DAN: I believe the inventor should be given a chance to become established, a chance to be first in the market. To be the first in business means a great deal.

Mr. BRAND: I understand from your brief that you want to give him complete and total protection with no compulsory licensing.

Mr. DAN: None at all.

Mr. BRAND: Would this not mitigate against your group?

Mr. DAN: I do not believe so. I discussed this point and they agreed that the inventor is entitled to a degree of protection.

Mr. BRAND: Would you feel, the way section 41(3) of the Patent Act reads now, on compulsory licensing, that shortly after it is on the market you could immediately apply for a compulsory license?

Mr. DAN: In theory, yes; in practice, some time may elapse. In short, I am in favour of retaining the law as is.

Mr. BRAND: That is what I wanted to know. You do not want to change the act at all.

Mr. DAN: Fundamentally, no.

Mr. BRAND: You would disagree with the brief presented by the Patents and Trade Mark Institute of Canada at our last meeting?

Mr. DAN: I was not here. I could not get an airplane flight. I wanted to be here.

Mr. BRAND: That seems to be a problem that has been overcome.

Mr. DAN: It was announced about half an hour ago in the house of commons that the air strike is over. You can make reservations for next week.

Mr. BRAND: You are an optimist. Basically, this is what you would like to see. Tell me one other thing. I get the distinct impression you are being so nice to everybody in your brief, sort of in favour of motherhood. I notice you mentioned that the Hoffman-LaRoche brief was a magnificent presentation or words to that effect, and then you go on to say that you support their views but—and then, of course, you do not support all their views. Would you like to see your group as members of the P.M.A.C. group eventually?

Mr. DAN: I can speak only on my behalf but as it was pointed out before, the larger our group becomes the less will be the differentiation. Probably it will be very much the same.

Mr. BRAND: I believe in your brief you pointed out that some in your group already have consolidated or grown.

Mr. DAN: Well, let us go back ten years. I dare say that ten years ago half of the members who today are in P.M.A.C., were not in. I am sure it is only evolution which allows firms to become larger, to develop standards and to practise certain habits.

Mr. BRAND: You would not object, if you got an invitation from the P.M.A.C., to join them?

Mr. DAN: I presume they are not inviting me at this moment.

Mr. BRAND: I am not a member of the P.M.A.C. I do not know how they feel.

Mr. DAN: We probably have a lot of things in common but we may have certain opinions in which we differ.

Mr. BRAND: I know there is one major one with which you differ. One is that you call yourselves the Canadian Drug Manufacturers, referring to the fact that you are totally Canadian-owned, and the P.M.A.C. are not. This would not interfere with any desire that you may have in the future through the process of evolution to join such a group?

Mr. DAN: It is not necessarily "join" but practise the manufacturing profession in very much the same fashion as they are doing.

The CHAIRMAN: I think, Dr. Brand, there perhaps are some misconceptions of P.M.A.C.

Dr. WIGLE: Mr. Chairman, on a point of privilege, and I do not mean to be touchy, I would like to make it clear that P.M.A.C. is not a private club, as has been intimated in some presentations to this Committee. The P.M.A.C. is an organization, as I have tried to represent it, of responsible manufacturers, research-oriented largely, trying to present to the Canadian people high quality, safe and effective pharmaceuticals. To imply that this is some organization to which one has to be invited to join is absolutely incorrect. We have rules and regulations, codes and a membership application which is available to any company which wishes to make application to join the Pharmaceutical Manufacturers Association of Canada. There are requirements that have to be lived up to, and amongst those there may be an inspection by what we believe are competent people in operations, marketing, ethics of pharmaceuticals and so on. They may inspect that plant and then decide whether that person or corporate body is acceptable to the membership. I repeat what we mentioned this morning, that we apparently have been accepted as responsible and respectable corporate citizens of Canada.

Mr. HOWE (*Hamilton South*): Dr. Wigle, when you say this is made up of responsible drug manufacturing companies, are you intimating that other representatives here are irresponsible?

Dr. WIGLE: I apologize for that, if there was such an inference, Mr. Chairman. It is the same sort of use of terms that Mr. Mackasey had trouble with this morning, and I am very sorry. No, I do not imply that. I was referring to our membership. We try to prove that we are responsible. We have no knowledge whatsoever of people who are not members of our Association. The communications with such organizations are such that the doors are open; we can communicate with them any day of the week, and they are able to communicate with us.

Mr. BRAND: Thank you very much for your comments, Dr. Wigle. You have had your invitation, Mr. Dan. I was merely attempting to heal what appeared to be some divisions in the pharmaceutical industry. Divisions are something about which I have had a passing familiarity in the past few weeks.

Dr. WIGLE: Mr. Chairman, if I might say one more word. There was an implication, perhaps an inference, that the Quebec group of manufacturers were

a separate body from this organization. I would just like to have it known that one of the companies which is a member of the Quebec group of manufacturers is also a member of the P.M.AC. In fact, I believe the head man of the company which is a member of P.M.A.C. is the president of the Quebec group.

Mr. BRAND: I would like to ask the P.M.A.C a question or two now, if I might. They referred to their tribunal I would like them to enlarge on this a little bit and say if it is the same kind of tribunal, if I may use that term since they did, which is used in Great Britain at the present time?

Mr. HENDERSON: No, not quite. The tribunal that is used in Great Britain is a court. As you know the Patent Appeal Tribunal sits in Great Britain as a single judge. Again, it is legalistic. I am sorry; initially it is the Comptroller of Patents, equivalent to our Commissioner of Patents, and then it proceeds to the Patent Appeal Tribunal, a court. But again, similar to the existing system in Canada.

What we are suggesting here is that this is an economic problem, a problem depending upon prices and, as a result of that, there should be a tribunal consisting of at least one member who is in a position to examine costs, to examine prices in relation to those costs, to determine if in that aspect of it, the public interest is being met in relation to prices, a matter with which this Committee is concerned. Second, it is a committee that should have regard to safety. So we contemplate that the tribunal would have as a member someone who would be concerned with that aspect of the matter. I am not unconscious of the fact that legal problems may be involved, so we would consider that the third member should have a legal background. It is that kind of a tribunal that we have in mind.

There is a grave tendency for a purely legal tribunal to think in purely legal terms and not look at the matter economically. A court tends to disregard the economic; it tends to examine the matter by way of precedent only and to develop stereotypes. We think this is what has happened. There is no real examination of the economic factors. I have here an example of the manner in which the Commissioner deals with this matter now. He said to one of the investigating bodies that has been referred to by Mr. Dan: reasons to the contrary—and this is against granting a compulsory licence—being such as a patentee already manufacturing in Canada, public demand being fully supplied, prices being reasonable, the applicant intending to produce only the bulk material, leaving to others the tableting, and so on. All those matters are disregarded by the tribunal as it is presently constituted. We do not think that is in the public interest. We think there should be a real enquiry, where the statements made are subject to cross-examination. No one should be in the position of making a statement that he is not prepared to support on cross-examination before a tribunal that will look at the matter economically and legalistically as well. So we do not envisage the Commissioner of Patents being a tribunal equivalent to the Comptroller of Patents in England.

Mr. BRAND: So you feel that right now the compulsory licensing is loaded heavily in favour of the applicant.

Mr. HENDERSON: It is not a matter of feeling, sir; it is a matter of experience. I can assure you that that is so.

As a matter of fact, the section of the act reads that a compulsory licence shall be granted unless the Commissioner of Patents sees good reason to the contrary. One may be pardoned for trying to find what is good reason to the contrary today because none of these reasons are. I read to you earlier this morning that safety is not. As a matter of fact, the situation today is that compulsory licences are being granted as a matter of right, except in only one situation where a licence has not yet been granted to import. Apart from that one exception, licences as a practical matter, are being granted today. Let us take Stelazine by way of an example, where the company was prepared to justify its price. It was manufacturing in Canada; it was exporting from Canada; it was doing research in Canada. The compulsory licence was granted automatically without a hearing by the Commissioner of Patents. That is the context in which we are making our submission.

Mr. HOWE (*Hamilton South*): How long after the inception of this drug was this compulsory licence granted?

Mr. HENDERSON: Very shortly after. I know I am not giving you a number of years, but perhaps that can be furnished by one of the members of the company who is here. As you are aware, a compulsory licence application under section 41 can be granted the day after the patent issues. Contrary to what Mr. Dan has suggested, I have had experience where it has been applied for immediately after the patent is issued. There is no period of delay as the law reads today.

Mr. HOWE (*Hamilton South*): Do you mean to say a compulsory licence on any drug is automatically given on application at any time?

Mr. HENDERSON: Your question is susceptible of interpretation in this way. The application can be made immediately the patent issues. So one day after the patent issues, the application can be made. There is a period of time when documentation may pass between the Commissioner and the applicant, the patentee and the Commissioner, where their respective points of view are put on paper. Once that is done, within a period of months, a licence can be granted. So within months of the issuance of the patent a licence can be granted as the law stands today.

Mr. HOWE (*Hamilton South*): Can be, or is, as a rule?

Mr. HENDERSON: As a matter or practice, they tend to get involved in a lot of paper work between the Commissioner and the applicant and the patentee and the Commissioner of Patents. I would say, as a practical matter, six months is not an unreasonable period to find yourself with a licence. It may be longer but it could be shorter. This, as the law stands today, is not an impractical situation.

Mr. HOWE (*Hamilton South*): I wanted to ask this question of both parties concerned. What would you think of allowing compulsory licensing for imported drugs? What effect do you think that would have?

Mr. HENDERSON: Let me say that it is contracy to the entire spirit of the act. That is the first point I make. I have mentioned section 67 subsection (3) of the Canadian Patent Act as being a statement of the philosophy behind the granting of patents, that philosophy being that there be production in Canada. If you permit importation, then that is a disincentive toward manufacture in Canada. If that is done, you do it with that risk. Also you put the Canadian purchasing

public in the hands of the United States producer. It is very difficult to control from here the drugs that are going to be imported. I would think that you would create a situation where there would be no incentive to invest in Canada; there would be no incentive to research here. There would then be an incentive to centralize your research in the United States and sell from that location. So you have created a disincentive for the very things, I would submit to you, that are in the interest of the Canadian public.

An hon. MEMBER: Why the United States?

Mr. HENDERSON: Or whatever country you centralize in. I gave the United States as an example because it is just across the border. In other words, I think that it would be a grave step backwards in developing an effective pharmaceutical industry in Canada. I think there would be a flight of capital.

Mr. HOWE (*Hamilton South*): By the same token this would tend to lower the price of drugs from parent companies to the subsidiary companies here.

Mr. HENDERSON: I would think that there would be an immediate effect. I mean in the short run this would likely happen. Whether it would happen in the long run I am not sure because experience has not been altogether that way because you find that it tends to control in the country of export. Cases have been indicated to me where in the long run it has been found that the control ultimately ends in the hands of the exporter in the United States and prices ultimately do not come down. In the short run, I agree; I think that there might be an immediate lowering of prices which would tend to climb up.

Mr. HOWE (*Hamilton South*): You know from where my question came? The source of my question was the Hall Commission report.

Mr. HENDERSON: Yes, the Hall Commission report. I agree. I appreciate that this has been proposed.

Mr. HOWE (*Hamilton South*): That is why I asked the question. It was not a suggestion of mine.

Mr. HENDERSON: I think one must also look at the other side of the coin, the risks that are inherent in that proposal. In my view, it would very much weaken the incentives that arise from the issuances of patents.

Mr. HOWE (*Hamilton South*): Do you mind, Mr. Chairman, if I just repeat that same question to Mr. Dan? What effect do you think it would have?

Mr. DAN: Could you rephrase it because I could not follow it?

Mr. HOWE (*Hamilton South*): What do you think the effect would be of allowing compulsory licensing on imported drugs?

Mr. DAN: By imported drugs, you imply—

Mr. HOWE (*Hamilton South*): I imply that a compulsory licensing now is only granted on drugs that are manufactured in Canada and not allowed on imported drugs. My question to you was, what do you think the effect would be?

Mr. HENDERSON: The way I interpreted your question—because, it may help Mr. Dan—a compulsory license is granted in Canada to permit the importation of drugs. That is the way I interpreted your question.

Mr. HOWE (*Hamilton South*): Yes, you are quite right.

Mr. DAN: If my understanding is correct, even at the present time when the laws are a little tighter you can apply for a compulsory licence for imported drugs. That is to say, you have a basic manufacturer in Canada, including in Britain, you could have a compulsory license and you yourself could import any medication.

Mr. HOWE (*Hamilton South*): Yes, but my question still stands. What effect do you think this would have on Canadian drug prices, and what effect would it have on your group if this were allowed, as the Hall Commission report recommends.

Mr. DAN: I think the prices would go down.

Mr. HOWE (*Hamilton South*): Would this help your cause?

Mr. DAN: I believe we are all here to find ways and means to lower the cost of drugs. This is one of the ways and means.

Mr. HOWE (*Hamilton South*): Do you think that this would destroy incentive in Canada, as the other group believes.

Mr. DAN: As I have pointed out before, we have to make a differentiation among these so-called larger firms between those who wish to carry out more research, exportation and raw material production and the ones who do not. The ones who wish to do more in this country should be given preferential treatment, whereas the others who do not do research, who do not export, who do not take raw materials should not get the maximum protection and the maximum benefits, in my opinion.

Mr. HOWE (*Hamilton South*): If one of your companies was working under the protection of a patent, yourself for instance, how would you feel then about compulsory licensing on this imported drug?

Mr. DAN: I still would feel that in the first two years you could become established in the market, and you would be half way there.

Mr. HOWE (*Hamilton South*): Even if this new drug came in at a much lower price, which it likely would?

Mr. DAN: When you say new drug, do you mean new drug, therapeutically?

Mr. HOWE (*Hamilton South*): No, I am sorry I worded it wrongly. I mean if this same drug came in at a much lower price. If you were manufacturing a drug under your own patent and a compulsory licence was granted to an importer to Canada who was able to sell at a much lower price than you were selling at, how would you then feel about it yourself?

Mr. DAN: I would probably have to face facts and I would have to make sure that my own drug sold at such a price that the incoming drug would not throw me out of the market.

Mr. HOWE (*Hamilton South*): So consequently, you would lower your price.

Mr. DAN: I would have to.

Mr. HENDERSON: Mr. Chairman, in response to what Mr. Dan has said, in one connection, as to the law, it is true that there has been an interpretation of the English section to say that the law does permit the Controller to allow a licence to import, but no case has yet arisen where such a permission has been granted.

The CHAIRMAN: Mr. Laidlaw, I believe you brought to the attention of the Committee one day some correspondence that you had had with the Patent Commissioner in Canada. Have you any knowledge of how many compulsory licences have actually been applied for, how many passed, and how many actually were turned down?

Mr. LAIDLAW: Yes, Mr. Chairman. I have the letter here from the Commissioner of Patents. Supplementary to what Mr. Henderson has said, this letter is dated September 22nd, this year. I am advised that up to 1949 no applications had been made at all. Since 1949, 34 applications for licences on drugs have been made. Since 1949, 14 were granted, 13 were abandoned or withdrawn, 1 was refused, and 6 still are pending. Of these 6, negotiation toward settlement between the parties is taking place in four cases. Now, in respect to the time that Mr. Henderson suggested—and the Commissioner is replying to a question of mine—he said the time necessary to process an application is very difficult to determine. It varies considerably with different cases. According to the established practice of the office, it would take six months provided there are no delays. This checks with Mr. Henderson's statement. The delays are usually occasioned by the parties requesting extensions of time to do certain things that they are required to do, mostly requests by the patentees to extend the time for filing a counter statement, or by the applicant to file a reply. When oral hearings before the Commissioner are required the time is extended considerably. Of the 14 cases listed—these are the ones granted—the shortest period was five and a half months and the longest two and a half years.

The CHAIRMAN: Thank you, Mr. Laidlaw.

Mr. DAN: I want to make one very important point clear. Even though you have a compulsory licence, it does not mean that you can sell the drug right away. You have another hurdle to pass, the "New Drug" application, and you may not receive the "Notice of Compliance" from the Food and Drug Directorate for one, two or three years, depending on the drug. Therefore, if I have a compulsory licence today in my pocket, I cannot sell the drug for perhaps another two or three years.

Mr. BRAND: The Commissioner of Patents said that six months was the shortest time?

Mr. LAIDLAW: Dr. Brand, the course of prosecution for the application extends from five and a half months to two and a half years.

Mr. BRAND: I was just wondering because before the Hall Commission I think he said from seven to eight months was the minimum time. He has expedited his procedure here. That is on page 702 of the Hall Commission report.

I would like Dr. Wright and Mr. Dan to clarify this for me. Since Dr. Wright is referred to as the counsel on patents for the Canadian Drug Manufacturers, I will ask him first. Do you favour patenting the substance or do you not? I think if I understood Dr. Wright correctly, he was in favour of patenting the substance as well as the process, and Mr. Dan was opposed to that.

Mr. DAN: I pointed out in my brief that today we are opposed because today issuing a patent on a substance would be strengthening the patent laws which, in our opinion today, is not the right time. However, it is conceivable that in three, four or five years, if certain promises come to fulfilment, if we see the emergence

of an industry here which has been sadly lacking perhaps at that time, the answer will be to tighten the patent laws. I merely look at the economy as is; I look at the industry as is, and I draw my own conclusions based on the performance.

Mr. BRAND: You mean if a member of your group finds a new drug.

Mr. DAN: It is not our group. You see, there are more people involved than just our group.

Mr. BRAND: I wonder, Mr. Chairman, if we could have Dr. Wright's views. I would like to hear him.

Mr. George F. WRIGHT (*Counsel for Canadian Drug Manufacturers*): I would point out, Dr. Brand, that a counsel is a man who gives advice. He does not always expect that it will be accepted.

Mr. BRAND: We have all had that experience. I wonder if you could give your views again, Dr. Wright, on this. Do you believe that the substance should be patented as well as the process?

Mr. WRIGHT: I think that one should be able to patent the substance if it can be demonstrated to be patentable because it is useful. Of course, "useful" here, means not only safety but also efficacy. I also was corrected by Mr. Henderson, or he supplemented my remarks and I endorse them, that there also should be process patents, but that one should not be tied to the other as it is at present.

Mr. DAN: If I might add, further, that if he had a patented substance, the cost, or should I say the price of medicines, would increase. My understanding is that you are looking for ways to reduce the cost, and this would be another way of reducing the cost of medicines.

Mr. BRAND: Would you not agree that if you patented substance you would give more incentive to an industry in Canada, the industry that you would like as you have just said to see developed, to produce such substances?

Mr. DAN: But are they producing the substances? It appears to me that they are not yet.

Mr. BRAND: No, but you said you would like to see it. I believe I am correct in saying that.

Mr. DAN: I believe we should give protection to those firms which are doing it, but there are 50 firms that are not doing this.

Mr. BRAND: But you have confused the picture again a little bit, Mr. Dan.

Mr. DAN: You have here perhaps six or seven firms which are engaged in full line pharmaceutical activities, and I feel these firms should be given greater support than the majority because at the present time they are not engaged in full line pharmaceutical manufacturing activities.

Mr. BRAND: But then if they came up with a substance that was patentable and, let us say, that the patent was changed, would you be in favour of this, if it was a useful and efficacious drug, or whatever words Dr. Wright used?

Mr. DAN: If they would make greater research contributions, yes.

Mr. BRAND: But do you not think that by allowing the patenting of substances you would then encourage this sort of thing.

Mr. DAN: At the present time the major consideration is the cost. That is more important than the new material at the present time.

Mr. BRAND: I do not agree with this. I do not agree with you at all.

Mr. DAN: For instance, if I see another ten firms opening up research laboratories and engaging in greater activities, at that time, we should have a look at our patent laws.

Mr. BRAND: But how are you going to encourage them if you do not give them the incentive? That is the point.

Mr. DAN: There are several ways of giving incentives.

Mr. BRAND: Well, tell me. What are these ways? I want to hear them.

Mr. DAN: Not at the level of legislation but, rather, at the level of industrial incentives. The Department of Industry could give incentives. There are several ways whereby government can give incentives to each particular industry—but not by legislation; that is the whole point of my presentation.

Mr. BRAND: Can you give me some specific examples in the drug industry? How could the Minister of Industry help? I am sure he would welcome any advice. He seems to me to be amenable. You can strike that political comment from the record, Mr. Chairman.

Mr. DAN: It was said that one of the reasons a certain company located a research centre in Canada was the incentives he received. So there is a perfect example of where the government is coming up with an incentive, and this encourages companies to engage in activities which they have not engaged in in the past. This is the type of incentive I had in mind. Now, what exactly should be done, I do not know, because I am not in the Department of Industry.

Mr. BRAND: You see, we have this problem. We are in the situation where we have this group here now. You say they are not doing enough of this although obviously, they have had these incentives. Do you not think it is time to add a few more incentives to try and have more manufacturing done in our country since obviously these have not been efficacious in producing the type of research you would like to see.

Mr. DAN: From the Department of Industry but not at the legislative level.

Mr. BRAND: What have you got against the legislative level?

The CHAIRMAN: You mean not at the patent level.

Mr. DAN: By strengthenening the patent laws at the present time, you give an opportunity to the majority of the present firms, specific firms, to derive benefits which in my opinion today they are not entitled to. If they change their activities in three or five years, they perform more research in Canada at that time than I think they are entitled to. I refer to the pharmaceutical industry in Britain. There you have an industry which exports 50 per cent of their manufactures. I am sure there are a great number of working in plants, not for their own home market but for the export markets. You have major research centres. They make the raw materials and I feel that there they are entitled to greater protection.

Mr. BRAND: Now, that you have talked about them, let us talk about your group. What is your group doing now to encourage research among your members? What incentives have you found that have encouraged your group to go into research and new drugs?

Mr. DAN: As I pointed out in the beginning of my brief, at this stage we have to undergo a reorganization, become larger, and then probably go public.

Mr. BRAND: But is it you intention to get into the research field?

Mr. DAN: And when you go into the research field, in the beginning you co-operate with the larger houses; you bring in good quality medicines which are made by medium sized firms, say, in France, England or Germany—there are some firms that have to establish their contracts—and you market their product. For example, Elliott-Marion is a medium sized firm in Sweden and they market in Canada salazopyrin—and I am not saying that salazopyrin is the greatest medication ever discovered.

Mr. BRAND: You mentioned Elliott-Marion. In your brief, I believe you referred to them as a subsidiary of American Home Products which was the parent company of Ayerst, McKenna and Harrison.

Mr. DAN: That was before they were sold out.

Mr. BRAND: Oh, I see.
In other words, another "217".

Mr. DAN: It is mentioned as an example. I know of several products which could be brought into Canada and sold, and I think they will be. That is the first step. The second step is to enlarge and eventually develop a research department at the same time.

Mr. BRAND: Can I be speculative for a moment, then, and perhaps put you on the spot a bit? Let us say that you form this large group; you come up with a new drug, which you get a patent for under the patent laws as they are now. What would be your reaction if, let us say, Hoffman-LaRoche came and asked for a compulsory licence to manufacture it?

Mr. DAN: I think I answered that very question when Dr. Howe asked a question. I pointed out that I would use the first few years to become established.

Mr. BRAND: In other words, you would resist.

Mr. DAN: I beg your pardon.

Mr. BRAND: You would resist giving them a compulsory licence. You said you did not want the act changed, so presumably it would be the same.

Mr. DAN: According to the recommendation, for the first few years there should be aid to assist these companies to become established. Then I would have to compete with them.

Mr. BRAND: I think you missed the point of my question. I said you have already recommended that you do not want the patent laws changed. Let us assume that it is not changed. They can, therefore, apply for one within the five and a half months to two and a half years, whatever the Commissioner of Patents said. They could apply right away. What would be your reaction to this? Do you think it would be fair? In other words, I am putting you in their shoes just temporarily.

Mr. DAN: I am putting myself into their shoes in thinking out this problem, if it is there, because everyone has equal opportunity.

Mr. BRAND: Fine. There is one question I would like to ask Dr. Wright on the basis of his brief, if I can find it amongst this welter of paper. He mentioned something about 150 per cent tax benefit, and I question that very much. It is in one the briefs if I can find it.

Mr. WRIGHT: I do not have that brief with me right now, Mr. Chairman, but the 150 per cent is based on the tax relief that we can get for research.

Mr. BRAND: At the present time.

Mr. WRIGHT: Yes. This has been altered somewhat recently. That was at the time I was working this out, but now I think they withhold some of it from us until later.

Dr. WIGLE: Mr. Chairman, I believe that there was a section which was brought to our attention—I have not this document here either—that implied that 150 per cent of all moneys spent in research areas were deductible for tax purposes. I am not by any means an expert in this area but my understanding from the people who commented on it was that this was not so; this is somewhat related to capital expenditures and not a processing and development expenditure. These have to be expenditures which are in the establishment of capital —well for that matter, bricks and mortar—for research purposes, or something to that effect. I am not positive but perhaps there is somebody here who can clarify it.

Mr. BRAND: The only reason I ask is that I have in front of me section 72 (a) (1) of the Income Tax Act which says, after the preamble, that a company or a corporation, may deduct in computing its income for the year, 50 per cent of the amount. I would say the aggregate of all expenses of a current nature, all expenses of a capital nature, and so on. That is why I questioned that.

The CHAIRMAN: What is the date on that, Dr. Brand?

Mr. BRAND: I cannot find it. I do not know.

The CHAIRMAN: I think it is 150 per cent that has been mentioned on capital costs.

Dr. WIGLE: Mr. Beauchemin has just advised me that his understanding of it was to the effect that it is 150 per cent of the increase on expenditures in research over the past three years, or something to that extent.

An hon. MEMBER: You have to show that you have had expenditures of a certain nature previously, that you have increased those, and on the increase you get 150 per cent.

Mr. WRIGHT: Yes, Mr. Chairman. Obviously we are talking about new research.

The CHAIRMAN: Over a base line that is established at the time the rule came in.

Dr. STEWART: Mr. Chairman, that ends this year too. It was for a period of five years which has now expired.

Mr. BRAND: Is that one of the incentives we were talking about?

Dr. STEWART: Yes. That is right.

Mr. BRAND: Legislative, I might add.

Mr. HOWE (*Hamilton South*): Mr. Chairman, are we dealing with just patents today, or do duties come into this at all?

The CHAIRMAN: Duties?

Mr. HOWE (*Hamilton South*): Duties.

The CHAIRMAN: No, just patents and research.

Mr. HOWE (*Hamilton South*): I will save my question then for a more appropriate occasion.

Dr. WIGLE: Mr. Chairman, might I just add further to the record because there are some bits of evidence that come to mind as we go along. We have not everything in our brief, especially current efforts. As you are aware from the remarks that Mr. Mackasey has made, he has been very concerned that the industry somehow gives some indication of what its intentions are relative to research, increased production and expansion in Canada, if patent protection is strengthened in Canada. I have nothing that I can document with facts and figures. I can only say that our Association is making a current effort, which I just give to you off the cuff because, as I say, there is nothing official yet. Meetings are going on to try to find out exactly an answer to that question. We are very hopeful at the moment. Some of our membership have gone to top-level consultations regarding this. At the moment there is a good indication that our membership feel that there is a great possibility of increasing production and research in Canada if there is strong patent protection. Mr. Mackasey has raised this issue several times; I am sure you are aware of it. I just thought that we might acquaint you with the fact that we are not ignoring his question. We are doing our best to try to find an answer, but you do not get these overnight.

The CHAIRMAN: Have you any questions, Mr. Laidlaw?

Mr. LAIDLAW: There are one or two, Mr. Chairman. I would like to present some kind of a neutral picture on the words, which have come up repeatedly here, "innovators" and "copiers".

It seems to me, if I might be permitted to make a comment, that both sides in this argument should abandon their piety in this respect and admit to the truth of the situation. As I understand it from what we learned today an innovator, as used throughout the evidence by P.M.A.C., includes their parent companies. Am I correct in that remark?

Mr. HENDERSON: An innovator is a person who has, by research, discovered a chemical that has ultimately been proved to have pharmaceutical use by an extensive program of development. It has then undertaken a marketing program which will enable that drug to be commercial. It has gone through the series of steps to ensure that that which is used by the individual is safe. It has performed many functions. I suggest to you that whatever term or label you use—and these have developed—"innovator" as against "copier", one side performs several functions not performed by the other.

Mr. LAIDLAW: I suggest to you, Mr. Henderson, that the word "innovator" has a respectable connotation whereas the word copier has not.

Mr. HENDERSON: I did not choose the words. I just picked them up as they have been developed.

Mr. LAIDLAW: But these words have been used repeatedly. I think the Committee should be made aware of the truth. I think that when the word "innovator" is used—please correct me if I am wrong—the members of P.M.A.C. are by themselves innovators or are innovators through their parent company.

Mr. HENDERSON: The word "innovator" is used by me to designate someone who has performed the given functions that I have outlined. Those functions may be performed within a family of companies, if you will, parent and subsidiary. This may well be true, but the functions are performed by the parent and/or subsidiary throughout the world. That group performs functions, on the one hand, and that is what I have designated as innovator. The other group, on the other hand, in my submission do not perform those functions. Somebody has put on the label "copyist". Any other label could be used. As I say, there is no magic in the name, but I do think there is magic in knowing what functions are being performed by which group.

Mr. LAIDLAW: But a large number of the members of P.M.A.C., as I understand it, are under licence from their parent companies, and in so far as the active ingredient of the drugs are concerned this know-how is given to them or the drug itself imported by them. It seems to me that it is not too long a step away from the compulsory licensing system whereby the so-called copier now obtains through a government agency a compulsory licence also to be supplied by his licensor the same active ingredients. I just want to stress this because I feel that there has been an unfair comparison in the use of these two words which have been bandied about.

Dr. Wigle, how many voluntary licenses have been granted by one of your members to another of your members?

Dr. WIGLE: I would ask Mr. Henderson to answer.

Mr. HENDERSON: Mr. Laidlaw, we cannot give you numbers but we can say to you that Smith, Kline, French gave evidence as to one situation of this kind. You will recall that in that licence there were provisions for control which would enable safety precautions to be practised by the licencee. When a licence is granted by the Commissioner of Patents, there is no know-how that goes with it. I suggest to you that it is not fair to equate what you have equated, the status of a subsidiary company that acquires the know-how and the ability to control and to ensure that that drug is going to be used safely, with—I will not use the word "copyist", substitute any word you like—the compulsory licencee who has no knowledge relating to it and is dependent merely on producing it without that background.

Mr. LAIDLAW: But you will admit that the Food and Drug Directorate have control over how that licencee produces that drug.

Mr. HENDERSON: Within certain limits. I think you will agree with me Mr. Laidlaw, that they do not ensure public safety. They are not in a position to ensure that every batch of that product that is produced by the compulsory licencee is safe. It is just not fair to expect them to do that. I do not think that they assert that they do. They do take precautions and they check the matter but I do not think we should have the feeling that the Food and Drug Directorate is

guaranteeing the safety of the public in relation to drugs that are produced. This would be a misconception.

Mr. LAIDLAW: Surely, Mr. Henderson, the Food and Drug Directorate also cannot check all the batches of drugs produced by any member of the P.M.A.C.

Mr. HENDERSON: Quite right.

Mr. LAIDLAW: It seems to me that if the Food and Drug Directorate could be strengthened—and I just throw this out as a suggestion then your argument would not be quite as strong. Am I not correct?

Mr. HENDERSON: As somebody put it earlier this morning, I do not have a crystal ball; I do not know what the situation would be with a stronger Food and Drug Directorate. I am dealing with the facts as I see them. Certainly as of now, the experience that the patentee companies have had in relation to the drugs that have been marketed by the compulsory licencee, I do not think has been a good one.

Mr. LAIDLAW: From your experience, Mr. Henderson, do you know of the approximate number of so-called copiers in the P.M.A.C. group who get by voluntary licence from other members of the same group, the right to manufacture particular drugs?

Mr. HENDERSON: I have given you one example. I heard it in evidence, the Smith, Kline, French license.

Mr. LAIDLAW: From your own experience.

Mr. HENDERSON: That is one within my experience because I was involved in that subject matter. There are others that I am aware of where the licences have been granted. Again, not using labels, "innovator" or "copier", there have been licences that have been granted. The licences of such a nature are such the licensor, through his experience, can control the quality, and the licence will be cancelled if that quality is not maintained to the standard prescribed by the licensor. In the voluntary licences, provision is made by the licensor to enable the know-how that he has to be passed on to the voluntary licencee.

Mr. LAIDLAW: What concerns me, Mr. Henderson, is this. Does the voluntary licensor in this instance control the price?

Mr. HENDERSON: No.

Mr. LAIDLAW: Would the group you are representing, let the Committee know whether the prices of the drug sold by the licencees under voluntary licence are less than the prices for the same drug sold by the licensor? I think that is very important.

Mr. HENDERSON: Let me say this. Mr. Henry is here. I would never say, in any event, that we would enter into an agreement where the licensor required the licencee to maintain a fixed price. There are two licences that come to my mind in which I have had personal experience. One of those happens to be the licence Mr. Dan has referred to on tolbutamide. There was no provision in that agreement whereby the licencee would maintain the price of the licensor. This may relieve his mind. I know of no licence that I have entered into or have had occasion to advise on in respect of which the parties have entered into where there has been such a control of price. Mind you, it would be most dangerous for anyone to do that, having regard to section 30 and 31 of the Combines Act.

Mr. LAIDLAW: I understand perfectly, Mr. Henderson, but what are the actual facts? Can P.M.A.C. give to this Committee certain cases where voluntary licences have been given between members of the same organization and the prices of the drug sold by the licensor and the licencee after the license was in effect? Is this possible?

Mr. HENDERSON: Is it possible the price would be the same?

Mr. LAIDLAW: Are the licencee charges to the retailer less by the licencee than by the licensor.

Mr. HENDERSON: I cannot comment on prices, Mr. Laidlaw. I do not know. As you know, my function is ended when the licence has been entered into. Then the parties will deal with the matter on the open market. So I have no experience as to what the prices are ultimately going to be on the market. I cannot answer your question.

Mr. LAIDLAW: The reason I brought it up, Mr. Henderson, as Dr. Wigle has said, there is some indication in Mr. Dan's brief that in the voluntary licensing situation the end price does not go down, and I just wanted to know whether you had any different view.

Dr. WIGLE: Mr. Chairman, just for the sake of the record, I believe that Mr. Laidlaw said something about the granting of licences between members of our organization. I would like to make it clear that the organization that I represent is the P.M.A.C. and, as far as I know this organization, and I am quite positive of this, has nothing to do with the granting of licences between members or any such agreement whatsoever. Our Association is concerned with ensuring the provision of high quality, safe and effective pharmaceuticals and that is it.

Mr. LAIDLAW: You are not in a position to find out from your members this information, Dr. Wigle? It is not part of the terms of reference.

Dr. WIGLE: No, this is not within the scope of the activities of our Association.

Mr. HENDERSON: Of course, this may bear no real relation to the price to the consumer because there are many intermediaries between the price the manufacturer sells at and the consumer.

Mr. LAIDLAW: Apart from those remarks, Mr. Chairman, might I turn to page 4 of Dr. Wigle's initial statement this morning, because I think this is rather important, in which he quoted the prescription drug index compiled by the Dominion Bureau of Statistics. In the second paragraph he indicates that an actual decline in the drug price index occurred during a time when the general cost of living index for all items rose substantially, and the index for total health and personal care also rose substantially during the same period. I wonder if Dr. Wigle can inform the Committee how many drugs were taken into consideration by the Bureau of Statistics when they came to this rather remarkable conclusion?

Dr. WIGLE: No, I am not certain, Mr. Chairman, I am happy that Mr. Laidlaw questioned this because we ourselves have queried this for some time. It was just too good to believe. But we were happy to find that when we questioned this in a meeting recently with the Dominion Bureau of Statistics people, they supported this and they did not indicate to us that they had any reason to

feel that this index was any less justifiably correct than any of the other indices they were using. This is the only thing I can say about it. The details exactly at the moment escape me; I do not know how many it was, whether five, ten, fifteen or how many drugs. Maybe Mr. Laidlaw does know. But I do know that we took it to the Dominion Bureau of Statistics and they felt that this was a justified index and we felt that as it was a Dominion government figure we were quite justified as Canadians in using it.

Mr. LAIDLAW: To ease your mind, Dr. Wigle, I was told that this index was based on five drugs. They were all generic drugs. In view of the fact that the average prescription price in Canada has gone up 200 per cent in the last few years, it would seem to indicate that the Bureau of Statistics should revise its method of tabulation.

Dr. WIGLE: This was the reason you raised the question, Mr. Chairman.

Mr. LAIDLAW: The third question I would like to put, Mr. Chairman—and again we get into the will-o'-the-wisp named research—deals with a statement in Dr. Stewart's presentation this morning on page 1 in which, about ten or eleven lines from the top of the page, he says that:

> It does not make sense to grade pharmaceutical research into first, second or third class or to divide it into fundamental, basic or applied.

Now, this Committee, Dr. Stewart, has been endeavouring for some time to ascertain just how much—we have been talking about it most of the day—basic and fundamental research is done by the drug companies in this country. This is research that will lead, or possibly lead, to invention. We all know that with the tremendous amount of valuable clinical research, of necessity it has to be carried out by the companies. But how much, when you talk about research, as a percentage is devoted by the companies in research that leads, or could lead to patents?

Dr. STEWART: Mr. Chairman, making that statement was not meant to hide what Mr. Laidlaw wants; that is, I take it, the laboratory costs of research as opposed to clinical investigations. This figure is available, and if you look in our statistics you will see that clinical investigations are itemized separately. I think they are close to $2 million. Taking the figures that we quoted in our brief, $6½ million went for other forms of research. Mr. Laidlaw, if you want these figures, they are available, but they have no bearing on what I am saying. What I am trying to say is that we look at research as an industrial scientist in toto, as it continues, from the beginning until we achieve our objective. I feel personally that to get off at this level outside of economics, to discuss what is worth doing and what is not worth doing, what is first class, what is applied and what is pure, is not in the interests, of industrial research, that is to achieve the aim of producing an effective new medication.

Mr. LAIDLAW: But you will appreciate, Dr. Stewart, that this Committee has a duty that goes beyond that. We are now talking about the patent situation. We are talking about whether the patent situation relating to drugs should be tightened or given some relaxation. This can only be done if we know, or the Committee knows, the facts relating to the basic fundamental research that is practised by the drug companies.

Dr. STEWART: Well, you know it. It is already available, Mr. Laidlaw.

Mr. LAIDLAW: Could we have the figures some time at your convenience, Dr. Stewart?

Dr. STEWART: By all means.

Mr. LAIDLAW: Thank you, Dr. Stewart. Mr. Chairman, if I might pursue another subject, at the bottom of page 4 of Mr. Dan's brief he says that it is fallacious to believe that compulsory licensing will destroy the pharmaceutical industry. Many drug industries have appeared before this Committee which have taken the position that if compulsory licensing is not removed from the Patent Act as it now stands, there is a great danger—and the words have been used to an extreme degree—of bankruptcy setting in. One witness said: "You will not see me in five years." I think was his expression. I feel that these comments that have been made have been extravagant. I would like to know whether P.M.A.C. considers that these remarks are extravagant and also, after Dr. Wigle has expressed a view on this, whether Mr. Dan might also make a statement on this.

Mr. HENDERSON: Well, Mr. Laidlaw, may I interject for Dr. Wigle the experience of Hoffmann-La Roche that has been outlined to this Committee in terms of the royalty that was granted to that company in the compulsory licence grant to Delmar Corporation and the compulsory license grant to Bell-Craig. I know that you are aware that the amount of the royalty as fixed by the Commissioner of Patents was 15 per cent of the bulk chemical which worked out to be somewhere in the neighbourhood of $52 on that which was going to be sold by the compulsory licencee at $3,600 or, to put it another way, $52 to cover costs which Hoffmann-La Roche established, in my view, to the Commissioner of Patents in the neighbourhood of $3,000 per kilo. One does not have to be an accountant to realize that Librium ceases to be an instrument whereby Hoffmann-La Roche is going to be able to pay for those necessary costs. One does not have to be an economist to realize that you cannot carry on business much longer on that type of operation. So if compulsory licences are going to be giveaways, and this is what we have come to, the companies must take another look at this country in terms of what they are going to produce here. I do not think it was extravagant. Certainly my experience in the Hoffmann-La Roche case was such that if I were asked I would have to say they should take another look at Canada in terms of what recompense they are getting for their patents.

Mr. HOWE (*Hamilton South*): Is Bell-Craig a member of P.M.A.C.?

Mr. HENDERSON: No. I may say that Bell-Craig has been purchased since that application was made. Bell-Craig was owned by a Mr. L. D. Craig at the time of the hearing. During the course of the litigation that ensued, Bell-Craig was purchased by the Denver Chemicals Corporation, and the purchasing company is not a member of P.M.A.C.

Mr. LAIDLAW: Mr. Henderson, as you are aware, under the United Kingdom's new statute in 1949 there are also compulsory licensing provisions similar to ours—in fact, even more stringent than ours; and that is seventeen years ago. This is a primary area, as Mr. Dan pointed out using one of his terms. In spite of that the industry is apparently doing extremely well; it is exporting 50 per cent over and above its domestic market. In your knowledge has the industry in the United Kingdom taken the same stand as the industry here and would like to see those compulsory licensing provisions removed?

Mr. HENDERSON: Very definitely. As you know, the Sainsbury Commission, a commission somewhat similar to this is sitting in England; representations have been made to it that section 41(3) be recast and re-examined because it has been recommended that it is not in the public interest. Very strong recommendations have been made in this regard, even in a situation much less serious to the industry than we face. The compulsory licence grant, as you know, in the Geigy case in England was much more realistic than that which prevails here in that the comptroller and the court in that case gave a payment which ended at 18 per cent of the drug in dosage form, which was a much more realistic payment to the patentee. Notwithstanding the more realistic situation, representations are being made to the Sainsbury Commission that section 41(3) be re-examined with a view to the setting out of an objective standard or objective criteria against which the industry knows it can act freely, because at the moment we have not such an objective criteria. This is being urged in England today, notwithstanding the much more favourable legislation and the much more favourable interpretation given to that legislation in England.

Mr. LAIDLAW: Have you any idea, Mr. Henderson, when that commission will report?

Mr. HENDERSON: I have no idea.

Mr. LAIDLAW: Thank you.

Mr. BRAND: I think it was 19 per cent in the Geigy case.

Mr. HENDERSON: The comptroller gave a payment of 16 per cent and in the case of the Court, it was 18 per cent. This is at page 412 of the judgment.

Mr. LAIDLAW: I have one final question, Mr. Chairman, to direct to Mr. Henderson because of his experience in this field. Are many of these voluntary licences between the industry granted because they are afraid of the validity of their patents being tested in the courts?

Mr. HENDERSON: That has not been my experience in the licences that I am familiar with. The licences that I have been familiar with within the P.M.A.C. have been carefully considered. There are occasions when one must assess the risks inherent in a lawsuit, having regard to what Dr. Wright has quite properly said, the minimal protection you get under section 41(1), and that it is better to enter into a licence agreement than get nothing because the protection is so narrow under section 41(1) that it is sometimes better to enter into a licence agreement. I do not want to give you the impression that no licences have been granted because of the risks inherent to litigation. I am convinced some have. I think this is true. But again, this is because the protection is so tenuous having regard to the limitations or the type of claim that you must make in this deal.

Mr. LAIDLAW: Section 41(3) does not come into this.

Mr. HENDERSON: No, section 41(1).

Mr. LAIDLAW: I am talking about voluntary licences.

Mr. HENDERSON: I said section 41(1). Because of the fact a patent on a drug is vulnerable under section 41(1)—take the Boehringer case, the Winthrop chemical case—companies have been impelled to grant licences. I think that has happened.

Mr. LAIDLAW: This is no reflection on patent attorneys.

Mr. HENDERSON: No; I hope it is a reflection on section 41(1).

Mr. LAIDLAW: Thank you, Mr. Henderson. That is all, Mr. Chairman.

The CHAIRMAN: Thank you, Mr. Laidlaw. Are there any other questions?

Dr. WIGLE: Mr. Chairman, I think what I have to say is pertinent to this particular discussion that we are having at this moment. It is my impression that the manufacturer who has a patent is reluctant to fight and defend that patent in court, even if there is someone imitating it in Canada, because he realizes that at the present time, in addition to perhaps losing the fight in court, he also loses because the imitator could then apply for a compulsory licence. So the defensive patent is limited by this weakness. Perhaps Mr. Henderson would care to comment.

Mr. HENDERSON: I think that what you have said is quite true because you are facing two disabilities: first, the validity of the patent and, secondly, if the patent is found valid and infringed, then you face a compulsory licence application afterwards. So you face two disabilities, the risk inherent in the minimal protection you get under section 41(1), and then the risk of compulsory licence even if you do sustain your patent.

Mr. DAN: I believe it was mentioned a minute ago that it was the desire to question both sides, but nobody has questioned me.

The CHAIRMAN: I am sorry, Mr. Dan.

Mr. DAN: This particular section on compulsory licences is a very important one because it allows a valuable flow of products shall I say, from more than one supplier, in other words, compulsory licensing allows other suppliers to enter into the market who, in turn, compete with each other and the prices go down. I also explained that it is completely fallacious to dream that if compulsory licensing is working as it should the original inventor, if such exists—and I put original in parentheses—would be squeezed out. The facts are to the contrary; I have examined cases where there was no protection at all. Obviously, if there is no patent protection, you cannot say that he buys and sells his medications because he has patent protection. We do not have patent protection on all the medicines and I picked a few items such as phenylbutazone, tolbutamides, phenetrazine, and pentaerythral tetranitrate to illustrate my case—and I could have picked other ones too. In spite of the fact that there is no protection at all the major houses still have the major share of the market, and I have no doubt whatsoever in my mind that as long as they have a more superior market organization, a better image or shall I say, greater resources, they will have the major share of the market, will do quite well, and will be able to expand as the market expands. However, after a while we have to revise the prices. If the pharmaceutical industry were overly concerned about compulsory licensing I would be inclined to accept their argument if they came here and showed that they are on the verge of bankruptcy, like the dairy industry. The dairy industry has a very serious problem, many firms are going out of business because they simply cannot exist. But for the pharmaceuticals the picture is exactly the opposite; they are doing quite well, and I am glad they do because I like to see the industry healthy. The doctor may visit a sick person but he likes healthy

people the best. I like to see a healthy industry but I do not think relaxing compulsory licensing will in any way attack the overall health position of the industry because facts are to the contrary. In the last forty years only a few licences were issued. I do think the industry suffered greatly. Of course, it had to adjust itself as every industry has to adjust itself to meet the challenge of competitors.

Mr. WRIGHT: Mr. Chairman, I would just like to make a point, if I may.

The CHAIRMAN: I think it would be reasonable at this point, as most of the questioning has ceased, to ask each of the people who have come before us today to say a few remarks in conclusion. Perhaps you will begin Dr. Wright.

Mr. WRIGHT: Thank you, Mr. Chairman. I take great exception to two points that Mr. Henderson has made. The first one is the point with respect to guarantee of safety by a patentee who has granted a voluntary licence. I submit that no patentee or anybody else can guarantee safety in a drug. Related to this point is his apparent denigration of the Food and Drug Directorate as a body capable of controlling the situation of safety and efficacy in this country. I submit that if there is any weakness at present we should strengthen it through the Food and Drug Directorate rather than by making the patent law more stringent. Thank you.

Dr. WIGLE: I have nothing further to add, Mr. Chairman, but perhaps Mr. Henderson has a remark or two.

Mr. HENDERSON: I have only this to say. Dr. Wright, if my remarks struck you as being critical of the Food and Drug Directorate, let me hasten to say I was not intending to be critical. I was merely trying to prevent a false assurance of their function and capabilities, having regard to the staff that is available to them, and the function assigned to them under the act. There are limitations. We must face reality and realize the existence of those limitations. That was my intent, not to in any way say that the functions that have been assigned to them are not being performed satisfactorily. I did not intend that at all.

The only other comment I would make is that we have urged that there be criteria against which we would be able to tell whether we are complying with the public interest. If there are criteria established and a tribunal created which will enable those criteria to be investigated, all we ask for is the opportunity to satisfy that tribunal that we are operating in the public interest as the legislature has defined it and we suggest that that criteria should not include a licence to import. We do not think that is in the public interest. It creates an industry here. We think that the incentive to production is the proper criteria and that there should be an incentive to produce the drug in Canada. We think research will then follow. We are quite prepared to satisfy the tribunal as to our price. We are prepared to satisfy them on the safety steps that we take. We ask that a realistic opportunity be given to us to establish that we are operating in the public interest. We do not think that opportunity exists now. We also ask that section 41(1), which creates an impediment against true protection to drug patents, be abolished as recommended by the Ilsley Commission. I think that is the burden of our submission relating to patents.

Dr. STEWART: I have no comments.

Mr. DAN: In summing up, I would submit to you that in essence we should leave our patent laws as they are with a few minor adjustments; allow competi-

tion to enter into this field which, in turn would regulate the price and bring it down. I believe the function of this Committee is to recommend ways and means while, on the other hand, maintain an environment which is also conducive for the larger houses to exist having due regard to the particular economic conditions that we have in Canada and to the secondary nature of the market.

The CHAIRMAN: Thank you. Are there no other questions? It is now 5.15. Mr. Henry from the Restrictive Trade Practices Commission has been here, and I know that he would like to speak to the Committee. His remarks would probably take half an hour. I think in all justification to Mr. Henry, because of the questioning that will follow, it would be better to have Mr. Henry back on a separate occasion. We will invite him to come back on January 31st, at 9.30 a.m.

We would like to thank the witnesses for appearing before us today. A very co-operative spirit existed. Next Tuesday we will have before us the Canadian Society of Hospital Pharmacists. The following Thursday we will have the government people who are conversant with and experienced in the government purchase of drugs.

The meeting is adjourned.

APPENDIX "A"

SUBMISSION

to

THE SPECIAL COMMITTEE OF THE HOUSE OF COMMONS

on

DRUG COSTS AND PRICES

on the subject of

PATENTS

by the

CANADIAN DRUG MANUFACTURERS

Representing the Views of the Canadian-Owned Companies

I. *A Brief Background on Pharmaceutical Patents in Canada*

Our Association considered the question of Pharmaceutical Patents in Canada and could not arrive at any new and startling observations over and above those which have already been described lucidly and very accurately in the following detailed Reports:

1. Green Book (Director of Investigation & Research) 1961
2. Restrictive Trade Practices Commission (1963)
3. Select Committee of Ontario Legislation
4. Royal Commission of Health Services (Vol. 1—1964) (probably the most important of all the Reports)
5. Royal Commission of Health Services—
   Provision, Distribution and Cost of Drugs in Canada—
   prepared by Department of National Health & Welfare 1964.

It is of great significance that ALL of the above reports, prepared after thorough and exhaustive studies by learned people, arrived at the SAME CONCLUSIONS in essence, with regard to Patents, namely "It is the conclusion of this Commission that the control over drugs exercised through Patents in Canada is disadvantageous to the users of drugs in this country, by enabling the suppliers of such drugs to charge such high prices in relation to the cost of production and distribution of medicines" p. 709 Royal Commission Report, and p. 523 Restrictive Trade Practices Commission.

No amount of persuasion, pleading, arguments and indignations by the large international pharmaceutical houses are strong enough to overshadow or to minimize the powerful indictment against the original patent holders by the above reports, or alter significantly their accurate and detailed analysis of the pharmaceutical manufacturing industry in Canada.

Our Association therefore strongly urges the Members of this Committee to familiarize themselves thoroughly with the relevant sections of the above Reports for their better understanding of the Patent Issue. We are certain that they are fully aware of the heavy responsibilities in their mandate and will discharge them dutifully.

Our Association firmly believes that in our everyday Commerce the fundamental laws of the Free Enterprise System prevail. Our system is based on COMPETITION, since ultimately this should move to the Consumer the largest quantity of goods at the lowest prices.

Patent protection however stifles competition and serves the interest of the few only, since it creates a virtual market control with a tendency of higher commodity prices. Patent protection also allows the inventor to amortize his research costs several times and earn beyond his due reward. This certainly was not the intention of our Patent Laws.

We also fully endorse the statement made by the Royal Commission that "Although we accept that the manufacture and distribution of drugs in this country is a private enterprise venture, we have no hesitation in stating that the public interest is dominant." p. 40 Royal Commission of Health Services Report, Vol. 1. The very same principle has been embodied in Section 41(3) in the Patent Act of Canada. It is our impression that this shall remain the guiding principle on pharmaceuticals in Canada for many years to come.

Our Association therefore endorses the views expressed in the above listed Reports and refers the reader to them for details. (See Appendix I for some excerpts).

II. *The Attitude and Views of Canadian Drug Manufacturers regarding Pharmaceutical Patents in Canada*

Our attitude concerning pharmaceutical patents is "REALISTIC" and is based on the particular Canadian economic environment in which we live.

Our Association is prepared to acknowledge pharmaceutical patents and to give a reward to the inventor which should serve as an incentive for future inventions. It is our opinion that—

1. Inventors should be given COMPLETE PROTECTION for about a period of 3-5 years (from the Drug Notification date) in order to amortize the research investment costs and to become first established in the market;
2. In the next 3-5 years Royalties should be paid to the inventor as established by our courts or agreed among the parties on a voluntary basis;
3. After 8-10 years all patent protection on pharmaceuticals should cease, since the manufacturer has amortized his expenses likely more than once.

Our views differ markedly from those of the large pharmaceutical houses who demonstrated until now great intransigence and lack of flexibility regarding licensing and yielded only upon court order. The members of our Association are not averse to appear before the courts to get a compulsory license, however we do prefer to receive licensing on a voluntary basis, which should be more advantageous to both parties. Furthermore, in the future our Association will likely meet as a group and deal in a united manner when Patents are involved.

III. *Fundamental Fallacies in the Beliefs of the "Inventors"*

In the arguments presented by the original inventors, there are a number of fundamental fallacies which our Association wishes to make clear to the members of this Committee:

1. It is fallacious to believe that the inventor of pharmaceuticals will reduce his price by his own volition in order to "keep it fair and reasonable". The facts are to the contrary. The inventor will maintain his price as long as he can, and will make substantial reduction only when competition steps in and forces him to do so;

2. It is fallacious to believe that compulsory licensing will destroy the pharmaceutical industry. The facts are to the contrary. There are several pharmaceutical products on the market today without any patent protection, such as Phenylbutazone, Tolbutamide, Phenmetrazine, Pentaerythrol Tetranitrate and so on. Despite the lack of Patent protection, the original inventor STILL HAS THE MAJOR SHARE of the market and the so-called copy houses could not seriously affect the market position of the original inventor. In short, under strong patent protection the inventor has 100% of the market and he usually sells at a higher price, whereas under competition he has only about 60% of the market, however now he has to reduce prices to a more realistic level;

3. It is fallacious to believe that ONLY the original inventor is capable of making the pharmaceutical properly. The fact is to the contrary. Any pharmaceutical company can have access to the necessary resources to manufacture properly if the firm takes the trouble;

4. It is fallacious to believe that the large pharmaceutical firms are in need of "greater protection", so that they may reap greater benefits at public expense. The facts are to the contrary. The large manufacturers already hold about 90% of the Canadian market, their parent companies had a sales increase in the year of 1965 of about 15% (and their shares also increased about 15%. They are quite capable of looking after themselves. If the government wishes to offer help to the pharmaceutical manufacturers then this should be directed to the medium-sized Canadian-owned companies such as the members of Canadian Drug Manufacturers and the A.F.Q.P.P. (L'Association Des Fabricants du Quebec de Produits Pharmaceutiques), in order to balance the influence of the large houses and bring down the costs of drugs;

5. It is fallacious to believe that a "tribunal" as proposed in the PMAC Brief should handle compulsory licenses. The facts are to the contrary. Effective organizations existed under the leadership of one dominant person who employed judiciously a group of highly qualified advisers. The PMAC suggestion is reminiscent of the Troyka system which the Russians proposed in order to replace the Head of the United Nations, and thereby scuttle the entire United Nations Organization. Their plan fortunately did not succeed because a tribunal system, vesting the power in several individuals, is not the most effective way of getting things done, besides, in case of Patents, according to our Canadian Laws, it is also unconstitutional and ultra vires.

IV. *Incredible ABSURDITIES in our Patent Situation*

Absurdities in our Pharmaceutical Industry would cause an "outsider" to be left in wonder and amazement. Here are just some of the instances:

1. Who is the real inventor of a patent?—according to our laws only the original inventor can patent an invention. We know of at least one case—as we learned from the court records—that the "so-called" inventor under whose name the patent was filed, was not the original inventor, but some one else.

2. The President of Ayerst, McKenna & Harrison Ltd., a very fine and sincere gentleman descending from a long line of proud Canadian pharmacists, made a statement pleading for a greater patent protection and a lesser compulsory licensing. We have no quarrels with his views, he is entitled to them. His Parent Company, American Home Products Inc., the largest American pharmaceutical company, however also owns Elliott-Marion Company, which "copy house"—as called by Roche Ltd.—just received a compulsory license on Chlorodiazopoxide—a product of Roche. One might get the impression that American Home Products plays the game at both ends.

3. P.M.A.C., speaking on behalf of some 57 pharmaceutical manufacturers submits a lengthy proposal also requesting stronger patent protection and less compulsory licensing. Again, we do not quarrel with their views, but like to point out to them that some of their own members just finished Patent fights against each other, or are still involved in them.

4. Patent conflicts among companies have been described as the fight be-

tween the "copy houses" and the "innovator". In our opinion this is an OVER-SIMPLIFICATION.

We studied the Patent fights of the last ten years which took place in Canada and learned that, according to the above nomenclature, the following companies at one time could be considered as "copy houses"—Charles E. Frosst, Delmar Chemicals, Fine Chemicals.

All of these companies have "aspired" after the fruits and labours of the "innovator".

We wonder whether the above companies, consider themselves as "copy houses" as conveniently described by the "innovators".

5. If one company, however, was admitted to the "Club" and obtained a "voluntary" license, suddenly the tarnish of a "copy house" disappeared—although the company did not invent the medication, merely acquired it by a private arangement. Now the erstwhile "copy house" becomes an "inventor" and the entire play has a "happy ending".

Not quite... For strangely enough—to the amazement of most of us—the "licensed" house rarely, if ever, UNDERSELLS his benefactor. Now we may justly wonder why? We may also express surprise why the price of Tolbutamide sold under the two well-known brand names, Orinase and Mobenol, sell EXACTLY at the same price, while the public pays the piper. The fact that other companies sell Tolbutamide at considerably lower prices and raw material production costs have been decreased, have no influence at all on the selling price of Tolbutamide by the inventor and his "licensee". The additional funds they earn are used partially to prepare scientific papers to discredit their "competitors".

Far be it from us to criticise the various companies mentioned, they are all led by conscientious and able businessmen with a long record of success in the business world.

We cannot help but observe these ABSURDITIES which have the perfect setting for a ludicrous TRAGI-COMEDY. Here the giants battle the giants, then they battle the midgets, then they batle each other.

It is our impression that even under the best patent system these absurd situations will still persist, because they are inherent in the drug industry, where companies fight for "special privileges" and a "place in the sun".

V. *The "Secondary" Position of the Pharmaceutical Manufacturing Industry in Canada*

The views and the attitude of our organization, like those of the various investigating commissions, are based upon the economic environment of the pharmaceutical industry in Canada.

It is our opinion that Canada offers to the International Pharmaceutical House a "SECONDARY MARKET", for the following reasons:

1. The entire Canadian market likely represents to most International Drug Houses about 3-5 per cent of their total world-wide volume, therefore it is a minor market only;

2. Major policy decisions by the large international phamaceutical houses will be influenced by conditions prevailing on the "Primary" market, rather than on the "Secondary" market;

3. Little or no original pharmaceutical research is done in Canada, presently amounting to about 3 per cent based on sales;

4. Most pharmaceutical basic raw materials (about 80 per cent) are imported into Canada by all manufacturers, large and small alike;

5. Subsidiaries engage in pharmaceutical export in a half-hearted manner, since total exports amount to only about 6 per cent based on sales, (of which 3 per cent—about six million—is done by one company only).

6. It does not appear to be likely that the above conditions will change in the immediate future.

WHY SHOULD THE LARGE INTERNATIONAL HOUSES RECEIVE MAXIMUM PATENT PROTECTION FOR A MINIMUM INPUT?

VI. *Recommendations*

Having reviewed the particular economic conditions which exist in Canada and considering the international nature of our industry, our Association would like to make the following recommendations:

1. Our law makers and judiciary should continue with the interpretation of our patent laws by following the principles which have guided them in the past;

2. Our Canadian Patent Laws should be further relaxed by making compulsory licensing more effective and more quickly obtainable;

3. Patents on pharmaceutical products or on SUBSTANCE should not be issued, because this would be inconsistent with the general patent relaxation trend;

4. Pharmaceutical patents in Canada should be terminated after 8-10 years since by this time the original inventor has already amortized his research cost probably more than once and has become established in the market;

5. Canadian Patent Laws should create an environment in which the Canadian-owned pharmaceutical manufacturer, such as the members of Canadian Drug Manufacturers and A.F.Q.P.P. should thrive, while at the same time provide suitable conditions for the large pharmaceutical houses to prosper too, having due regard to the secondary market position of our country.

APPENDIX TO SUBMISSION

VII.

"Although it is extremely difficult to evaluate in precise amounts the effects on the retail price of pharmaceuticals, it would be unrealistic to assume that patents are not a major factor in the pricing of a large number of ethical drugs."

...Provision, Distribution and Cost of Drugs in Canada—

prepared by Department of National Health & Welfare 1964.

—Page 30—

"As to the first objective there are a number of reasons why patent protection is not likely materially to stimulate research and invention in the Canadian drug industry. In the first place Canadian patents are overwhelmingly owned by foreigners who have in the past found it more efficient to concentrate research activity elsewhere. In the second place recent increases in research spending in

Canada do not reflect a major shift in this situation but are largely due to increased clinical testing in Canada, now required under regulations of the Food and Drug Directorate."

"In the third place the main Canadian research contributions have come from non-commercial activities of organizations like the Connaught Laboratories for example. Patents therefore cannot be a sine qua non of major advances in the drug field. In fact as we have indicated earlier, there is considerable controversy about how important the contribution of the patent system elsewhere has been to major advances in drugs. It does place a profit premium on the development of minor modifications which can be patented but which may have slight value or even questionable merit. In the fourth place there are suggestions that a plateau has been reached and that recent discoveries in the realm of fundamental research have now been fully exploited by the drug companies, and until a major break-through again occurs the same opportunities will not exist anywhere for the development work which the drug companies have so far engaged in outside Canada."

. . .Royal Commission of Health Services (Vol. 1—1964)

—Page 708—

"In respect of the older penicillins, for which no patents were obtained, and the streptomycins, for which licences were freely given, prices soon began to decline and over a period of some years reached a level that appears to have been very close to costs. However, in respect of later drugs controlled closely by patents, notably the five broad spectrum antibiotics, the story is quite different. Chlortetracycline (Aureomycin), chloramphenical (Chloromycetin) and oxytetracycline (Terramycin) came on the market in Canada successively within a year or two, beginning in May 1950. Price reductions occurred down to 1953, due largely to improvements in methods of production. From 1953 till late in 1960 no reductions occurred. When Cyanamid introduced tetracycline (Achromycin) in 1953 and demethylchlorotetracycline (Declomycin) in 1959 it adopted the prevailing price of the three earlier broad spectrums. When price reductions did occur late in 1960 there may have been several contributing factors, but the Commission is of the opinion that the lower prices of imported European drugs constituted the most important one. During the intervening years, notwithstanding that all of these drugs enjoyed large sales and that the costs of both basic drugs and finished dosage forms showed remarkable variations between companies, no company thought it desirable to reduce its prices. It was as if the price established in 1953 had come to be regarded as the right price".

. . .Restrictive Trade Practices Commission, op. cit., p. 323
and Royal Commission of Health Services (Vol. 1—1964) p. 694

"One of the consequences of the foreign domination of the Canadian drug manufacturing industry and at the same time a further measure of the degree of such dominance is the extent to which drug patents are held by foreign firms. To answer a question in the House of Commons, the Patent Office compiled information about patents granted and compulsory licences issued for 14 important pharmaceutical products. The return compiled by the Patent Office is reported in the House of Commons Debates for February 10, 1960. (page 929). The 14 products were: nystatin, tyrothricin, neomycin, dihydrostreptomycin, streptomy-

cin, tetracycline, oxytetracycline, meprobamate, chlorpormazine, chlorothiazide, chlorotetracycline, erythromycin, chloramphenical, and penicillin. There were 395 patents granted which related to these 14 products. Of the 395 patents only 9, that is less than 2.3 per cent, were held by genuine Canadian firms. There were only three such firms. In addition there were only two other Canadian companies holding licences under patents. These related to 3 drugs and were owned by American firms."

...Royal Commission of Health Services (Vol. —1954) p. 656

APPENDIX "B"

CANADIAN DRUG PATENTS

by

George F Wright, Ph.D.

The arguments about high costs of drugs versus unfair patent monopoly seem to have reached white heat. On the one hand the consumer organizations who protest the high prices, together with the Canadian-owned pharmaceutical houses who are restricted by foreign-owned patents, complain that the patent monopolies are unreasonable. On the other hand the Canadian subsidiaries of the foreign companies who own the patents protest that the patent monopoly enables them to produce drugs of higher quality (and thus, necessarily, of higher cost) than are obtainable from suppliers who for one reason or another do not use material manufactured by the patentee. Is there a solution of this argument?

I do not choose to answer the question at once. First, it will be my task to show that most of the arguments brought forth in support of the patent-holders are specious, and intended to persuade rather than to enlighten the reader or listener. There is some indication that this voluminous and repetitive persuasion is based on desperation.

One of the favorite devices is denigration of the dosage-form manufacturer as a cheat with questionable business ethics when he uses material not manufactured by the patent-holder. The propaganda is based on several fallacies, the first being the sanctity of a patent. A patent is a piece of paper covered with words. These words may tell the whole truth, part of the truth, or no truth at all. There are good patents and bad patents and the so-called infringer is oftentimes a man who knows that the patent is bad. He dares the patent-holder to meet him in a court of law where the truth can be examined. This test of validity has occurred repeatedly during the past eight years. In many cases the drug patent-holder has lost the case, although even with his bad patent he has inflicted grievous financial damage to his less wealthy opponent.

A second reason why a dosage-form manufacturer will use a bulk pharmaceutical not manufactured by the patent holder without infringing is based, not on evasion as the propaganda asserts, but in perfect conformity with Canadian Patent Law. This law, which has been in force for more than 30 years, states in Section 47(1) that for chemicals used as foods or medicines:

> ..."the specification shall not include claims for the substance itself except when prepared or produced by the methods or processes of manufacture particularly described and claimed or by their obvious chemical equivalents."

If the user knows that the material he uses is made by a different process then he has no fear of the law, although indeed he may fear harassment by the frustrated patent-holder.

Some might say that this law is unfair to patentees, but if this is so, it is strange that prospective patentees have not attempted to change it during the past thirty years. Actually, there is reason to consider revision. There is no question but that drug patents are anomalous, because the real invention is a new cure for a disease (which is not patentable as such) whereas the chemistry by which the drug is made is seldom original and oftentimes is easily replaced by another equally simple chemistry. Perhaps the inventors do not propagandize against the law because they are almost never Canadian citizens. This does not prevent them from propagandizing against the man who follows the law as it is written.

There is another section of Canadian patent law which the foreign patent holders find to be iniquitous. They inveigh against Canadians who attempt to

employ this section relating to licences, calling these persons "opportunistic businessmen" and using every possible delay and subterfuge in order to prevent its application. This section, 41(3) of the patent act, provided that a licence to manufacture on a royalty basis (to be fixed by the patent commissioner) shall be granted to a bona-fide applicant. In the few instances where such an application has been successful some of the bickering about the royalty borders on the ludicrous. In a recent instance the patent holder claimed for his product a value of $3,528.00 per kilogram while the licensee claimed a value of $150.00 per kilogram. They were both high because the material can be bought from Europe at a price of $72.00 per kilogram. Comparison of these values may afford some insight into the effect of foreign-owned patents on the costs of drugs in Canada, especially when it is realized that the drug in question already had enjoyed more than 5 years of monopoly in the country of its origin. How many times must development and costs be re-imbursed?

The foreign owner of the patent uses another argument which gains credence only because of its interminable repetition. This is the argument that foreign made material is somehow inferior in quality to that made by the patent holder. In the first place this argument is fallacious because in the vast majority of cases the foreign patent holder does not make his product in Canada; his subsidiary imports it from the foreign-based factory. For another reason the argument is specious because a chemical (unlike a bottle of vinegar wine) is a concise entity, the quality of which can easily be ascertained by chemical and/or microbiological analysis. Is it reasonable that a foreign manufacturer would risk the double costs of overseas shipment by delivering material to Canada that would be found to be defective? Of course the risk of loss would not be so great if the material came only the short distance from the United States! Perhaps that is the reason why in some instances I have found that a European product is higher in quality than the same drug imported from the U.S.A.

Despite these obvious anomalies the propaganda flows on and the repetition is effective. A recent example is the report in June 1966 of the committee headed by Dr. Irwin Hilliard. These men cast up the old bugaboo of inferior quality and then made the outstanding recommendation that legislation be enacted in order that the Food and Drug Directorate have authority to examine incoming shipments of drugs from abroad. This committee is comprised of intelligent men. Had they not been brain-washed by the propaganda, would they not have investigated to discover that the F.D.D. has had this authority since 1963? And this is not the only one of their recommendations which is redundant. And it is not the only strawman that they have set up for demolition. Why?

The fact is that the need for the propaganda that they have accepted (without confirmation if they are honest men) has very little to do with patents. It has to do with lethargy. The major drug houses in Canada (all foreign owned) have not had to work very efficiently during the past 15 years. They have been lulled into their attitude by a false reliance on the patent protection and they are highly frustrated when the more avid Canadian manufacturers challenge their comfortable position. It is only natural that they will strike out with any weapon that is available, even if it is a weak one like patent protection.

An example of the significance of patents in respect of drug costs may be obtained in the case of Pentaerythritol Tetranitrate, 20 mg, the vasodilator. The foreign-owned company who offers this product sells it net at about $2.70 per

hundred tablets. A Canadian-owned company who sells only under the official (generic) name sells it at 55 cents for the same quantity. This Canadian company, whose analytical control facilities on the percent-of-gross sales basis exceed that of the foreign-owned company, has slightly over 100 per cent markup on the product because its materials and labour cost is 21 cents per hundred. What then accounts for the five-fold difference in price to the pharmacist? Difference in dosage form? The foreign-owned company does include a sustained action feature of questionable efficacy (according to the Food and Drug Administration in the U.S.A.) but this layered tablet feature adds less than 5 cents per hundred to the cost of fabrication and is ordinary shop practice. Patents? The fact is that Pentaerythritol Tetranitrate has been in the public domain (i.e. unpatentable) since before the year 1900. Quality? Both companies purchase the same bulk pharmaceutical from Canadian Industries Limited. What is left to account for the monstrous five-fold differential in price which must be passed on to the patient who needs the drug for long-term treatment? The answer as I see it involves the simple word, inefficiency. It is inexcusable. When Canadian public health is involved every drug manufacturer has the moral obligation to run "a tight ship".

Still the fables continue about patents. According to another phantasy it is implied that the chemist who originates a patentable product is somehow able to guarantee a higher quality than can his fellow-professionals. By contrast, in my forty years of experience in chemistry, I have found that the research chemist is usually a mediocre analyst and vice-versa. The wise drug manufacturer will not use his research chemists for quality control. But of course, all of these facts are inconsequential in view of the patent fetish, which is used for public relations rather than for enlightenment.

Let all of the drug manufacturers in Canada put an end to the hypocrisy. By and large they are all respectable Canadian citizens or residents no matter what their international allegiances. If those who have fallen into bad business habits will endeavour to correct them and start to cultivate the Canadian pharmaceutical market rather than to mine it for all the wealth that can be extracted from it, then remarks by persons like myself about foreign-owned companies and patents will cease to have any meaning.

OFFICIAL REPORT OF MINUTES

OF

PROCEEDINGS AND EVIDENCE

This edition contains the English deliberations and/or a translation into English of the French.

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Translated by the General Bureau for Translation, Secretary of State.

LÉON-J. RAYMOND,
The Clerk of the House.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 22

TUESDAY, NOVEMBER 29, 1966

WITNESSES:

Representing the Canadian Society of Hospital Pharmacists: Miss Mary Gannon, Executive Secretary; Mr. D. J. Stewart, Past President, both of Toronto; and Mr. Nathan Fox, of Montreal, Council Delegate, Quebec Branch.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
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SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

MINUTES OF PROCEEDINGS

TUESDAY, November 29, 1966.
(32)

The Special Committee on Drug Costs and Prices met this day at 9.45 a.m. the Vice-Chairman, Mr. Patrick Asselin, presided.

Members present: Mrs. Rideout, and Messrs. Asselin (*Richmond-Wolfe*), Brand, Forrestall, Goyer, Howe (*Hamilton South*), Howe (*Wellington-Huron*), Hymmen, Isabelle, MacDonald (*Prince*), Mackasey, O'Keefe, Orlikow, Rynard (14).

In attendance: *Representing the Canadian Society of Hospital Pharmacists*: Miss Mary Gannon, Executive Secretary; Mr. D. J. Stewart, Past President, both of Toronto; and Mr. Nathan Fox, of Montreal, Council Delegate, Quebec Branch.

Also in attendance: Mr. A. M. Laidlaw, Q.C. of Ottawa, Legal Counsel for the Committee.

The Committee proceeded to the consideration of the submission of the Canadian Society of Hospital Pharmacists.

Miss Gannon summarized certain points of the submission.

On motion of Mr. Forrestall, seconded by Mr. Brand,
Resolved,—That the above submission be made part of this day's proceedings, with the exception of appendices A and B. (*See Appendix "A"*)

Miss Gannon, Messrs. Fox and Stewart were examined.

Mr. Laidlaw also asked questions of the witnesses.

At 12.10 p.m., the Acting Chairman adjourned the Committee to 9:30 a.m., Thursday, December 1, 1966.

Gabrielle Savard,
Clerk of the Committee.

25320—1½

EVIDENCE

(Recorded by Electronic Apparatus)

TUESDAY, November 29, 1966.

The VICE-CHAIRMAN: Gentlemen, I see a quorum.

The Chairman, Dr. Harley, is unavoidably absent today and he has asked me to chair this meeting.

This morning we have with us the Canadian Society of Hospital Pharmacists. Representing this group is Miss G. Gannon of Toronto, who is the executive secretary; Mr. Nathan Fox of Montreal, who is a council delegate in the Quebec branch, who is immediately on my right; and Mr. D. J. Stewart from Toronto, who is a past president of this association.

Miss Gannon will give us an outline of the brief, and then we will carry on with the discussion. Miss Gannon?

Miss G. GANNON (*Executive Secretary, Canadian Society of Hospital Pharmacists*): Mr. Chairman and members of the Committee, it is a privilege for the Canadian Society of Hospital Pharmacists to meet with you this morning.

I wish to summarize certain points in the presentation. I want to establish that, although the area of competence of the Society is professional rather than financial in nature, it is our desire to be helpful to the Committee by providing information on pharmaceutical professional service, rather than a submission of a direct financial or statistical nature, in the belief that cost and price of medication is more than the medication commodity itself, and involves a professional service.

We have indicated that an understanding of professional service requires an examination of standards of practice, and such standards which have been developed and adopted by the Canadian Society of Hospital Pharmacists have been applied in the presentation to show the application of hospital pharmaceutical service in the provision of the safe use of drugs, their control and distribution.

Following a description of the functions of a pharmacy and the general responsibilities of the pharmacist, specific reference is made to the pharmacist's responsibilities to the inpatient. It is indicated that each medication order that the pharmacist receives requires professional judgment, resulting in decisions which can only be made by legally qualified pharmacists whose professional training and education equip them to assume this responsibility.

The dispensing of prescribed medication, although perhaps the most obvious of the pharmacist's responsibilities, is only one of 18 responsibilities which are designed to give the patient the best pharmaceutical care. Drug use control in the hospital, through a procedure known as the formulary system, is described, with the conclusion that in the Society's view a medication list or formulary on a provincial or national basis would not be feasible. The Society believes, however, that a comprehensive drug information service could contribute to the quality of

care provided for patients of Canadian hospitals. The Society has, in fact, studied this question and has prepared a proposal for financial support.

With regard to pharmaceutical service to out-patients, it is realized that certain medications are, because of their nature, available only through the hospital pharmacy. The hospital pharmacist's first responsibility, however, is to those seriously ill patients who depend solely on the hospital for their pharmaceutical needs. The Canadian Society of Hospital Pharmacists believes that no service should be instituted or expanded which would interfere with, or detract from, this vital function. It is our belief that greater encouragement should be given, and ways and means found, to enhance present pharmaceutical service to the hospitals' in-patients. Regardless of where medication is obtained by the patient, we believe that the service of the pharmacist is not a function of the cost of the drug, and that a reasonable method of payment is cost of the medication commodity plus a professional fee.

In making this presentation we hope to give some assistance to the Committee by presenting our concept of the professional service that is involved in the safe use, control and distribution of medication.

The VICE-CHAIRMAN: Thank you very much, Miss Gannon. Before we proceed with the questions, I would like to ask for a motion to print the brief as an appendix to today's proceedings.

In the brief there is an appendix A which outlines the by-laws of the Canadian Society of Hospital Pharmacists. It is not necessary to include this, but I would like to find out whether in your opinion Appendix B, which outlines the standards for the practice of pharmacy in Canadian hospitals, should be included.

Mr. HOWE (*Hamilton South*): Mr. Chairman, I would like to say a word here. Neither of these appendices has any reference whatsoever to drug prices and costs. I cannot see the necessity for printing them.

Basically, the whole brief has nothing to do with prices or costs. I am not opposing the printing of the brief, but I do not see the necessity for printing either of the appendices. They have no relationship to our terms of reference. It is only going to confuse us, when we are making our decision to have extraneous material that is not applicable to costs. That is my personal feeling.

The VICE-CHAIRMAN: Are there any other comments on this? Shall we include just the actual brief itself and not appendices A and B?

Mr. FORRESTALL: Moved.

Mr. BRAND: Seconded the motion.

Motion agreed to.

Mr. HOWE (*Hamilton South*): How did that work out? I am sorry, I did not hear it.

The VICE-CHAIRMAN: Exactly as you suggested, doctor. Just the brief itself, neither appendix A nor appendix B will be included in the proceedings.

Gentlemen, we have heard the outline by Miss Gannon. Are there any questions?

Mr. HOWE (*Hamilton South*): Mr. Chairman, I have expressed my feeling that this brief basically does not have anything to do with prices and costs. There

is only one mention of costs on page 8, I believe, and it really has nothing to do with this association.

There are a few questions that I would like to ask. It appears that the hospital pharmacists act as detailmen for the various drug manufacturing companies by the fact that you decide, according to this brief, which manufacturer's drug to select in order to prevent duplication of drugs in the hospital pharmacy. I would like to know by what criterion you determine this. Is it decided by cost—which you claim you have really nothing to do with—or has it to do with efficacy or lack of side-effects, or what is it, particularly when it is a duplicate drug that really has no criterion as far as efficacy and side-effects are concerned, presuming they are both the same? How do you determine which drug you stock in your pharmacy?

Mr. D. J. STEWART (*Past President, Canadian Society of Hospital Pharmacists*): I would be glad to speak on that. If a drug has been introduced originally by a company, this is usually the one which is first stocked in the pharmacy. Until such time as another brand is available, equivalent to the product already stocked, no effort would be made, of course, to do anything unless there were some possibility of buying the equivalent quality at a better price. In this case the pharmacist, with the permission of the pharmacy and therapeutics committee, would ask for quotations, and the drug which had the most economic price would be the one of choice then.

Mr. Howe (*Hamilton South*): How do you determine that a certain make of tablet meets the specifications claimed by the manufacturer? What means do you have in a hospital to determine whether a drug is of equal quality to another drug? What means do you have at your disposal for making this determination? You claim on page 5 that you must have certain specifications, and so on. How do you determine whether it does meet this specification?

Mr. STEWART: In some instances the manufacturer is asked to supply a verified copy of his assay—the protocol of his assay. In other instances the companies are well known both to the medical staff and to the pharmacist, and there is agreement by the pharmacy committee that both are reliable, and we would take either brand, whichever was the more economical.

Mr. HOWE (*Hamilton South*): You do not make any of these determinations personally? You accept whatever is given you by the manufacturing company involved. You intimate that you actually make these determinations yourself, but it is not really possible for you, in the sense in which you describe it, to determine in hospital that the specifications of a drug are such that they will meet the qualities you want in a drug. You are accepting the manufacturer's tables and so on, rather than actually investigating. You cannot carry out investigations in the hospital as pharmacists?

Mr. STEWART: Not usually; it would be too expensive, for one thing, for a hospital to have elaborate control laboratories. Pharmacists use the usual visual controls, and drugs can be sent out for independent assay if there is any question, but usually, with reliable companies, one accepts the facts as they are stated in the specifications and on the label. This is, indeed, reliable and can be accepted.

Mr. HOWE (*Hamilton South*): How do you determine the quality and effectiveness of any drug? For example, after a doctor has used a new drug in

the hospital are you given a clinical assessment by the physician, which you report back to the manufacturer in the case of investigational type drugs?

Mr. STEWART: In the case of investigational drugs the member who carries out the investigation may be asked to report them to the pharmacy and therapeutics committee, who will then make the decision as to . . .

Mr. HOWE (*Hamilton South*): Yes, but how do you get this in the first place?

Mr. STEWART: The pharmacist, being the secretary of the pharmacy and therapeutics committee, is the one who receives the information and takes it to the committee.

Mr. HOWE (*Hamilton South*): It appears, then, that in a sense you take part in the promotional process of the drug manufacturers by, you claim, recommending the use of these drugs to physicians from your pharmacy. Is this correct?

Mr. STEWART: No. The manufacturer approaches the physician directly, and if the physician desires a product to be stocked in the pharmacy he may request this through the pharmacy and therapeutics committee who will instruct the pharmacist, if it so decides, to stock a certain drug for future use in the hospital.

Mr. HOWE (*Hamilton South*): You say on page 7 of your brief, in subparagraph (4):

> the promotion of certain pharmaceuticals to encourage prescribing by physicians in private practice, or continued use by patients after discharge.

Therefore, by that statement, you must play a role, in part, in the promotional program of the drug manufacturing companies.

Miss GANNON: May I add something here? This description does not pertain to the role of the pharmacist in the hospital. It is to help to outline why medications are purchased from pharmaceutical manufacturers by the hospitals at perhaps a lower price than is available outside. We feel that the manufacturers, for this reason, quote a lower price, perhaps, than is available outside. It is not the pharmacist who promotes the pharmaceuticals in this area.

Mr. HOWE (*Hamilton South*): I gathered from the comment that it was the role of the hospital pharmacist to recommend to the doctor the use of drugs. That is what I gathered from this statement; and that thereby you were putting yourself in the role of recommending or helping in the promotion of, a drug to any doctor who might want this information from you. I am not being critical of it. I asking by what criterion you determine this. Is it just by the price or from some information that you have about its hospital use? What criterion do you use where you put yourselves in this position?

Mr. Nathan FOX (*Council Delegate, Quebec Branch, Society of Hospital Pharmacists*): I would like to make one comment. We refer at the top of page 6 to the "formulary system". This is a system by which the medical staff of a hospital decides on the medications that it feels are the best for their particular institution. These recommendations are generally made through the pharmacy committee. Once the decision is made the pharmacist is given the responsibility of purchasing the drug which has been chosen by the medical staff of the hospital.

The pharmacist might—and does—contribute to the basic information on the drug, but it is the medical staff which chooses the drug, with the help of the hospital pharmacist. It is not the responsibility of the hospital pharmacist to choose drugs for the doctor.

Mr. HOWE (*Hamilton South*): But he does take the role of recommending them, or getting the information from the drug companies to give to the physician who will be using them on a patient?

Mr. FOX: This is so. This is part of the total evaluation by which the medical staff arrives at their choice of drugs for this particular hospital. This is apart from the criteria which are used in purchasing the drug, once the decision is made by the medical staff. These are two things apart. The basic decisions to use the drug in the hospital are made by the medical staff.

Mr. HOWE (*Hamilton South*): I have just one other question. Although your brief does not deal with prices, you do step into the field of price on page 8 when you say that the retail druggist because there is no relation between value of the drug and the pharmacist's services, should charge a cost plus a certain fee. Now, my question is this: Since this cost is so variable, as we have found out in this Committee—it is dependent on quantity bought—what cost are you going to decide on as the basic cost on which to add your fee? We have figures, for example, on librium, which sells normally at $12 a hundred retail, varying from $4.68, when bought in large quantities, to $7.20, which is your 40 per cent discount. How are you going to establish this when the cost price is so variable? This is going to lead—and perhaps even more so than now—to different costs for every drug store.

Mr. FOX: I can only generalize on a situation of this sort by saying that it is up to a hospital, or an institution, or an enterprise, to establish its own cost by whatever method it determines. In a hospital perhaps we would do it from the invoice cost, but this has to be decided by each institution or enterprise that is selling drugs. I cannot establish what may be the cost for every individual pharmacy or every individual hospital. This cost may vary from place to place.

Mr. HOWE (*Hamilton South*): You put yourself in a field which really does not concern you when you make the suggestion on page 8 that you feel that the pharmacists should do this. You are not in this field at all in selling retail drugs. You simply dispense to patients drugs which are bought by the hospital. This suggestion about cost, on your part, is really not in your field of endeavour at all. Am I not correct?

Mr. FOX: Well, we feel very strongly about this. We do feel that, regardless of what the basic cost of the drug is, ranging all the way from a few cents to a few dollars, the function of a particular drug for a particular patient has no relation to its cost at all; it depends on the condition of the patient. Yet the service to provide the patient with this drug is the same, regardless of whether it is fifty cents or ten dollars; its action on the patient may be satisfactory in both cases. I believe that a pharmacist, regardless of where he is, performs a professional function which is not determined at all by the cost of the particular ingredient.

Mr. HOWE (*Hamilton South*): But the increased cost of a drug creates an increased cost and risk of money in the purchase of a large or more expensive

drug to put in his pharmacy. You are not in this field, and this is why I suggest that this suggestion in your brief is really more an opinion and is not rather based upon any experience that you have in this field? Am I correct?

Mr. Fox: Yes, this is probably right; but it could become a factor in the future when an equalization of a professional, service might be spread over a larger area. This is why we have included it as an opinion of the Society.

Mr. Howe (*Hamilton South*): You mean when the day comes when we may have a proper medicare plan?

Mr. Fox: Exactly.

Mr. Howe (*Hamilton South*): Thank you, very much.

The Vice-Chairman: Thank you, Dr. Howe. Mr. O'Keefe?

Mr. O'Keefe: Mr. Chairman, Dr. Howe has asked the question that I had in mind in connection with the stocking of single rather than numerous brands of the same drugs.

They say that the main concern is to provide the patient with medications of known quality and effectiveness, and to give the best possible care.

Now, on page 7, subparagraph (3), they talk about:

> the clinical nature of hospitals to which some manufacturers provide medication, without charge, for evaluation.

Does "for evaluation" suggest experiment on patients?

Miss Gannon: There are certain investigations that can be carried out in a hospital through studies between the Food and Drug Directorate and a particular manufacturer and a doctor; but when we discuss clinical trials, this could be a medication which has been approved by the Food and Drug Directorate, and which is supplied to a physician so that be can make his personal evaluation of this particular agent in comparison with something else which he has previously used.

Mr. O'Keefe: Does the patient know this is happening?

Miss Gannon: This is not in investigational drugs; this could be a drug which is ordinarily available but which the doctor has not used personally, or of which he would like to have a wider experience, shall we say.

I do not know whether I have clarified the point or not.

Mr. O'Keefe: I will pass, Mr. Chairman. You know the point I am trying to get at.

Miss Gannon: Mr. Fox can perhaps clarify this.

Mr. Fox: Drugs for evaluation might fall into two main classes. There is the drug that is released by the Food and Drug Directorate for which a notice of compliance has not yet been issued. This is called an investigational drug. It is released directly to qualified investigators who have the facilities, background and training to evaluate the drug.

Mr. O'Keefe: Are those doctors, or could they be druggists? Are they always doctors?

Mr. Fox: They are always doctors. They have to fill out the Food and Drug Directorate form prior to receiving the drugs from the company for evaluation.

This is one type of drug that is evaluated.

The second type of drug which is evaluated is one for which a notice of compliance has already been received. This is released for marketing, but it is a new drug, and, for their own benefit, a particular institution may want to gain more experience of it, to see whether it does contribute something new to drug therapy and whether it is better than the agent which is already in use in the hospital.

This drug is not released for general use in the hospital; it is usually released to an investigator, but this time he does not have to fill out the Food and Drug Directorate form because the drug is already marketed. Even a drug of this type, for the first two or three years, is still considered to be a new drug, and reports are still issued on the clinical experience. But I would like to re-emphasize that this is not an investigational drug. The first class is; the second class is not.

Mr. O'KEEFE: I quite understand that, sir, and I am not being critical, but it seems to me that all drugs are, to some degree, dangerous, and I suggest that, no matter what type of drug is being used for evaluation, an out-patient should know that this is happening to him. Would you agree with that?

Mr. FOX: I do not wish to comment on the medical responsibility, or the hospital responsibility, of this particular aspect, but the hospital does have the regulations and they have a constant view, and I am sure that the responsibility of the hospital and the medical staff are in relation to the task that they are undertaking.

Mr. O'KEEFE: Do you ever have drugs in the hospital that do not meet the standards of quality? Some of those drugs, I understand, are supplied to the hospitals at less than cost. I feel it is possible that some of them might not be of the proper standard. Have you had experience of cases like that?

Mr. FOX: There may be such drugs, but I have not seen them myself.

Mr. O'KEEFE: Thank you.

The VICE-CHAIRMAN: Thank you, Mr. O'Keefe. Dr. Rynard?

Mr. RYNARD: Mr. Chairman, there are a few things that I would like to establish. As I look over the brief I think that far too many big words have been used which has made it a little more complicated than is necessary.

In the first place, when a doctor writes a prescription the pharmacist fills it. Is that not the number one thing in any hospital? Is that right?

Miss GANNON: Basically, this is so, but I think we have made the point, sir, that in hospitals the order often does not come directly from the doctor to the pharmacist, but it can be transcribed by the nursing unit of the floor; so that, in effect, you get an order that has been written on someone else's authority.

Mr. RYNARD: Do you mean that today you are filling prescriptions without a prescription?

Miss GANNON: No, sir. The doctor's original order would be on the floor.

Mr. RYNARD: Do you get a copy of that?

Miss GANNON: Yes; that is right.

Mr. RYNARD: And you follow the doctor's order and you fill the prescription that he has written?

Miss GANNON: Basically, this is correct.

Mr. RYNARD: Well, where "basically" is it not correct? This is what I want to know. I think this is of very great interest to the people here. Do you have doctors writing prescriptions that you are not filling, or that you are changing? Let us get this straight.

Miss GANNON: Would you like to speak on this, Mr. Stewart?

Mr. STEWART: In Canada there are still many hospitals which have nurses transcribing the doctor's original order, and this is sent to the pharmacy. Not all hospitals in Canada get an actual carbon copy of the doctor's order. The other thing is—

Mr. RYNARD: Where do you see this order, then? Do you fill this by telephone?

Mr. STEWART: The transcribed order comes to the pharmacy by messenger.

Mr. RYNARD: It comes by messenger, on a written form?

Mr. STEWART: Yes, on a written form; transcribed by the nurse from the doctor's orders.

Mr. RYNARD: Why is it not signed by the doctor, then?

Mr. STEWART: Because the medical men write their orders and sign them in the doctors' order book, and this constitutes the legal order for the drug.

Mr. RYNARD: In how many hospitals in Canada is that going on?

Mr. STEWART: I cannot give you exact numbers, but I know it is going on in many hospitals.

Mr. RYNARD: Would you say in more than half, or in less than half?

Mr. STEWART: I would say that perhaps it is less than half, but it is still going on. For instance, there are many large hospitals that—

Mr. RYNARD: What about the Toronto General Hospital?

Mr. STEWART: There it is the nurse's transcribed order which is being filled.

Mr. RYNARD: It is the nurse's transcribed order. You have no fear of running into a mistake in this way?

Mr. STEWART: I might say, sir, that the pharmacists and the pharmacy committee are anxious to change this traditional concept and to use a carbon copy of the doctor's original order.

Mr. RYNARD: In other words, you are trying to do it, but you have not got around to it?

Mr. STEWART: This is in progress. This is a thing which has been done traditionally for many, many years, especially in larger hospitals throughout Canada, and it is not an easy thing to change to a new system overnight.

Mr. RYNARD: I know hospitals where you would not get the drug unless you wrote the prescription right there. I believe that is one of the requirements of

the Ontario Hospital Commission or one of their suggestions. I think it is misleading to say that you fill a prescription on a nurse's order. You may be doing it, but you are not doing it legally. Let us put it that way.

You do fill all doctors' prescriptions—we take that for granted—as they are written. You do not fill out any on your own. That fact is established.

The second thing is: Whether the doctor writes a generic name, or a name brand, do you fill it without question?

Mr. STEWART: If he prescribes a name brand and it is a product which is not stocked in the pharmacy and we have the equivalent, under the formulary system the medical staff gives the pharmacist the privilege of providing the brand which is stocked in the pharmacy.

Mr. RYNARD: Let us suppose that the doctor does not want to use that generic brand. Suppose that he is a little afraid. He has a sick patient and he wants to use a certain drug. Do you mean to tell me that you will substitute a generic brand for the one that he feels will work?

Mr. STEWART: With the permission of the medical staff this would be done, unless the doctor actually indicates on the prescription that he will not accept another brand.

Mr. RYNARD: In other words, the doctor has the final say on what drug he uses?

Mr. STEWART: Yes.

Mr. RYNARD: Well, let us say this and keep things in their order.

Where research is being carried out, those drugs are being provided by the firms free of charge, in most cases to your dispensary. They are not a cost?

Mr. STEWART: This is true.

Mr. RYNARD: So that does not enter into the picture. That is why I say that although your brief is well-written, and there are a lot of big words in it, it is rather misleading.

Mr. STEWART: But, sir, the ultimate cost to the public of providing pharmaceutical services to patients is actually a matter of service as well as cost of medication.

Mr. RYNARD: Yes; when your recommendation is taken; but how often does the Ontario Hospital Commission come around and check on you? How often does a representative come in and say: "How are you running this place"?

Mr. STEWART: There are representatives from the Commission who are willing to come to any hospital at any time.

Mr. RYNARD: But do they not go? They are not only willing, but they go and they make it their business to go. Then, we have all the facts on hand here, gentlemen; that this is checked by a member of the Ontario Hospital Commission; that the doctors do write the prescriptions; that the doctors have filled the prescriptions that they specify; and that in the case of research the drugs are provided free of charge by the firms which are interested in carrying it out. I think this covers the field.

The VICE-CHAIRMAN: Is that all, Dr. Rynard?

Mr. RYNARD: Yes.

The VICE-CHAIRMAN: Mr. Orlikow?

Mr. ORLIKOW: Mr. Chairman, I would like to explore just a little bit the question of costs which Dr. Rynard has been asking about and which are referred to on page 7 in the section headed "Pharmaceutical Service to the Outpatient". You list four reasons why the cost of drugs, as dispensed in a hospital, may be lower than those charged to the retail trade. This is merely an opinion. You have not had access to the books of the pharmaceutical manufacturers to know what their costs are, have you?

Mr. STEWART: No; except that we know that in promoting a new drug a manufacturer would come to the hospital and offer either to give this drug to the hospital for a certain period of time, or to sell it at a special price which is later increased. Therefore, we do know that very often the consideration is given of allowing the hospital to use this medication for a period of time at a cost less than the normal charge to the hospital.

Mr. ORLIKOW: Has your organization looked at any of the studies made by the Restrictive Trade Practices Commission, or the Kefauver committee in the United States, which would indicate that the pharmaceutical manufacturers actually made money—or did not lose money—on the drugs which they sold to hospitals and veterans' hospitals, and so on?

Mr. STEWART: I do not believe that our Society has made any study of these matters, sir.

Mr. ORLIKOW: In other words, then, there is not much factual evidence in your submission with regard to the cost of drugs and the prices charged by drug companies, either to you or to the retail druggists?

Mr. STEWART: Although we are not aware of actual manufacturers' costs, we believe sincerely that the four points which we have outlined are factual.

Mr. ORLIKOW: I think it has been established by a number of questions, including those by Dr. Rynard that the drugs which you dispense are drugs which are prescribed either in the original form by the doctor who writes the prescription or, in some cases, by the medical staff of the hospital which authorizes the use of the particular brand that is being stocked by the hospital dispensary. But it is the doctors who make the decision to what brand or make of a particular drug shall be used. That is correct, is it not?

Mr. STEWART: The doctor has the privilege, certainly, of specifying the drug of his choice, but the medical advisory board and the pharmacy committee very often give the pharmacist the responsibility of making the choice where there are a number of competitive brands available.

Mr. ORLIKOW: Perhaps you can tell us only about the hospital in which you work, but I understand that a large number of hospitals—not all hospitals—use a generic product instead of one of a brand name made by one of the big companies, in the case of drugs used very frequently, such as tranquillizers and antibiotics. Perhaps you cannot answer for all hospitals, but can you tell me what happens in the hospital with which you are connected? Let us take tranquillizers as an example.

Mr. STEWART: Yes, this is true. Where it is a large volume item and it is available on a competitive basis the drug would be purchased on a generic specification. However, it could be that one of the name brand companies are actually the suppliers. It does not necessarily follow that a name brand is not the drug which is actually bought in the final analysis.

Mr. ORLIKOW: Does the hospital save a substantial amount of money by this type of purchase as compared to using, for example, a tranquillizer like equanil?

Mr. STEWART: There certainly is a considerable saving to be made when only one brand is stocked, because one may buy a much larger quantity without the further consideration of splitting up the usage into four or five different brands. This in itself is a saving; and then, too, there may be competitive bidding for the product, which serves to decrease the price, as well.

Mr. ORLIKOW: If the hospital dispensary is using a generic tranquillizer is it the medical staff which has decided that this is the proper one to use?

Mr. STEWART: The medical staff, through the formulary system, gives the pharmacist the privilege of buying and stocking one brand only.

Mr. ORLIKOW: This Committee has been told frequently by the large drug companies that this country has to be very careful about the use of generic drugs, because very often—I am not quoting exactly, but I do not think I am exaggerating—the generic drug will be of inferior quality to the brand name product, and that there could be very serious effects on the health and welfare of the patient. To your knowledge, in the hospital in which you operate, has there ever been any difficulty as the result of the use of generic drugs such as tranquillizers and antibiotics?

Mr. STEWART: To my knowledge there have been no reported problems through the use of drugs which have been purchased by generic name. I do want to clarify, though, that although it is purchased by generic name it may be that the lowest bidder is a brand name manufacturer.

I believe there is confusion in the minds of the general public. They think the word "generic" automatically means cheap drugs. It is true that when you can go out on a generic specification to five or six possible sources of purchase, certainly there is more competition, and it is often possible to make a considerable saving in this way; but it is quite possible that the lowest bidder could be a brand name manufacturer.

Mr. ORLIKOW: But he would bid low only because, I assume—and you will have to make an assumption, if you answer the question—he knows that if he does not bid low he is not going to get the business. Is that not true? In other words, you have brought the element of competition in, and the company knows it has got to compete and it competes by cutting the price.

The point I am trying to make—and you can probably answer me with a Yes or No—is that if generic drugs are used, provided proper medical care has been taken to ensure that the drug used is satisfactory, there can be a substantial saving to the person or the institution which needs to use the prescription. Is that a fair assumption?

Mr. STEWART: Yes, I would say so.

Mr. ORLIKOW: Mr. Chairman, I think that answers my questions.

Mr. RYNARD: Mr. Chairman, I would like to ask a supplementary here, if I may. There was a little bit of wavering on the point of whether a doctor could get the prescription filled that he wrote and requested for his patient, on whether a generic drug might be put in. Now, the unequivocal answer was that he could, previously, but there was a little bit of wavering, if I interpreted it correctly, in the statement made to Mr. Orlikow and I want to know whether his first or last statement is the right one.

Mr. STEWART: To my knowledge they are both correct, sir. If the doctor really feels that he wants a brand name, and yet the hospital has purchased another brand and is routinely supplying this, he may, if he so desires, indicate on his order that he will accept no other brand, and this would have to be brought in specially for this doctor.

Mr. RYNARD: But you would do that?

Mr. STEWART: Oh, absolutely.

Mr. RYNARD: Then you are correct in your first statement. That is what I wanted to know.

Now, you say that your generic drugs work all right—and I am not going to belabour this point because I am sure some of the others will bring it up—but do you run any tests on those drugs to see that they are all right?

Mr. STEWART: Yes, we do.

Mr. RYNARD: You are running tests?

Mr. STEWART: Yes, we send them out to independent laboratories.

Mr. RYNARD: In other words, this adds to your expense.

Mr. STEWART: Yes.

Mr. ORLIKOW: I have just one more question, Mr. Chairman. The effectiveness of a particular brand of a particular drug is the responsibility of the doctor. If a doctor wants to use a particular brand he will use it. If the doctor wants to take the precaution of having it tested he will do it himself, or he will ask you to do it, and you will test it in the ways which the doctor wishes it to be done. Is that correct?

Mr. STEWART: If he insists on a certain brand which we do not stock we will obtain it for his patient. I doubt that it would ever occur that he would say: "Well, now, bring this in and test it", because he has already made up his mind that this is what he wants, and this is what he will get.

Mr. ORLIKOW: No, that is not my question. If the hospital dispensary is using a generic drug, and is not using any particular brand name and it is doing so on the decision of the medical staff of the hospital, if they have any doubts they wil ask for tests either by you or by themselves, or by some independent organization.

Mr. STEWART: Yes, that is correct.

Mr. ORLIKOW: So that in the final analysis the drugs which are used are decided upon either by the hospital medical staff or by the individual doctor, and they are responsible and make the decisions; is that correct?

Mr. STEWART: They make the ultimate decision, yes.

The VICE-CHAIRMAN: Dr. Isabelle?

Mr. ISABELLE: Mr. Fox, could you tell us if hospitals are receiving "kick-backs" from pharmaceutical companies?

Mr. FOX: I would like to know the definition of "kick-backs".

Mr. ISABELLE: I mean that if you are buying a thousand bottles of serum do you receive 25 or 100 bottles free?

Mr. FOX: I do not believe this would come within the context of what we understand by the term "kick-backs". I would say that whether the price is per unit, per dozen, or per lot, this is stated directly on the invoice. You can check whether a certain amount agrees with a certain quantity. Any way you look at it you can break it down to a unit price. It depends on the policy of the company you are dealing with, and ten different companies might have ten different policies.

Mr. ISABELLE: But when you buy a carload of serum, or any pharmaceuticals. As a matter of fact, this has no influence at all?

Mr. FOX: No; a hospital can only buy the amount they use in a certain given period of time, regardless of whether there is an extra quantity on the lot they purchase.

Again, I feel that this is directly broken down to the cost of the drug. As a matter of simple arithmetic most hospitals would like to have the unit price stated on the invoice so that they do not have to figure out, if they get one extra, how much it would be; but on the unit price, I do not believe that this has any bearing on the purchases of an institution if the institution cannot use the quantity stated. Naturally, if the institution can use it, and there are extra goods stated on the invoice, this is part of the better price.

Mr. ISABELLE: So that you know for a fact that it is written on the invoice, shall we say, "100 bottles free". I imagine that the 100 could be 50 or 10 or five. I know of some hospitals which are dealing with some companies and which, instead of taking the free pharmaceuticals, as you mention, on the invoice, change it to some kind of mineral waters. In other words, they exchange the free supply that they were to have received for mineral waters.

Mr. FOX: This may be occurring, but I do not have any personal knowledge of it.

Mr. ISABELLE: That is why I used the term "kick-backs". Perhaps that word is too sophisticated.

The VICE-CHAIRMAN: Is that all, Dr. Isabelle? Thank you very much, doctor. Dr. Brand?

Mr. BRAND: Mr. Chairman, I would like to ask a few questions here. First of all, in your experience as a hospital pharmacist is there ever a time when you would not buy certain types of drugs from certain firms because they were of inferior quality?

Mr. FOX: I would certainly say that one of the criteria would be the reputation of the company. If the Food and Drug Directorate had shown on their recall list that some products were confiscated or returned for mislabling, or for

other reasons, certainly it would not be very wise to purchase from that particular company.

Mr. BRAND: In other words, you have had the experience of refusing to buy from certain firms.

Mr. FOX: I have not had direct experience of it, but I have heard of it.

Mr. BRAND: Do you believe that the current Food and Drug standards are adequate to provide safety and therapeutic efficiency in the drugs which are offered to you?

Mr. FOX: I would say that it is the purpose of the Food and Drug Directorate to set what they consider to be the minimum standards and regulations for a drug appearing on the Canadian market; and we would assume that a drug which has been passed by the Food and Drug Directorate would meet those standards. Nevertheless, we have a responsibility to go a little further than that and, according to the established criteria to make a selection of drugs from a company of which we have intimate knowledge and which we feel has the facilities and equipment to produce this drug satisfactorily.

Mr. BRAND: You rather "waffled" around the question a little bit, did you not? On page 493 of the 1962 report of the Restrictive Trade Practices Commission, Dr. Morrell of the Food and Drug Directorate stated that the staff of this governmental agency would need to be increased two to three times its present strength to be able to test and check drugs adequately in Canada. Do you agree with that?

Mr. FOX: If Dr. Morrell said it I imagine he had a basis for saying it.

Mr. BRAND: I believe he had, too. Do you believe that there are any drugs on the market today which have been passed—and presumably available to be bought by hospitals—which may not meet the standards of therapeutic efficiency?

Mr. FOX: It is possible. The Food and Drug Directorate cannot, as you say, check every drug and every sample of drug from every company in this wide land of ours.

Mr. BRAND: What I am suggesting, of course, is that some of these drugs may be sold to hospitals. I know it is a fact, although you have not stated it, that in certain hospitals—for example, the University Hospital in Saskatoon—one of the conditions of membership of the staff is to accept the hospital formulary. Let us take the specific example of phenylbutazone. Even if you order butazolidine (Geigy), they would, nevertheless, substitute whatever drug they happened to have purchased in quantity. I noticed that you did refer to the "lowest bidder" a little earlier, so presumably you buy largely on price?

Mr. FOX: No, I would not agree with that entirely.

Mr. BRAND: Which part of that?

Mr. FOX: Economies may result from this system, but I think the first consideration is the quality of the drug, in order to render the best and safest treatment of the patient. This is the first consideration.

Mr. BRAND: The reason I asked this is that a recent paper has been published, which was presented before the annual convention of the Canadian

Pharmaceutical Association at Saint John, New Brunswick on August 16th of this year. Perhaps you were there. It is the Searle-Pernarowski paper of the University of British Columbia, which indicated that the results of an investigation showed that 5 of 23 brands of phenylbutazone at present on the Canadian market failed to comply with the existing specifications. In other words, this implies—and I quote from the paper—that "30.4 per cent of the preparations should not be on the market." How do you guard against buying this sort of thing in hospitals?

Mr. STEWART: May I make a comment, Dr. Brand?

Mr. BRAND: Certainly.

Mr. STEWART: We have had the experience of tendering and receiving bids and of rejecting them, too, starting with the lowest bidder, and then, by doing appropriate sampling and sending it out to independent laboratories, have had to reject two makers, and have had to accept the third highest. So that we cannot have these facilities, as I mentioned before, in the hospital; they are very, very expensive and very specialized; there are independent laboratories who can do this and, as was pointed out previously, it does cost money to have this done.

Mr. BRAND: This would certainly be true only in the larger centres. Is that not so? What about some of those hospitals out in the hinterland? What are they going to do?

Mr. STEWART: I sincerely believe that unless they are prepared to have this type of testing done—

Mr. BRAND: Where are they going to have it done?

Mr. STEWART: They could have it done by independent laboratories.

Mr. BRAND: Yes; but where? In the case of a small hospital of 100 or 200 beds, do you think that they can afford to have this done nowadays by sending it down to independent laboratories in eastern Canada from, say, the west?

Mr. STEWART: No, Dr. Brand; I think perhaps it would not pay the small hospital to have this expensive testing done for the quantities they are using.

Mr. HOWE (*Hamilton South*): Can this information not be passed from one hospital to another in the case of the large hospitals doing it?

Mr. STEWART: This would not necessarily be true because each lot number requires testing; and this is when you are buying from a reputable manufacturer. Your only alternative, if you are not prepared to do this, is to buy from a manufacturer in whom you have complete confidence.

Mr. BRAND: The next question obviously would be this: Have any of these drugs that you have rejected come from any of the members of the Pharmaceutical Manufacturers Association of Canada, the PMAC group, or have they come from the smaller generic houses?

Mr. STEWART: This is a difficult question for me. I am not trying to dodge it, but, of the two companies, I can think of the name of one, and I am not sure of the name of the other company; and I am not really sure whether they are members of PMAC or not. I actually do not know whether they are members of PMAC.

Mr. BRAND: And yet you have made the statement that you look into the background of a company before you buy and know the reputation of the company before you buy. You did make that statement, I believe, or one of you did?

Mr. STEWART: Mr. Fox is the one who made that statement.

Mr. BRAND: Therefore in these two instances you did not really look into the background of the company before you bought, I take it.

Mr. STEWART: In the instance where we rejected these two brands, it went out on a very wide tender because it was a product that was available from many, many different sources. This is not always true. Sometimes there are only two or three sources. In this case it was felt that the hospital wanted to do testing by independent laboratories; and these companies that did make bids were known—whether or not they are members of PMAC, I do not know—but they were known as suppliers of drugs. I believe one was in Montreal and the other in Toronto, although I would not want to make a definite statement because I am not sure. I know the name of the one we rejected, but I am not sure of the name of the other.

Mr. BRAND: Perhaps you can obtain those names for us and send a letter to the Chairman of the Committee. I think it would be very useful.

However, I think it becomes increasingly obvious from your statement that you do send drugs out for independent assay and therefore, that you distrust some of the present methods used by the Food and Drug Directorate in examining drugs, because otherwise you would not need to do this, would you?

Mr. STEWART: As Dr. Morrell has said, it is impossible for the Food and Drug Directorate to test every lot that is coming off the production line.

Mr. BRAND: The answer would be "yes" then, would it not?

Mr. STEWART: Yes.

Mr. BRAND: I noticed a basic ambivalence in your brief. I am curious about the reasons why. On pages 7 and 8 you make two conflicting statements, one perhaps because all of you are members of the Canadian Pharmaceutical Association; I do not know. But you do say on page 7:

> In the purchase of medications, hospitals enjoy a preferential position in obtaining price benefits for a number of reasons:

which you then go on to state; this is fine, and probably quite correct. At the top of page 8 you say:

> Without prejudice to the right to seek tender on quantity, the Canadian Society of Hospital Pharmacists approves a policy of like price for like quantity to all legally qualified to purchase, with the expectation that a more equitable cost can be achieved to the ultimate benefit of all patients.

Surely what you are suggesting here is that this is fine. You enjoy a preferential position at the moment due to the ability to purchase in large quantities on the bid system, because hospitals may buy together in a metropolitan area, and the traditional charitable nature of hospitals where you get drugs free, and all this jazz. However, you go on to say that really that is not very

nice, and what they should do is to sell for the same price to druggists as they sell to hospitals. In effect is that not what you are saying?

Mr. Fox: We are stating this in a general way as a long-range objective, whereby the public at large might benefit from lower drug costs.

Mr. Brand: Do you think that raising the prices to hospitals will lower drug costs?

Mr. Fox: Not necessarily. We say that the expectation of a more equitable cost can be achieved. Experiences have shown, however, that this may not be the case. We feel that the public at large should benefit from lower drug costs if the prices to hospitals were to be adjusted.

Mr. Brand: Which way?

Mr. Fox: Pardon?

Mr. Brand: Upwards?

Mr. Fox: Downwards.

Mr. Brand: You had better explain that one.

Mr. Fox: Prices to hospitals might be adjusted upwards, but there should be a corresponding benefit to the public.

Mr. Brand: That escapes me. I am afraid you will have to explain that a bit more. How can you lower cost to the public by raising cost to the hospitals?

Mr. Fox: As I say, this is a general statement that we hope could be achieved. Whether it can or not is debatable.

Mr. Brand: Let us give you some specific examples. You all received a letter from the Warner-Chilcott company two months ago in which they gave you, for example, agyrol, which I am sure most of your hospitals buy. The increase in cost of that one particular compound was 523 per cent over what you had been paying. Can you conceivably tell me that this is a method that is going to result in reducing costs to the consumer, whether he is in the hospital or outside the hospital as an outpatient, or do you feel that all it will do is placate the pharmacy trade?

Mr. Fox: We say this in the expectation that a more equitable cost can be achieved. This is the only thing we are saying.

Mr. Brand: That does not say very much, does it? What you are hoping, perhaps, is that the druggists will reduce their costs?

Mr. Fox: I am not saying the druggists.

Mr. Brand: How else could you make it cheaper for the public? I am afraid this escapes me completely.

Mr. Fox: The druggist has to base his cost on the price he pays to the manufacturer. Therefore, we would say prices of the wholesaler.

Mr. Brand: I am glad you mentioned that. We had a brief here the other day by Mr. Bass of London Drugs in Vancouver, and we asked him some specific questions. He is a retail pharmacist. We entered in evidence here that the cost of 25 librium capsules from Hoffmann-LaRoche varied in price between $1.98 from London Drugs in Vancouver to $5.98 in some other stores across Canada. Yet,

Mr. Bass stated that he bought the same capsules from the same firms as these other pharmacies. Outside of quantity buying which hospitals certainly do, perhaps the same as Mr. Bass does, although not on such a large scale, I find it very difficult to accept the idea that the cost to the consumer was based, therefore, on just the manufacturer's price, because it just does not seem feasible that there would be a prescription difference of $4—from $1.98 to $5.98—in one extreme case. It seems a bit excessive to me. I would like you to back up your statement a little more if you could.

Mr. Fox: I do not know the circumstances of this particular case, but every professional person has a right to establish the value of his services.

Mr. Brand: Do you agree with the Canadian Pharmaceutical Association's suggestion, then—I believe you do in your brief, although it is a little confusing to read—that a reasonable method of payment is cost of the medication commodity plus a professional fee. Do you agree that this will result in the lowering of prices? Will this be across the board, or in certain instances only?

Mr. Fox: I would say the ultimate price of the more expensive drugs certainly would be reduced to the consumer.

Mr. Brand: The more expensive drugs only? The average cost of a prescription in Canada today is about $3.54, although I may be a few cents out. I believe that is in the pharmacy brief. I took the pharmacy brief—and I have mentioned this before—and I found that by adding a professional component fee in the province of Saskatchewan, for example, which is the one I worked out, it would raise the cost of 77 per cent of prescription drugs. I found this a very peculiar way to lower costs to the consumer. What do you think?

Mr. Fox: Statistics can be very misleading.

Mr. Brand: I am not talking about statistics. I am talking about the costs which were presented to us by the Canadian Pharmaceutical Association, and the professional component fee which was suggested. Merely by adding the two it comes to 77 per cent. You can call them statistics if you like, but it would have increased the price of 77 per cent of the total prescriptions.

Mr. Fox: Did it tell you the percentage of prescriptions that this might have lowered?

Mr. Brand: I think if you subtract 77 per cent from 100 per cent you will get the percentage that are lower.

Mr. Fox: Twenty-three per cent, in dollars and cents, could mean more than the 77 per cent. Or it might mean an equalization—lowering the more expensive ones, and the ones that are less expensive built under a certain line, are the ones that might go out. It comes back to the professional service of dispensing an inexpensive drug which, in most cases, is equal to the service that it takes to dispense an expensive drug. This would merely be an equalization of costs.

Mr. Brand: What percentage of your total hospital purchases of generic drugs do you buy purely from generic drug houses?

Mr. Fox: It is difficult to answer this because of my definition of "generic". I like to use the given name or non-proprietary name. We use this term in describing products that come from large as well as small firms and, therefore, I

would like to see most drugs prescribed under their non-proprietary names, if possible.

Mr. BRAND: Do you encourage the doctors in the hospitals to write generic names?

Mr. FOX: I think this is a very good teaching tool.

Mr. BRAND: Is this done, in your experience?

Mr. FOX: It is done in a good percentage of the cases.

Mr. BRAND: In your experience how many prescriptions for meperedine were there in the past year?

Mr. FOX: We do see some, and in some cases some names are written more often than others. It depends on how the name sticks in the memory of the particular doctor.

Mr. BRAND: Do you agree that demeral would be written much more often than meperedine?

Mr. FOX: Yes, in this case I would say so.

Mr. BRAND: You do agree—I think we covered this earlier—that if the doctor wrote a brand name, according to the formulary system you would substitute as long as your committee and yourselves, in all fairness, were satisfied that it was a drug of adequate quality and kind, and as long as it was of exactly the same kind with no changes in the actual compound. Is that correct?

Mr. FOX: Provided an equivalent product is the responsibility of the medical staff. Whatever their desires are in this field, this is what we do.

Mr. BRAND: Do you think the formulary system could be extended to the retail pharmacy trade?

Mr. STEWART: I think we said in our brief that we did not see a published provincial or federal formulary as being feasible, but we do feel very definitely that if basic information, not just advertising, were readily available to all physicians—and we are not now making suppositions that physicians do not know what they are prescribing—that this would help the doctor in his choice of drugs. We bring out in our brief that this is one of the functions which we do now and which we would like to participate more in in assisting the doctor with obtaining, storing and retrieving information on drug products, when he desires it.

Mr. BRAND: I think this is a very sensible suggestion. Do you think this should be carried out by the Food and Drug Directorate?

Mr. STEWART: In our proposal we rather think that our Society would like to do this in cooperation with hospitals and the medical associations.

Mr. BRAND: Who would pay for this? Would this dissemination not be rather expensive?

Mr. STEWART: We have a proposal for which we are seeking financial assistance.

Mr. BRAND: From the federal government?

Mr. STEWART: We first approached a private endowment agency and we are now considering, because we were not successful in this first instance, that we might try other government agencies.

Mr. BRAND: Do you not think this would be a legitimate source of government aid? If you believe this would help to reduce the costs and multiplicity of drug forms and therefore make it cheaper to the consumer, do you not think that this would be a very useful function of government?

Mr. STEWART: Yes, we would like to do this. As a matter of fact, the University of British Columbia now has a federal grant for a phase of this drug information, but we would like to see this spread right throughout Canada.

Mr. BRAND: I have one more question. Are you satisfied with the present information provided to poison control centres in your hospitals?

Mr. STEWART: I can speak only for the metropolitan area where I am located. The Sick Children's Hospital has the poison control centre, and we feel that that is serving its purpose. They seem to be happy with it, because it seems that it is mainly children who are involved in cases of poisoning. We certainly assist when there are overdosages and doctors approach us, and we have noticed very definite cooperation on the part of the pharmaceutical firms in making more and more of this information readily available.

Mr. BRAND: Thank you very much.

Mr. HOWE (*Hamilton South*): Mr. Chairman, may I interject a supplementary question to one that Dr. Brand was asking a while ago? The gentleman said that the results of private testing a drug could not be passed to a smaller hospital because it would not necessarily represent the same lot number and, therefore, the information would not be of any use. Does this imply that you would then have each lot that you get from this drug company tested?

Mr. STEWART: Yes. We buy only one lot at a time.

Mr. HOWE (*Hamilton South*): And you would have each one tested as it comes in.

Mr. STEWART: Yes. We insist, in tendering, that it be all one lot. If it were more than one lot we would have to have two different tests run. It would be too expensive; it would double our costs.

Mr. HOWE (*Hamilton South*): Then the next time you buy a lot you would go through this testing procedure again?

Mr. STEWART: Yes, but we are buying this type of drug in large amounts and it may be six months or a year later when the next lot is bought.

Mr. HOWE (*Hamilton South*): But this next lot would be tested again. This seems important. Otherwise this information would be of use to a smaller hospital. If you were not doing the testing it would put you in the same position, so you would, therefore, have to test each lot that you got, whether it be six months or a year later.

The VICE-CHAIRMAN: Mr. Forrestall?

Mr. FORRESTALL: I have just one or two questions. We will get away from some of the technical matters, because I am neither a doctor, a druggist, nor a professional man of any sort. Perhaps each one of the three of you could answer

this for me. It is a straightforward question. Do you think the cost of drugs to people who have to use them is too high?

Mr. Fox: I think perhaps some adjustment could be made for chronic users of the type of drugs that are life-maintaining. There again, it all depends on the type of drug that a person is using, and what the drug is doing. If the drug is life-maintaining and life sustaining, I think it is cheap at any price. Nevertheless the patient himself might not be able to afford it, and I think these patients should be assisted.

Mr. Forrestall: You are like most people; you hesitate a little bit. Drugs, then, in your opinion, are not too high?

Mr. Fox: It is very difficult to make one blanket statement of that sort. I said before that I would hope that prices of drugs in hospitals could be reduced, and I still feel it is not generally realized that the cost of many of the drugs that hospitals purchase is quite high.

Mr. Forrestall: I am just interested in your three individual opinions as to whether or not drugs are too high. Would you, Miss Gannon, think that the cost of drugs is, indeed, too high?

Miss Gannon: I tend to agree with Mr. Fox. I think that one of the reasons that we have suggested the idea of a professional fee plus the cost of the medication commodity itself is to reduce those higher priced drugs to the point where the burden on the patient would be not quite so great. I would be inclined to think that in general, perhaps, the lower priced drugs are not excessively priced to the patient, and that this system could help to lower what could be a problem.

Mr. Forrestall: Would you care to make a brief comment on this, Mr. Stewart?

Mr. Stewart: In a general sense, I really honestly do not think drug prices are too high, but I do agree with the statement that where there is an unusually expensive drug the professional fee concept certainly would help to lower the cost. Considering many other commodities that people buy, I think drugs are actually very reasonable on the basis of what they do.

Mr. Forrestall: Because you are primarily concerned with work in hospitals, could I ask you a couple of questions which may be outside of your purview altogether? First of all, what percentage of drugs used in hospitals would fall into the category that we know as "samples". You refer to hospitals being "charitable institutions". I am sure what you mean is that the nature of the relationship between the drug manufacturer and the hospital is charitable in some instances. I have not run into a charitable hospital yet. What percentage of drugs that come into your hospital are samples. Would it be 5 percent or 50 per cent that are supplied to the hospital either as samples or free of charge?

Mr. Stewart: I would say, at least in my experience, that it is a very, very small percentage of the total volume of drugs used in the hospital. It is rather insignificant compared with the overall volume of drugs used.

Mr. Forrestall: How does the cost of these drugs administered in hospital show up? Is it a straight billing to the patient? I have never been in a hospital.

Mr. STEWART: In the various provinces I suppose there are different plans, but in those provinces that have a "drugs included" plan with their hospitalization—

Mr. FORRESTALL: I am sorry to interrupt; I know somebody has to pay for it. For example, if somebody orders an aspirin tablet, how much does that aspirin tablet cost the patient in the hospital?

Mr. STEWART: Under this scheme there is no billing for the individual patient for the cost of drugs, but simply an overall cost to all the patients who are hospitalized.

Mr. FORRESTALL: The hospital says in 1965 the cost is so much to have trained pharmacists and to buy drugs; they can anticipate so many patients, and they just divide the patients into the drug costs and build it in to the basic per diem cost.

Mr. STEWART: That is right; the number of patient days is divided into the overall cost of drugs and this gives a per diem cost of drugs to patients.

Mr. FORRESTALL: Because the total load is shared, there is no way of determining drug costs in that sense at all?

Mr. STEWART: Not to an individual patient, although there may be studies made where, for instance, the hospital may be interested in knowing what it is costing in a heart area, a neurology area, a special intensive care area and so on. In that case an accounting is kept of what is used in this particular area—but as a group, again; not for the individual patient.

Mr. FORRESTALL: It has been suggested to us in an earlier brief that in Canada today we are placing too much emphasis on the need for trained pharmacists. In connection with that I would ask you two questions. First, what percentage of drugs—and you can restrict it to the hospital—would come in a prepackaged, predosage ready-to-be-used form? It has been suggested to us that possibly 99 per cent of today's drugs, particularly from the PMAC firms, are already prepackaged and predosaged; all you have to do is count pills or something of this nature. How much of the basic pharmaceutical skill that you learned in university is put to actual day to day work in the hospital?

Mr. STEWART: I would like to make a comment on that. Actually, as far as the dosage form is concerned, this is very true. There would be perhaps 5 per cent of drugs or possibly even less depending on the prescribing habits of the medical staff, that would have to be processed or mixed again. But as far as the packaging is concerned—the labelling, proper storage, checking of dosages and the checking of storage on the wards—we sincerely feel that not enough of this is being done yet. We are encouraging our members to take more care with drugs in the hospital. We feel that drugs often can leave the pharmacy and be carelessly stored in the nursing area. If this is done the drug may deteriorate and then the patient is actually not receiving the benefits.

Mr. FORRESTALL: I keep getting the impression from various people that pharmacists today have to be better administrators than pharmacists.

Mr. STEWART: Although it is administration it is also drug control, and it requires a concept of what drugs need to be stored and how, and knowing the physical and chemical stability of the drug requires scientific knowledge. I

believe it is important that the pharmacist be a highly trained individual in order to carry out these functions properly.

Mr. FORRESTALL: The suggestion has been made to the Committee in the past that instead of the full postgraduate training that is now required, possibly an abbreviated period in a professional school and a professional institution would be sufficient. Would you disagree with that?

Miss GANNON: I would disagree with that.

Mr. FORRESTALL: You must continue the high standards?

Miss GANNON: Yes.

Mr. FORRESTALL: What percentage of actual prescriptions or orders by doctors, in the hospital would find its way all the way back to the pharmacy? Would it be half of them? Or what percentage would the nurses, having knowledge of their patients, simply provide from their own drug locker?

Mr. STEWART: A rather small percentage. The so-called ward stock, as we refer to it in hospitals, is usually limited to such items as common laxatives, aspirin and this type of thing that do not require specific directions.

Mr. FORRESTALL: They keep narcotics, too, because you see them around with their little keys.

Mr. STEWART: This is done not because they are less dangerous or less potent but as a matter of convenience. The nurse has them in a locked cupboard, and when the doctor orders them she can obtain them. Of course, she sends full records back to the pharmacy of how they have been utilized.

Mr. FORRESTALL: In short then, she is a druggist.

Mr. STEWART: No.

Mr. FORRESTALL: What I am getting at is that we have been told before that nurses dispense drugs, and I am rather interested. Mind you, I do not think there should be any lessening of your professional training and background, but this has been strongly suggested to us by others. It makes a lot of sense to a lot of people, and they use nurses for an example. They say, "Well, you are people who have a lower professional training than might be required of a pharmacist." They are, in fact, acting as druggists, are they not?

Mr. FOX: May I interject here? This rather has to do with the administration of the medication. In a patient's home the patient would take the medication himself; in a hospital the medication is administered by the nurse. But this does not mean that she is providing pharmaceutical services because these are provided by the pharmacist.

Mr. FORRESTALL: This is a good distinction. It is the first time I have heard it suggested, and that is a clear distinction. Can I take you out of your hospitals just for a moment and put you out in the mundane stream of life? It has been suggested to us that one area of intervention the government or a Committee of this nature could consider is the suggestion that drug stores under the control of a registered pharmacist could very well find themselves an integral part of some of our larger food shopping areas. For example, is there anything wrong, with Dominion Stores putting a pharmacy in the corner of a grocery store? Do you see any dangers inherent in sweeping away the traditional isolation that drug stores

have had in Canada? The drug store has been the drug store. You do not go to the grocery store, the hardware store, to Eaton's or Simpson's to buy drugs. Is there anything wrong, in your professional opinion, about that concept?

Mr. STEWART: Personally, I would no more like to see the drug store associated with general merchandising than I would like to see the doctor set up his office in a supermarket—I mean not as part of the supermarket; he may be in a shopping centre.

Mr. HOWE (*Hamilton South*): Is not a drug store now simply a pharmacy in the corner of a general store?

Mr. BRAND: According to the evidence of the Canadian Pharmaceutical Manufacturers and the the Canadian Pharmaceutical Association, this is true.

Miss GANNON: I am sorry; I did not hear what was said.

Mr. BRAND: The Canadian Pharmaceutical Association pointed out that in their opinion there were very few, if any, drug stores which are purely dispensaries. I disputed this but, nevertheless, they say that most of them are general stores with a pharmacy tucked in the back.

The VICE-CHAIRMAN: Are there any other questions.

Mr. MACKASEY: I have a few but perhaps a lot of them have been answered. I apologize for being late, Mr. Chairman. Are the members of the Canadian Society of Hospital Pharmacists in the employ of hospitals, or are you independent pharmacists working in conjunction or cooperation with hospitals?

Miss GANNON: The Society is a voluntary organization of pharmacists who work in hospitals.

Mr. MACKASEY: Do you work in hospitals for the hospital? Does your pay come from the hospital?

Miss GANNON: Hospital pharmacists are traditionally salaried by the hospital.

Mr. MACKASEY: These are really dispensing units within a hospital where perhaps outpatients go to have a prescription filled at the same time as they are being treated?

Miss GANNON: The outpatient service is provided by some hospitals but not all. Primarily the pharmacy department of a hospital is for the patients who are being treated there.

Mr. MACKASEY: The reason I am asking is that when I go through the Children's Hospital in Montreal on Saturday—my boy is a diabetic and his doctor is in the hospital—I see quite a few people lining up at a wicket, with a prescription to be filled. I presume it is a lot less expensive than the corner drug store. Are the people who actually work in these units the ones who are represented by your Association?

Miss GANNON: The hospital pharmacists who work in these places, yes.

Mr. MACKASEY: In other words, you are not a drug store in a hospital administered in theory by employees of the hospital. I notice that you hold your annual meeting at the same time as the Canadian Pharmaceutical Association. Is

there any link between your association and the Canadian Pharmaceutical Association?

Miss GANNON: Yes. The Canadian Society of Hospital Pharmacists is represented on the council of the Canadian Pharmaceutical Association.

Mr. MACKASEY: But, at first glance, do you not represent an element that the corner drug store may not favour because a person can buy drugs through the drug store in the hospital quite a bit cheaper, in many instances than if he filled the prescription in his neighbourhood?

Mr. STEWART: Traditionally the outpatient departments in the hospitals were confined to indigent patients, and even today it is only fair to say that a large proportion of many drugs are free to the outpatients. Other drugs go out at perhaps only a fraction of the cost, and so on. Some hospitals have a system of evaluating a patient to determine what fraction of the cost they should pay.

Mr. MACKASEY: So do some doctors, I understand. I have been interested in your discussion of the cost-plus dispensing fee because this has been brought up on several occasions. Most witnesses have emphasized that it would probably equalize our bill over the year. The point I am getting at is that the druggist's brief, with which I have some sympathy, states that the profession of a druggist is obviously not fully appreciated in this country, perhaps because there are too many drug stores. Therefore the druggist who may start out with the type of setup you recommend in a hospital has to take on the character of a general store to justify the dispensing area. I suppose this is the reason why. Do you feel there are too many drug stores in Canada?

Mr. STEWART: I personally sincerely believe that many druggists could not make an adequate living on prescription business alone and this has forced them to support their livelihood with other lines of goods. The fact is, particularly in the smaller communities, that the druggist is providing the health needs, but if this is not sufficient to make a living he must, of necessity, stock other lines of goods in order to make a reasonable living. I believe this is forced on him. I think most pharmacists would prefer to do nothing but prescription and professional business.

Mr. MACKASEY: There was a very excellent example brought in by Dr. Brand earlier. As a pharmacist, can you explain the very wide range of prices in any way except, as you say what a person is entitled to charge because of his professional standing? I read into the record a few weeks ago a fully documented authentic case of a man in Montreal who visited three different drug stores and found that the price of a particular Smith, Kline and French tablet—I forget precisely what it was for, I think it had something to do with hypertension—varied from 11 to 22 cents and, if he could have got back to his place of employment, he could have bought it at a little dispensary there for 7 cents. Would the cost-plus professional fee apply here? What guarantee would the public have as to which cost would be used, or how the cost would be based?

Mr. STEWART: I am afraid I could not answer that because we are not involved.

Mr. MACKASEY: But you are pharmacists. I think you mentioned earlier that your organization is represented on the council of the druggists association of

Canada. Surely you are not isolated from the industry or the druggists in general just because you are in a hospital.

Mr. STEWART: It is true that even hospitals would vary their prices to outpatients. It is quite possible that a patient if he so desired and it were possible to do so, might go and shop in one hospital and get it free, because they might class him as one who is eligible for free drugs, and yet, in another hospital he might have to pay.

Mr. MACKASEY: But I am talking about the corner drug store now. Are there any recommendations you can make to the Committee which would make it easier for the buying public to shop around a little more when filling prescriptions? For instance, would you recommend the abolition of the pad pre-inscribed "with the compliments of such and such a druggist" that the doctor uses? Would you prohibit this by law, or would this be a good move?

Mr. FOX: May I interject? In Quebec this type of prescription form is prohibited.

Mr. MACKASEY: Do you think it would be a good move to extend this right across the country?

Mr. STEWART: I think we would like to see the name prescription pad withdrawn. However, I think this is really more a matter of medical profession ethics than for the pharmacists.

Mr. MACKASEY: Have you any recommendations that would make it easier for the public to shop around when filling prescriptions at drug stores?

Mr. STEWART: Again, this is a personal opinion. I choose my physician because I have confidence in his ability, and I think that by and large the consumer chooses his pharmacist the same way, through trust and confidence in his professional services and in his integrity.

Mr. MACKASEY: How are you going to have faith and trust in the integrity of a druggist in view of the examples Dr. Brand and I gave? I can give you another one. I know of a case where a lady who is three or four months pregnant is required to take progestoral and it is costing her $14 a week. I know of another person who, unable to pay this amount shopped around in the Montreal area about three weeks ago and procured it for $4.90. How are we going to maintain this type of happy relationship between the druggist and the patient, particularly in a big city like Montreal?

Mr. STEWART: I would say that living in what you might call a free economy, unless there are welfare plans where the cost is defined at an actual list less a certain percentage plus a professional fee, like those which have appeared in certain provinces of Canada—and there may be something like that in the future right across the country or in regional areas—it would be very difficult to have two, three of four hundred pharmacists all quoting the same price. If they did perhaps they would be suspect under the Combines Act.

Mr. MACKASEY: You talk about a free economy system. My experience is that restrictive legislation on a free economy system is imposed reluctantly, and then only when different groups abuse the desirable features of free economy. The reason I ask these rather pertinent questions about the drug industry is that we have concentrated on the manufacturers in an effort to drive their costs

down, but it seems to me that druggists are also partly responsible. I think it has been established definitely that drugs are too high in many instances.

Mr. STEWART: I do not know what the answer to these fluctuations are, but I feel that if the professional fee system was in vogue a lot of this would be eliminated.

Mr. MACKASEY: Why is the practice not in vogue? What is to prevent it?

Mr. STEWART: It cannot be done overnight, and neither can it be imposed. It has to be accepted, and I think it will be.

Mr. MACKASEY: In the final analysis, under our system the druggist—and properly so—has to operate at a profit. In all fairness to the druggist I feel that we do not realize that it is a profession, and that the average druggist earns a lot less at the end of the year than he should, considering the degree of study he puts into it. It is almost humiliating to see him resorting to cosmetics and silk stockings to keep the front door open. I am not anti-druggist. At the same time it seems to me that perhaps we should take a closer look at certain countries where they limit the number of outlets to the number of people where statistically it can be shown that the druggist will be recompensed for his profession—and it is an honourable profession.

In concluding, Mr. Chairman, Dr. Brand mentioned demerol. Again, I am fully in accord with Dr. Brand. This is another area of drug costs. We talk about the integrity of the doctor; why does the doctor not prescribe the less expensive substitute more frequently?

Mr. FOX: He would, but sometimes he just does not remember the name, and he may have a particular opinion about a certain brand.

Mr. MACKASEY: How long would it take him to look up the generic name of "demerol"?

Mr. FOX: It could be that certain doctors like this particular brand, or this is the only brand of this particular drug that they know, and perhaps they are too busy to check further.

Mr. MACKASEY: You say he cannot remember and he is too busy. How long would it take him to look it up in a pharmacopeia?

Mr. FOX: I think this would be one of the functions of the drug information service that we have been talking about. This would be of assistance to the pharmaceutical and medical professions, and the associated professions who would like to have this type of information. We have proposed that this be furnished and, in my opinion, not only would this lead to a very good drug therapy and safety, but economic advantages would accrue from it, naturally and automatically.

Mr. MACKASEY: I can understand a doctor prescribing a brand name, particularly in an area where safety is a tremendous factor, and he wishes to avoid any side effects and so on. But doctors on the committee have emphasized that certain brand name drugs have been on the market for five or ten years now but suitable substitutes which have been on the market for almost as long have proven to be safe, yet the doctors do not prescribe them.

Mr. FOX: Doctors are very busy and given the proper opportunity in relation to their time—

Mr. MACKASEY: If I were a doctor I would think that sometimes a patient's mental anguish because of the cost of drugs would be an impediment to the eventual cure of the patient. If a doctor can spend 20 to 30 minutes with a patient to find out what is wrong with him, he can spend 3 more minutes, if necessary, to find out the generic equivalent of a particular drug and help that patient go out and get a prescription filled at a reasonable cost.

There are too many people who go home with prescriptions and never fill them because they cannot afford it. I think you know that as well as I do. Ironically, it is not the indigents because they get them filled; it is not the wealthy man; it is the growing class in between that does not fill its prescriptions. We have heard many estimates here, which I will not repeat or bore you with, of the number of prescriptions that are never filled, because people cannot afford them. I think more and more it is the fault of the doctor—not the manufacturer —who does not want to pass on to the patient, for some reason or other, the obvious advantages of a substitute. Why can the doctor not put on his prescription "demerol or an equivalent substitute"? Is this against the law?

Mr. FOX: In many cases doctors are taking more interest in this aspect; they are calling to enquire and, given the facts, the results are admirable. But there again I think that the doctor, being so busy, just does not have the time to read all the pharmaceutical references, and he sometimes does not associate the given name with the brand name. Of course, there are times when he does know the brand name but does want to prescribe it. I may say that many of these so-called brand names are available at a reasonable price as well. In some cases doctors are enquiring about the price of these drugs for patients who have to take large quantities of them. They are taking an interest, but I think we have to help the situation along by creating an easily available information system, one that does not exist now on a country-wide basis.

Mr. MACKASEY: Thank you, Mr. Chairman.

Mr. HOWE (*Hamilton South*): Mr. Chairman, may I follow that up? If this formulary system were injected into the private drug stores, would you not foresee that this would lower prices by drug companies tendering in order to have their particular stock in that drug store? Also, the advertising sent to doctors would not be necessary then which would also eliminate considerable cost from the drug. Do you not think, with the drugs properly tested, that the ultimate prescription the patient has to have filled could cost considerably less for these two reasons?

Mr. FOX: It might. The conditions, though, that exist in a community are quite different from those that exist within a closed institution where one pharmacist can carry out the policies of the total medical staff of 50, 100 or 150 physicians. Out in the neighbourhood you have 200 or 300 physicians dealing with 200 or 300 pharmacists. On that basis it would be difficult. Nevertheless, a wide list approved by the medical staff of the community, supplemented by a compendium or drug information service might achieve in the end a result that is very close to that.

Mr. HOWE (*Hamilton South*): Possibly a federal formulary of tested drugs of equal efficiency and lack of side effects could be listed, and when this generic name were written it would be up to the individual druggist to dispense whichever one he carried in stock, which would cut down his expense in stocking

various makes to satisfy the needs of different doctors. If this were prescribed on a generic name basis it could conceivably lower his need for stock. He would get a lower price by virtue of tendering, the doctor would not receive the advertising, and the ultimate cost to the patient would be considerably less.

Of course this would not apply to all drugs. We mentioned demerol, and I do not know of any generic substitute for demerol. I am speaking of drugs that are duplicated now that are of equal efficacy and lack side effects. Is it not conceivable that this could lower the price?

Mr. Fox: It is conceivable.

Mr. Brand: Do you know of any generic substitute for demerol meperidine?

Mr. Fox: There are drug products that are known as "meperidine" and are also known under other brand names. There are at least one or two.

Mr. Brand: I am referring to those available in this country. I know there is preparadol, but that is in the United Kingdom.

Who puts out meperidine? This is news to me and, I am sure, to Dr. Howe as well.

Mr. Fox: There is at least one that I can think of, and I have seen them on the list of various other companies under the name of meperidine. Meperidine is spelled m-e-p-e-r-i-d-i-n-e. There is also another given name, pethidine, which is spelled p-e-t-h-i-d-i-n-e.

Mr. Brand: But are they cheaper?

Mr. Fox: I just do not remember whether they are or not. I feel that initially they were cheaper, but the prices are very much the same today due to competition.

Mr. Brand: In all fairness, is it not true that in hospitals you buy in ampules for purposes either of sterility or ease of dosage for patients rather than buying in the much cheaper multiple dosage form, and that you keep up the price this way although there may be valid reasons for doing so. You did make the statement that doctors do not know the generic names; I want the other side of the picture as well.

Mr. Fox: I should not say that doctors do not know the generic names. I say that some doctors do not know all the generic names. Doctors by and large are better informed today than they ever were. Going back to your question about unit doses compared to multiple doses, I do not agree with the supposition that these are more expensive or increase drug costs. There could be a loss of material in a multiple does vial; it could lead to transfer of infections, in which case the cost of treating these infections could be considerable, and it could lead to medication errors.

Mr. Brand: I would be interested in hearing about any case you know of where there has been a cross-infection caused by use of a multiple dose vial of demerol. I challenge you to produce one.

Mr. Fox: I do not know of any cases with demerol in particular—

Mr. Brand: I am sure you do not.

Mr. Fox: —but we have read of transfer of hepatitis through multiple dose vials.

Mr. BRAND: Yes, but you are going back a few years. As you know, in most hospitals now disposable units are used for each individual patient, so you cannot really say that you are going to transfer by using the same needle which is improperly sterilized, and I think that is a different question. My question was this: In unit dosage which comes in 100 milligrams of the drug let us say, and you give 25 milligrams to a patient the 75 milligrams is discarded. Is this not correct? Whereas, if you use a multiple dose vial, which can be just as sterile if handled properly—and we presume in modern hospitals they are—it would be cheaper in one particular area to use this multiple dose vial. But is it not correct that it is just as easy to account for and things of this nature.

Mr. FOX: This would be a decision for the medical staff to make. We have found from our personal experience that these are not easier to account for. Many times with multiple dose vials we have found—for instance with pentobarbital—that in entering the dosages the staff on the wards come to the bottom of the bottle and find that they are short several doses, and this is a matter of wastage.

Mr. BRAND: It is wastage the other way too; surely you must admit that.

Mr. FOX: I still feel that the advantages greatly outweigh the disadvantages in a product like meperidine, where the use is so tremendous.

The VICE-CHAIRMAN: Thank you, Dr. Brand. Are there any other questions from the Committee members?

Mr. LAIDLAW: Mr. Chairman, I would like to take a leaf out of Dr. Brand's book, if I may, and refer to the brief submitted on November 17th last year by Mr. Bass of Vancouver. For the information of the witnesses Mr. Bass appears to be a very highly organized retail prescription druggist. We understand he fills in his pharmacy, some 1,500 to 2,000 prescriptions a day and, I believe, if my memory is correct, that there are ten pharmacists or more on his staff. In his brief he makes some remarkable comments, and in expressing how a prescription is dispensed today—and perhaps I should address this question to the Canadian Pharmaceutical Association rather than to you—he goes on to say, and I am quoting from page six of his brief:

> All it is is a matter of counting; being able to use a typewriter, being able to use a razor blade properly, and transferring pills from one bottle to another. A pharmacist does not need as wide a knowledge today as he did many years ago. He might like to make you believe that the great knowledge he has involves years of university and difficult exams but in actual fact he is being called on less in this daily task than Pharmaceutical Associations would like the public to believe.

You are a Canadian association. Perhaps this question, as I said, should be directed to the Canadian Pharmaceutical Association or one of the provincial bodies. Is there a modicum of truth in that statement?

Mr. STEWART: May I speak to that?

The VICE-CHAIRMAN: Certainly, Mr. Stewart.

Mr. STEWART: With respect to the mechanics of dispensing, such as counting pills and typing, even a high school student can do that without a college education. We realize that there is a mechanical aspect to dispensing. However,

we believe in the interest of patient safety that the proper interpretation of the prescription is a very important factor, and that you cannot leave this to the decision of some technician or high school student.

In hospitals we have taken steps to eliminate as much of the mechanical work of the pharmacist as possible by packaging ahead of time. Where quantities of drugs are used we have packaged them ahead of time using non-professional personnel under supervision, and careful supervision I must say, because it would be a worse error if the product were mislabelled and the pharmacist thought that he was giving the proper drug when he was not doing so. Therefore, the proper interpretation of the prescription, the proper labelling of the drug and the checking to see that the doctor's directions are fully understood by the patient is, I think, an important function for a patient's safety.

Mr. LAIDLAW: I felt, Mr. Stewart, that your views about this should go on record because of the comments that were made. Mr. Bass makes another statement in his next paragraph that perhaps you would like to remark upon. Referring to the pharmacists he says:

> ...his every action is controlled by various provincial associations which, through their disciplinary committees, help to control prices. A pharmacist who gets "out of line" on prices will be called before the disciplinary committee and may have his licence suspended or even cancelled.

Have you any comments to make about that, Mr. Stewart?

Mr. STEWART: I am not aware that this is a fact, in my experience. I do believe that the professional associations frown on unethical advertising by pharmacists.

Mr. LAIDLAW: I assume you are a member of your provincial association?

Mr. STEWART: Yes.

Mr. LAIDLAW: I presume you attend the meetings. Do they have disciplinary committees?

Mr. STEWART: All professional associations have a disciplinary committee, but this is not open to all members. A member might be called before a disciplinary committee for unethical practice.

Mr. LAIDLAW: Do you know whether they disapprove of retail prescription druggists discounting? Do they permit this? Do they frown upon it?

Mr. STEWART: I believe the acts are confined to unethical activities in the way of advertising.

Mr. LAIDLAW: Would discounting be considered an unethical activity on the part of the druggist?

Mr. STEWART: I am sure that there are many pharmacies in Canada today that are discounting and are not up before disciplinary committees.

Mr. LAIDLAW: This leads me to another question on which you might help the Committee, and that is another statement by Mr. Bass which appears on page eight of his brief. It reads, in referring to this select committee:

> ...if this Committee would move to repeal Section CO-1044 of the Food and Drug Act...

which is a regulation which prohibits advertising on a retail level of prescriptive drugs,

> I can almost guarantee that you would see the prices of prescription drugs drop 30 to 40 per cent.

He goes on to say on the next page:

> This would allow the merchandising of prescription drugs through advertising media by name only.

I wonder if you have any comments as a Society with respect to the advertising of prescription drugs by retailers?

Mr. STEWART: I would ask Miss Gannon to answer this, but in my estimation it is unethical to use the prescription as a means of merchandising.

Mr. LAIDLAW: Mr. Bass elaborates later on in his brief, saying:

> The Pharmaceutical Associations would control our advertising in the retail trade, although I have been fighting them successfully on this in our courts.

Do you have any further comment? He has stressed throughout his brief that this is one way of bringing the cost of drugs down.

Mr. STEWART: I honestly could not accept the statement that prices of drugs could be lowered 30 to 40 per cent, although I do not feel entirely confident. I am simply giving an opinion, as I believe he was giving an opinion that really could not be substantiated.

Mr. LAIDLAW: Could you express your concern to the Committee that this might be harmful?

Mr. STEWART: Yes.

Mr. LAIDLAW: I put it to you that advertising of prescription drugs, provided there are qualified pharmacists in the drug store, would do no harm. Would this not allow the public to shop around as Mr. Mackasey said?

Mr. STEWART: Look at it this way. If I were a druggist out in a small community and there was someone within 100 miles of me who advertised all his prescription prices he could take all my prescriptions business away due to his great volume of business and other methods. Then I, as a pharmacist, could not exist in a small community, and I would have to leave. You might get bargain rates by concentrating all your buying in one store, but the pharmacist gives a health service to the community. Are you going to deprive him of this by having everybody get their prescriptions filled at a bargain rate? Certainly the more prescriptions he gets the less he can sell for because he can use volume, just as the supermarkets use volume.

Mr. LAIDLAW: Mr. Stewart, is this not perhaps a fact of life, though? Thirty or forty years ago the local grocery stores used the same argument when the chain stores came in. Are you going to continue the past into the future at the expense of the consumer?

Mr. STEWART: All I can say is that I honestly do not believe that the prescription should be a commodity of commerce to be sought at a bargain rate. This could even be harmful. If a patient is going to mail in the prescription and then have to wait a day or two to start taking an antibiotic it might in the end,

be less expensive to have it filled immediately in the neighbourhood drug store. Two day's delay might mean a much more expensive experience in the end.

Mr. LAIDLAW: I have one final question, Mr. Chairman, to direct to the witness. This was discussed earlier this morning. The statement by Mr. Bass on page seven of his brief seems extraordinary. I will read it.

> I would remind the hon. members of this Committee that you do not have to be a doctor or a pharmacist to dispense a prescription in Canada today. In our armed services, prescriptions are dispensed by orderlies; in our hospitals they are dispensed by nurses.

Dr. Rynard brought this up earlier this morning, but I wondered if you could elaborate on the armed services at least. Do you have any knowledge of this?

Mr. STEWART: No. I have acquaintances who are pharmacists in the armed services. I presume that they have proper pharmaceutical services. As far as dispensing by nurses is concerned, I think you are aware that the Canadian Nursing Association opposes nurses taking this on, because they feel that it is not within their competence.

Mr. LAIDLAW: Thank you, Mr. Stewart. I wanted the point elaborated. That is all I have, Mr. Chairman.

Mr. BRAND: I have one question on price-cutting, Mr. Chairman. I do not think you answered absolutely my question as to whether you felt that pharmacists did not agree with price cutting. I wonder if I could quote to you from the code of ethics of the Ontario College of Pharmacy, Code of Professional Conduct. Section 28 reads as follows:

> The pharmacist should not deliberately underprice a prescription or copy for the purpose of injuring the reputation for fair dealing of other pharmacists.

That is in the code in this province. Do you not think that would support what you were saying, that they are against price-cutting? It would certainly tend to support that, would it not? I have some from other provinces if you would like to hear them. And on page 498 of the restrictive Trade Practices Commission submission of 1963 this statement appears:

> The evidence before the Commission does not indicate that the high degree of uniformity in retail drug prices...

Incidentally, I disagree with that statement

> ...is due to any agreement or arrangement between druggists or to any rules of professional conduct adopted by pharmaceutical associations. It appears to be due chiefly to a general feeling among pharmacists that price cutting lowers the dignity of the profession. Rules of professional conduct clearly indicate this attitude.

What do you think of them apples?

Mr. STEWART: Was the last statement from the Canadian Pharmaceutical Association?

Mr. BRAND: No, the last one is from the report concerning the manufacture, distribution and sale of drugs by the Restrictive Trade Practices Commission, Department of Justice, 1963.

Mr. STEWART: Whose evidence was that?

Mr. BRAND: That was one of the findings of the commission and that is why I am quoting from them. Section 28 that I read to you was from the Ontario College of Pharmacy's Code of Professional Conduct in relation to advertising and so on. That is exhibit T.24 as presented by that Council to the Restrictive Trade Practices Commission.

Mr. STEWART: I agree that prescription filling is a professional matter. I think we would frown at doctors putting out signs "Medicals at a bargain price, $4.99". I honestly and sincerely do not think that a pharmacist should be advertising his professional services at bargain prices.

The Vice-CHAIRMAN: Is that all, Dr. Brand?

Mr. BRAND: Yes.

The VICE-CHAIRMAN: Are there any other questions from the Committee.

Mr. FORRESTALL: You touched on something that intrigued me. Are we seeing the end of an era? I think we are. In my experience, the role of the druggist in a small community was that of community confessor. If you had a cold you did not go to see the doctor; you asked the druggist what you could take. Is that disappearing in Canada? Is the druggist becoming more mechanized? Is he simply a machine in society? Twenty-five or thirty years ago his relationship was much closer to people.

Mr. STEWART: I think that this relationship still exists to a large degree in the smaller community between the doctor, the patient and the pharmacist. However, people now go more and more into larger centres. If a patient is seriously ill perhaps his doctor even refers him to a health science complex type of institution where they might get highly specialized diagnosis and treatment.

I am sure the community druggist in the smaller centre is finding it more difficult as time goes on to maintain his existence on the basis of the business that is available in the community, just as the grocer is having more and more difficulty in maintaining his position.

Mr. FORRESTALL: That is sad, but you are probably right. That was all, Mr. Chairman.

Mr. HOWE (*Wellington-Huron*): Mr. Chairman, I have just one comment in this connection. In a lot of small communities there is only one doctor, and you were speaking about how busy all these doctors are. Do you not think that in some cases people go to their local druggist in a small community out of necessity because they just cannot find the doctor sometimes in his office or get him on the phone? They go the druggist to get assistance. In other words, in some small towns I realize that the druggists are doing some of the doctor's work.

Mr. STEWART: In a professional aspect, a pharmacist is not permitted to prescribe, but another reason I think a pharmacist should be highly qualified, is that he can be a means of referring a patient to the doctor. A patient may come in with a cold and wants a cough medicine, and a community druggist might say: "Mrs. Jones, it seems to me that you have had this cold for over a month. I think it is time you went to the doctor, and not keep on buying cough medicine." I have seen this done and I have done it myself many times.

Mr. HOWE (*Wellington-Huron*): In other words, the druggist is providing a service of that type in the community.

Mr. BRAND: Mr. Chairman, in conclusion may I say that although you may think I have been a little rough in some ways, I have a very high regard for hospital pharmacies because I think they do a most useful service, and I did want to put that on the record. I think that without the hospital pharmacists as we have them constituted today under the pharmacy committees we would not have such a high standard of care in our hospitals.

The VICE-CHAIRMAN: Thank you very much, Dr. Brand, I was just going to suggest that myself. I would like to thank the witnesses for appearing today and answering questions on the brief that was put forward.

On December 1st we will have witnesses from the departments of Defence Production, Industry, National Defence, National Health and Welfare, and Veterans Affairs. These are all scheduled for 9.30. The meeting is adjourned.

APPENDIX "A"

A SUBMISSION

to the

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

by the

Canadian Society of Hospital Pharmacists

The Canadian Society of Hospital Pharmacists is pleased to present its views to the Special Committee on Drug Costs and Prices, as it has previously expressed its views in a submission to the Restrictive Trade Practices Commission in October 1961 and in a submission to the Royal Commission on Health Services in May 1962.

Introduction

The Canadian Society of Hospital Pharmacists founded in 1947 is a national voluntary organization of pharmacists engaged in the practice of pharmacy in Canadian hospitals. It is composed of 409 members organized in seven branches governed by a Council as defined in the By-Laws. (Appendix A)

The objects of the Society are:

(a) To improve and extend the usefulness of hospital pharmacists to the institution which they serve and the profession of pharmacy in general.

(b) To provide a means by which pharmaceutical information can be conveyed to hospital pharmacists.

(c) To endeavour to make pharmacy an important part of the program of health services in Canada.

(d) To take such action as may be within its power to obtain a higher standard of proficiency among hospital pharmacists in Canada.

Although the sphere of competence of the Society is professional in nature rather than financial, it is our desire to provide helpful information to the Committee, in the belief that cost and price of medication is more than the medication commodity itself, and involves a professional service.

Aim

The aim of this submission is to provide information on pharmaceutical professional service, particularly as it relates to the individual prescription medication, the total hospital pharmacy, and the hospital setting, rather than a submission of a direct financial or statistical nature.

An understanding of professional service requires an examination of standards of practice, and how such standards apply and function, in various situations. Standards for the Practice of Pharmacy in Canadian Hospitals, developed and adopted by the Society in 1962 (Appendix B) serve as a guide in the establishment, development, and implementation of hospital pharmaceutical services, which will provide for the safe use of drugs, their control and distribution.

These Standards describe the function of the total pharmacy, and the responsibilities of the pharmacist, which are administrative and professional in nature, and are applied in this presentation, in relation to inpatient and outpatient service.

Functions of the Pharmacy Department

1. Dispensing, distribution and control of all drugs and chemicals issued to patients and other hospital departments.

2. Bulk compounding and prepackaging of pharmaceuticals.

3. Purchasing, accounting for, storage, labelling, issuing and controlling all drugs.

4. Maintenance of records on pharmaceuticals as required by federal and provincial law.

5. Education: Participation in any educational or training program in which there is a necessity to include pharmaceutical background, supplemented by means of communication to advise professional groups or recent developments in the drug field.

6. Serves as an information centre on pharmaceuticals and matters pertaining to the handling and administration of drugs.

7. Research: Clinical investigation on new drugs shall be carried on in co-operation with the pharmacy department. Research programs of either practical or scientific nature shall be carried on to an extent consistent with policies of the hospital.

Responsibilities of the Pharmacist

A. Direct Professional

1. Responsible for the planning, organization, direction and representation of the Pharmacy department.

2. Dispensing and distribution of all drugs, chemicals and diagnostic agents issued to patients and other hospital departments.

3. Bulk compounding and prepackaging of pharmaceuticals.

4. Preparation and sterilization of injectable medications when prepared in the hospital.

5. Filling and labelling of all drug containers.

6. Inspecting all drugs and pharmaceuticals in all hospital departments.

7. Maintaining the approved stock of drugs.

8. Issuing all narcotic drugs and maintaining a perpetual inventory of them.

9. Maintaining records concerned with the operation of the pharmacy department.

10. Supervising the maintenance of the facilities of the pharmacy.

11. Maintaining current information on provincial and federal laws pertaining to drugs and drug handling, and keeping the hospital administrator properly informed.

12. Specifying quality and source of supply for the purchasing of all pharmaceuticals, chemicals, and diagnostic agents.

13. Preparing periodic pharmacy reports for submission to the administrator of the hospital.

14. Maintaining, in co-operation with the accounting department, a satisfactory system of records and bookkeeping in accordance with the policies of the hospital.

B. Advisory and Teaching

1. Furnishing information concerning medication to members of the medical and nursing professions.

2. Participating in formulating pharmacy policies and carrying them out in accordance with the establishedd policies of the hospital.

3. Co-operation in teaching courses in the School of Nursing and in other educational programs.

Responsibilities of the Pharmacist to the Inpatient

The hospital pharmacist's first responsibility is to the inpatient who is dependent on the hospital for his pharmaceutical needs.

Certain features of inpatient medication include:

(a) A wide range of medication as well as different dosage forms, such as injections that ordinarily are not used by patients outside the hospital.

(b) Administration of the medication by a nurse or doctor, rather than by the patient himself.

(c) Frequently the doctor's original medication order or prescription, is transcribed on the nursing unit, before being sent to the Pharmacy.

Each medication order or prescription which the pharmacist receives, requires professional judgment on the following aspects:

(1) the dosage is within official limits.

(2) the route of administration is logical for the dosage ordered.

(3) if the drug ordered is a drug manufactured by a pharmaceutical firm, purchase of the drug

(a) meets specifications

(b) has been stored after purchase under conditions which assures it will meet labelled potency.

(4) Uses special professional knowledge and skill where medication requiring compounding is concerned.

(5) Packages drug in containers which is compatible with its particular form.

(6) Labels with specific instructions to nursing personnel concerning the method of preparation, where required, and the exact quantity to be administered.

(7) Categorizes drug according to its particular legal implications and keeps records as required.

These decisions can only be made by legally qualified pharmacists whose professional training and education equip them to assume this responsibility.

The dispensing of prescribed medication, while perhaps the most obvious of the pharmacist's responsibilities, is only one of the eighteen responsibilities outlined in the Standards, all of which are designed to give the patient the best pharmaceutical care. These responsibilities require teamwork with the physician

and nurse, involving the pharmacist in Adverse Drug Reactions Recording and reporting programs, Drug Information Services, and the handling of Investigational Drugs.

Drug use control which has been defined as "the sum total of knowledge, understanding, judgment, procedures, skills, controls and ethics that assures optimal safety in the distribution and use of medication", is exercised by the medical staff, pharmacist, and hospital, through a procedure known as the Formulary System.

The Formulary System

This is the system by which the medical staff of an individual hospital decides on medications, in various pharmacologic and therapeutic categories, which will be stocked in that particular hospital.

The medical staff makes these decisions upon the advice and recommendation of its Pharmacy and Therapeutic Committee, which is composed of medical staff members specialized in certain areas and the pharmacist. The pharmacist's responsibility is to present factual information on medication to the committee, to assist the physicians in their responsibility of evaluating the comparative usefulness of medications in specific situations.

The decisions of the medical staff result in a list of medications (or Formulary), which reflect their judgment of the most effective medications to treat the patients in that institution. The pharmacist is then charged with the responsibility of implementing the decisions of the medical staff, in purchasing and distributing medications of known quality and effectiveness.

The primary purpose of the system is to make valued judgments, to select and to inform those authorized to prescribe and dispense, of the medications stocked and readily available in the hospital.

Although certain economies result through this selective process, and also by the stocking of a single rather than numerous brands of the same drug, the main concern is to provide the patient with medications of known quality and effectiveness, to give the best possible care.

The effective operation of the system requires constant re-evaluation, in view of new developments and research findings, coupled with the communication of this knowledge to medical, nursing, and pharmacy personnel.

The decisions of the medical staff of an individual institution regarding medication, as reflected in the hospital medication list (or Formulary), are not necessarily transferrable to another institution with different needs. In the view of the Society, a medication list (or Formulary) on a provincial or national basis would not be feasible. The Society believes, however, that a Comprehensive Drug Information Service could contribute to the quality of care provided for patients of Canadian hospitals.

Pharmaceutical Service to the Outpatient

An outpatient has been defined as a person, who in the course of his attendance at the hospital receives the services of that hospital including its pharmaceutical services.

Hospitals which have outpatient pharmacy services, usually supply medication without charge to those unable to pay, or at a minimal charge to those with limited financial means.

In the purchase of medications, hospitals enjoy a preferential position in obtaining price benefits for a number of reasons:

(1) the traditional charitable nature of hospitals to which some manufacturers contribute, by providing special discounts, or providing drugs without charge.

(2) the ability to purchase in large quantities and on the bid system.

(3) the clinical nature of hospitals to which some manufacturers provide medication, without charge, for evaluation.

(4) the promotion of certain pharmaceuticals to encourage prescribing by physicians in private practice, or continued use by patients after discharge.

Without knowledge of the fact that the hospital does not charge for the services of its pharmacists, and obtains and supplies the medication commodity at benefit prices, the erroneous impression may be created that this is the true cost at which medication could be obtained by the general public.

Without prejudice to the right to seek tender on quantity, the Canadian Society of Hospital Pharmacists approves a policy of like price for like quantity to all legally qualified to purchase, with the expectation that a more equitable cost can be achieved to the ultimate benefit of all patients.

It is realized that certain medications are, because of their nature, available only through the hospital pharmacy. The hospital pharmacist's first responsibility, however, is to those seriously ill patients who depend solely on the hospital for their pharmaceutical needs. The Canadian Society of Hospital Pharmacists believes that no service should be instituted or expanded that would interfere or detract from this vital function. Indeed, it is our belief that greater encouragement and ways and means should be found to enhance present pharmaceutical service to the hospital's inpatients.

It is the view of the Canadian Society of Hospital Pharmacists that the existence of an adequate medication inventory and the professional services of the pharmacist in the community are essential to public health.

Regardless of where medication is obtained by the patient, we believe that the service of the pharmacist is not a function of the cost of the drug and a reasonable method of payment is cost of the medication commodity, plus a professional fee.

We believe that the pharmacist whether located in the hospital or community makes available to physician and patient not only the medication, but also his background of technical and scientific knowledge, in his interpretation of the prescription, and his ability to communicate required essential information.

In conclusion, we have attempted to illustrate some of the duties and responsibilities of the pharmacist which may have no direct application to the dispensing of medication, or the price paid for drugs, but which are, nevertheless, vital to the provision of the best pharmaceutical care.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 23

THURSDAY, DECEMBER 1, 1966

WITNESSES:

Mr. D. M. Erskine, Director of General Purchasing Branch, *Department of Defence Production;* Dr. H. A. Showalter, Chairman, Inter-Departmental Advisory Board on Standards for Pharmaceutical Manufacturers, Distributors and Agents, *Department of Industry;* Mr. H. H. Poyntz, Director, General Requirements; Major A. R. Friesen, both of the *Department of National Defence;* Mr. M. G. Allmark, Assistant Director General—Drugs, Food & Drug Directorate, and Mr. I. C. Ellis, Pharmacist and Chief, Material Services Division, *Department of National Health and Welfare;* Dr. K. S.. Ritchie, Assistant Deputy Minister and Mr. B. J. Larocque, Pharmacist, both of the *Department of Veterans Affairs.*

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1967

25322—1

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*)
Mr. Enns,
Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee,

MINUTES OF PROCEEDINGS

THURSDAY, December 1, 1966.
(33)

The Special Committee on Drug Costs and Prices met this day at 9.50 a.m. The Chairman, Mr. Harry C. Harley, presided.

Members present: Mrs. Rideout, and Messrs. Brand, Enns, Forrestall, Harley, Isabelle, Mackasey, O'Keefe, Orlikow, Rynard, Tardif (11).

In attendance: Mr. D. M. Erskine, Director of General Purchasing Branch, Department of Defence Production; Dr. H. A. Showalter, Chairman, Inter-Departmental Advisory Board on Standards for Pharmaceutical Manufacturers, Distributors and Agents, Department of Industry; Mr. H. H. Poyntz, Director, General Requirements, Major A. R. Friesen, both of the Department of National Defence; Mr. M. G. Allmark, Assistant Director General—Drugs, Food and Drug Directorate, and Mr. I. C. Ellis, Pharmacist and Chief, Materiel Services Division, Department of National Health and Welfare; Dr. K. S. Ritchie, Assistant Deputy Minister and Mr. B. J. Larocque, Pharmacist, both of the Department of Veterans Affairs.

Also in attendance: Mr. A. M. Laidlaw, Q.C., of Ottawa, Legal Counsel for the Committee.

The Chairman introduced the officials of the departments.

Mr. Erskine, Dr. Showalter and Mr. Ellis made preliminary statements.

Agreed,—That information supplied by the Department of Defence Production at the request of the Chairman, with reference to the last purchase of specific drugs by that department be printed in this day's Minutes of Proceedings and Evidence (*See Appendix "A"*).

Agreed,—That the Standard for Manufacture, Control and Distribution of Drugs of the Canadian Government Specifications Board, 74-GP-1b-7 October 1966, Department of Defence Production, be printed in this day's Minutes of Proceedings and Evidence (*See Appendix "B"*).

The Governmental officials were examined on the purchasing of drugs for their departments.

Mr. Laidlaw also asked questions of the witnesses.

The Chairman thanked the officials for having supplied information to the Members.

At 1.00 p.m. the Committee adjourned to 9.30 a.m. Tuesday, December 6, 1966.

Gabrielle Savard,
Clerk of the Committee.

25322—1½

EVIDENCE

(Recorded by Electronic Apparatus)

THURSDAY, December 1, 1966.

● (9.30 a.m.)

The CHAIRMAN: Gentlemen, we have a quorum.

We have with us today a multiplicity of witnesses who really all deal with the same subject, namely, the government purchase of drugs.

First of all I think I should go around the table and introduce these people to you. Sitting on my extreme right, Mr. D. M. Erskine, Director, General Purchasing Branch, Department of Defence Production. Next to Mr. Erskine is Dr. H. A. Showalter, Chief of the Consumer Chemicals Division of the Department of Industry. Dr. Showalter has appeared before the Committee in a previous hearing. Next to him is Mr. Poyntz, Director, General Requirements, Department of National Defence. Sitting next to Mr. Poyntz, as an adviser, is Mr. Friesen, who is a pharmacist. Next to Mr. Friesen is Mr. Ellis, from the Department of National Health and Welfare; Mr. M. G. Allmark, Assistant Director General, Drugs, Food and Drug Directorate, with whom we are all familiar. He has been at almost every meeting in one capacity or another. Also with us is Dr. K. S. Ritchie, Assistant Deputy Minister, Department of Veterans Affairs and Mr. B. J. Larocque, a pharmacist from the Department of Veterans Affairs.

I think we should start the meeting today with a statement from the first gentleman I introduced, Mr. D. M. Erskine. If I have misstated the title of any of you gentlemen I wish you would introduce yourselves properly.

Mr. D. M. ERSKINE (*Director, General Purchasing Branch, Department of Defence Production*): The General Purchasing Branch of the Department of Defence Production is charged with the responsibility of procuring a very wide range of commodities, and among these are drugs. Until this year our sole customer, of course, was the Department of National Defence. However, during the year we have taken on the responsibility of purchasing for the Department of Veterans Affairs and the Department of National Health and Welfare.

Our purchase action takes place after we are in receipt of a requisition from the user department that properly describes the particular commodity that is required, and our normal practice is to invite competitive tenders. Contracts are awarded, of course, to the firm submitting the lowest price and meeting all the conditions of the tender.

In the case of the Department of National Defence, over 90 per cent of the drugs and pharmaceutical items which are bought are bought to generic descriptions. With the newer departments, we have not been able to establish sufficient records and data as yet—the percentage is somewhat smaller but it is rising.

I think that explanations have been given a number of times about the policies which are followed by the Department of Defence Production. The

acquisition of drugs and pharmaceuticals follows the standard pattern of buying. If there are any particular areas that you would like me to cover in the field of purchasing, I would be glad to do so.

The CHAIRMAN: Thank you. I am going to come back in a few moments to information which Mr. Erskine has given to the Committee. I asked for it on your behalf, and I will distribute it to you in the very near future.

Did you wish to say a few words, Dr. Showalter?

Dr. H. A. SHOWALTER (*Chief, Consumer Chemicals Division, Department of Industry*): Mr. Chairman, my function today is really to represent the Inter-Departmental Advisory Board on Pharmaceutical Standards, to use the short form of the term.

A couple of years ago I gave a complete history of this Board and its functions to the Committee; it was actually on November 17, 1964. The complete history of standard 74-GP-1, of which I have copies, if you are interested, was given.

Some things have happened in the interval and perhaps a little repetition could be made. As Mr. Erskine has said, traditionally the purchase of drugs has been by tender, and the bids are based on product description. I would like to stress that this is the standard for the manufacturer and that in buying by competitive tender one must also have a description of the product. These descriptions are necessarily rather brief and simple. They do not, for instance, contain requirements for clinical tests, but they do describe the product as well as it is possible to describe it, assuming that the examination of the product, when it is offered by the contractor, is of short duration. This, of course, you can see is more difficult as drugs become more complex, and that is the trend which has been occurring.

It has also been found difficult to describe some of the vague general qualities of drugs in these descriptions for purchase. Good workmanship and what is sometimes called pharmaceutical elegance are not easy to describe and to police with exactitude. Experience showed that the lowest bidder was often a firm without the best facilities or the best skills for manufacturing products. This was the situation we reached in the year 1960.

In an effort to do something about this problem the federal departments and governments which were buying drugs consulted together to find some further quality assurance system. They decided to establish a standard of company operation, the standard before you now, which is a prerequisite for bidding and at the same time retaining the product descriptions and the inspection of delivery. The result was 74-GP-1, first issued in September, 1961, revised in February 1964, and further revised about a month ago.

Arrangements were made for the Food and Drug Directorate to provide information obtained during its normal inspections of these companies on the basis of which we could assess the conformity of a company with the standards, and a board composed of representatives of the federal department was set up to decide about conformity in each case, and to maintain the list of companies which conformed. If you look at the standard, you will note that it contains requirements for a number of the aspects of the operation of the supplier. It describes facilities, personnel and their qualifications, production methods and

records, the system of quality control, arrangements for recall, and a few other things.

We judge conformity to the standard by a rating system. You will see that opposite each major requirement there is a number indicating the mark that can be granted, somewhat after the fashion of an examination at school. The rating, in the latter part of the standard, can be diminished by demerits which may be imposed in the case of delivery of unsatisfactory material to a user department.

At the outset, when we wanted to apply this standard to government purchasing, we sent notices to as many drug firms as possible, inquiring of their interest. This was purely voluntary: Do you wish to continue to supply government? If so, you will have to conform with this standard later on. What is your decision? The list of those notified totalled 145 firms and these all received a letter on the subject from an officer of the Department of Defence Production who at that time was acting as Secretary to the Inter-Departmental Board. We followed up with a later letter and as a result of that correspondence 86 firms out of 145 invited inspection, 19 replied that they had no interest and 35 did not reply.

In the course of time a further number of firms had become interested and invited the inspection. The list has undergone a number of changes, additions and deletions for several possible reasons. As of October 1, 1966 the situation was that 75 firms were listed, but this does not include some cases of multiple names which really are related to a single operation.

I think we should emphasize that if the name of a company is not on that list, it does not mean that that company does not conform with the standards. It may mean, and usually does mean, that the company is not interested in government procurement. There are many companies, as you may know, making certain products that are not of interest to government, for one reason or another. A small number of companies wishing to be listed actually has been found not to meet the standard.

You may wonder why government requires a standard of this kind. As Mr. Erskine has explained, federal government departments do not buy, in general, at retail levels. Their responsibility in the use of public funds requires that they buy by competitive tender as far as they can. In this system a product description is inevitable.

You are aware, no doubt, that brands are not necessarily equivalent or of fixed character. Therefore, the successful bidder has the privilege of making special production to the contract because the contract requires him to meet the description only and then his product need not conform with the standards used for his regular business. The product needs only to be as good as the description in the contract. Since a commercial brand does not have to be supplied, the quality is not necessarily a quality that has survived in competition in the market place as is the case with products for sale at retail. That is to say, brands appear to provide a means of protection to the user, which is lacking in purchases by tender.

This standard 74-GP-1 is no more than an added assurance in these circumstances. It conveys no certainty that the supplier can, or will, deliver only satisfactory goods. It is not a guarantee of the company's competence to make a given product. It does not provide certainty that errors will not occur in production. We all know that even the most enlightened and sophisticated

human systems go wrong. But we can say that prior to the use of the standard many products were submitted which failed to meet the description and many which came very close to failure although technically in some cases not quite close enough for legal rejection. Since the time of the use of the standard there has been a significant improvement in this situation.

Another thing happened. It would seem that many agencies outside the federal government, which purchase by tender, would like to have this added assurance. A number of requests have been received by our Board for the standard and for the list of those we believe conform with it. Therefore, with the consent of the member departments, the Board has now made the standard and the list available to the provincial governments and a number of the major institutions.

I understand also that there has been considerable interest shown in this standard by several European countries and also by the World Health Organization. There is evidence that the standard has exerted a considerable beneficial influence on the quality of manufacturing and handling of drug operations in Canada. This effect will, no doubt, be increased if the standard is made to apply to a larger proportion of drugs sold.

There may also be some grounds for hope that an increase in competitive buying of drugs will exert a downward influence on prices. In any event, a high standard of production in Canadian industry is the obvious aim of the federal government to the end that Canadian products may be fully competitive in the present state of the world.

The CHAIRMAN: Thank you, Dr. Showalter. Mr. Ellis, you have a short statement?

Mr. BRAND: Now that Dr. Showalter has made a very comprehensive statement, could we perhaps direct some questions to him before we go on to another area?

The CHAIRMAN: Mr. Ellis has the last statement to be given. You have Mr. Ellis' statement before of you.

Mr. I. C. ELLIS (*Pharmacist, Department of National Health and Welfare*): Do you wish me to read that, Mr. Chairman?

My only reason for putting forward a statement, Mr. Chairman, is that the Department of National Health and Welfare does have a variety of programs. We all seem to go along in different directions in the procurement of drugs. The Medical Services Branch, which covers the activities of the Indian health services and northern health services, sick mariners services and civil service health, requires pharmaceuticals and continuing supplies in varying amounts. The Emergency Health Services Division of the Health Services Branch require large annual purchases of drugs and pharmaceuticals for additions to, and resupply of, the national stockpile. One which is not mentioned in the statement which I have distributed is the requirement of the field inspectors of the Food and Drug Directorate, who make on-the-spot purchases of samples for cash in drug stores in order to carry out their responsibilities.

With reference to the manner of procurement, the bulk of the drug and pharmaceutical requirements of the Medical Services Branch are acquired by requisitioning on the Department of Veterans Affairs central medical stores—and I would imagine that the gentlemen from the Department of Veterans

Affairs will speak further on that—for shipment to service hospitals and other treatment facilities operated by the branch. Items ordered are based on a catalogue of pharmaceuticals and medical supplies, which is published by the branch. The nomenclature used is largely generic, but new products to which generic titles have not yet been assigned may be listed by brand name.

In addition to that, we have a requirement—and I have a word of explanation here, because I know that we have a number of physicians around the table. We have consultants and fee-for-service physicians who have their pet pharmaceuticals and drugs, and we endeavour to meet their demand. For this reason we requisition many pharmaceuticals, specialties and brand name products through the Department of Defence Production. If there should be recurring requests for certain products, or for the products of a specific manufacturer, we ask the Department of Defence Production to arrange standing order agreements against which designated establishments may call up deliveries as required. The nomenclature used on this type of purchase is generally the manufacturer's brand name.

In addition to this, the Medical Services Branch has arrangements with pharmacists in locations not convenient to service facilities whereby these pharmacists fill prescriptions issued by fee-for-service physicians to local beneficiaries of a treatment activity of the branch.

I might also add that all treatment facilities and all appointed medical officers of medical services have authority to meet medical emergencies by immediate local purchase action. They do not really have to depend on any of these sources.

As far as the emergency health services national stockpile program is concerned, the requirements are met through purchase by the Department of Defence Production for delivery to a central warehouse in Ottawa. There is a direct involvement of the Surgeon General's staff, Department of National Defence, because the nomenclature, product descriptions and specifications used are the same as those used for defence procurement, and quality control is achieved through use of that department's inspection services.

Field inspectors of the Food and Drug Directorate purchase sample packages directly from commercial outlets, as I previously mentioned.

The other question which you raised in your letter to my minister, Mr. Chairman, was the matter of quality. I am happy to be able to say that none of the branches concerned has reported any criticism of the quality of drugs and pharmaceuticals received through these various methods of procurement.

The CHAIRMAN: Thank you, Mr. Ellis.

Gentlemen, in explanation of the relatively large sheet that you have before you, I have provided Mr. Erskine with the names of twelve drugs that are commonly purchased and are in common use throughout Canada. I asked him to take the names of those twelve drugs and provide the Committee with the number of firms that tendered on the last government purchase of each of those drugs, a list giving a few examples of the lowest prices that were given in the tenders, the actual contractor who was awarded the tender and at what price he was awarded the tender.

In addition to that, there is a list showing which department used the drug, and the quantity of the drug ordered is also given, and in some cases over a million tablets at a time have been ordered.

For the record, the twelve drugs which I listed for Mr. Erskine are, by trade name: Chloromycetin, Achromycin, Gantrisin, Pentids, Decadron, Librium, Equanil, Enovid, Butazolidin, Mobenol, "222" and Premarin. Each one of those products is put out by a different drug company and each is in fairly common usage. We asked for the common sized tablet in each case, 100 tablet price, with the exception of "222's" for which we asked for the 1,000 tablet price. This is the explanation of this large price list that you have before you.

Is it agreed that this list be incorporated as part of today's Minutes of Proceedings?

Some hon. MEMBERS: Agreed.

The CHAIRMAN: The meeting is open for questioning. Mr. Mackasey.

Mr. MACKASEY: Mr. Chairman, I have a few questions that I would like to direct to Dr. Showalter, if I may.

I was present two years ago, Dr. Showalter, when you came before us with your 74-GP-1a. Have there been any revisions?

Mr. SHOWALTER: The revision in October of this year is 1b.

Mr. MACKASEY: Is there any great difference between the two?

Mr. SHOWALTER: Standard 1b is more stringent.

Mr. MACKASEY: In what area? It is stringent in what manner?

Mr. SHOWALTER: There is a rating system, as I mentioned, and for each of those sections you must meet a certain rating. Some of the sections had only to be met to the extent of 70 per cent in the 1a issue; In the 1b, I think it is four sections that now require a 90 per cent performance.

Mr. MACKASEY: Dr. Showalter, I wish to refresh my memory. I will use 1a because I am more familiar with it. We will start with section 5—premises and equipment. You lay out very excellent minimum standards. Who carries out this inspection?

Mr. SHOWALTER: The Food and Drug Directorate.

Mr. MACKASEY: Section 6—sanitation: Would this be the Food and Drug Directorate, as well?

The CHAIRMAN: Perhaps we should register a "yes" to that.

Mr. SHOWALTER: Yes; the entire standard is judged on the basis of evidence produced in the Food and Drug Directorate inspection.

Mr. MACKASEY: I will get to the Food and Drug Directorate afterwards. Who provides the health certificate to personnel under section 8?

Mr. SHOWALTER: I do not see the section to which you are referring.

Mr. MACKASEY: Section 8 says that everybody working in the manufacture should be healthy. Who issues the certificate of health?

Mr. SHOWALTER: I do not know that. The inspector would determine whether there is a practice in the plant of checking health troubles and of seeing to it that personnel not suitable are not on the job. This is the system, and to the extent to which that system works the inspector would give a rating under that section.

Mr. MACKASEY: But we do not have under government jurisdiction any plan whereby an employee has to prove to someone's satisfaction that he has a certain standard of health?

Mr. SHOWALTER: No.

Mr. MACKASEY: The inspector goes into a plant. What confuses me a little is how he determines who is, or is not, healthy? What standard or test does he use?

Mr. SHOWALTER: Well, I think one should ask the Food and Drug inspectors this, but I do not think that it is possible to have perfect enforcement of every point in the standard demonstrated at the time of inspection.

Mr. MACKASEY: Section 9—raw material tests: Each lot or batch of raw or bulk material used in the processing of the drug in dosage form shall be tested to ensure identity and purity of such raw or bulk materials. It says, "each lot". Who carries out this test?

Mr. SHOWALTER: The company does.

Mr. MACKASEY: And what do they do with the test?

Mr. SHOWALTER: It is recorded in their files. The inspector searches the files to find if he can detect the—

Mr. MACKASEY: The Food and Drug Directorate. In other words, all these tests are carried out on the premises by employees of the company and the results are filed for the inspector to check periodically?

Mr. SHOWALTER: It is not essential that the tests be done on the premises. It is required in the standard that the quality control system be on the premises, but quality control system is a system of supervision of various types of operations which, added together, make a quality control. Individual parts of those may be done elsewhere. You may have no spectrophotometer. You may rent one from another laboratory.

Mr. MACKASEY: Does the inspector or company run it?

Mr. SHOWALTER: I am referring to the operations of the company. The inspector's task is merely to look at the operations of the company.

Mr. MACKASEY: How often does the Department of Industry insist on a report from the Food and Drug Directorate on whether these things are being carried out on the premises of your suppliers?

Mr. SHOWALTER: First of all, I should explain that I am speaking not for the Department of Industry but rather for the Inter-Departmental Board which I described earlier.

As Chairman of that Board, I do not normally request an inspection by the Food and Drug Directorate of a company unless there is a specific reason. They have inspections of their own going on regularly. They do not, I believe, inspect all companies with the same regularity, but I do not know what that regularity is.

On occasions when they are inspecting a company that they know wishes to be inspected for 74-GP-1, they send me the information about the inspection. I will, however, request an inspection if a new company comes to me and says it wishes to be listed, or if a company which has been disqualified for some reason comes back and says, We are now ready to be inspected again.

Mr. MACKASEY: You mentioned two occasions, one of which is when a person is requesting the right to tender. Do you, under any circumstances, permit that company to tender before the Food and Drug Directorate has given it a clean bill of health?

Mr. SHOWALTER: No; if they do not appear on the list, the departments normally do not purchase from that company.

Mr. MACKASEY: Not until the Food and Drug Directorate has established to everybody's satisfaction that this is a legitimate, safe source of supply?

Mr. SHOWALTER: That is right.

Mr. MACKASEY: Naturally, in other cases, where the company has been disqualified for, say, dirty light bulbs, they have washed them in the meantime and they reapply? I ask this because the last time we had the Food and Drug Directorate before us Dr. Morrell made a very strong case of the fact that they are badly understaffed, and statistically we established two years ago that they did not have enough personnel to inspect the premises of all the manufacturing pharmaceutical outlets in Canada more than once every three and a half years, I think it was. I am wondering how you get around this obvious staff shortage in the Food and Drug Directorate?

Mr. SHOWALTER: Well, I do everything possible to avoid any unnecessary load on the Food and Drug Directorate. If a company comes to me and says that it wishes to be inspected, in order to avoid unnecessary inspection I say to them, "First, give me a story which will be your evidence that you have checked your operations carefully yourself." Often you believe that they have. When they send me a satisfactory statement, only then do I request the Food and Drug Directorate to make an inspection.

Mr. MACKASEY: I think you should be quite proud of the fact that after two years it has proved to be such a safety factor for the users of drugs purchased by the government. I am a little puzzled, however, in reading through these eight or nine pages and in looking over the list of people who normally supply the different agencies, when I come across a firm with an address, 1245 Sherbrooke Street West, Suite 1430, Montreal 25. I have no idea who they are. The only reason for picking it out is that I am familiar with the Montreal area, and knowing Sherbrooke street, 1245 must be around the centre of it. The name of the firm is Immuno. I am wondering about all these physical facilities that appear in here. Suite 1430 seems to be a rather glamorous address for a drug company. How can this happen? Can anyone explain this to me?

Mr. SHOWALTER: Mr. Chairman, I do not myself inspect these plants.

Mr. MACKASEY: I am not trying to blame anyone. I know that you have set up this thing and that it is foolproof provided that everything is carried out according to the plan. If the plan breaks down somewhere we want to help you by publicizing it.

There may be a pharmaceutical manufacturing outlet at that particular address in the heart of Montreal, in suite 1430, but the very impressive list of premises and equipment would hardly seem to be appropriate to a suite. There are one or two others here. There is one in Nova Scotia that also intrigues me a little. However, I am familiar with this one.

I am just wondering whether anyone has had occasion to buy from Immuno. Perhaps you could give me the answers later. I do not need them this morning. If I could have them this afternoon I would appreciate it.

The CHAIRMAN: Perhaps this is just an agent, or a mailing address.

Mr. MACKASEY: I would imagine that; but I am always suspicious of organizations hiding behind mailing addresses, particularly when dealing with drugs. I would like to know, from the Food and Drug Directorate, when was the last time that inspectors visited the premises of Immuno.

Mr. SHOWALTER: I am afraid I cannot answer that this morning, Mr. Chairman.

The CHAIRMAN: The Food and Drug Directorate are reappearing before the Committee on January 26, and I would ask that they bring that information.

Mr. MACKASEY: I would like to get it this afternoon. It should not take two minutes to find out whether or not you buy from Immuno. Certainly when he calls the Food and Drug Directorate it does not take Dr. Showalter a month to find out who has, or has not, been inspected. This leads to the other factor, Dr. Showalter, which has impressed me greatly—and I say this in all sincerity—that your standard has, according to your own statement, a certain amount of—not notoriety—justifiable compliments. Do you sometimes have cases of drug companies running around the country afterwards and saying, "We have passed the acid test. Why can we not sell your agency? This is something like the Good Housekeeping stamp of approval. Has this type of complaint been brought to your attention?

Mr. SHOWALTER: Mr. Chairman, this has not been the subject of complaint. We are aware that this is being done. I think the Board would probably say that they wish it were not being done. However, we do not feel that we can stop it.

Mr. MACKASEY: You mentioned that you do get requests from various other organizations, provincial bodies, European firms, and so on. In your correspondence with them do you emphasize the fact that there are certain limitations on this standard?

Mr. SHOWALTER: The list that we distribute to those who want it nowadays carries a preamble which describes the limitations of its use and the obligation placed upon those who use it which is principally to report material that is not in conformity—material that is found unsatisfactory—that they receive from a listed company. It does not in any way enjoin companies to keep quiet about their status.

Mr. MACKASEY: Well, the Chairman is looking at me very sternly. I have just three short questions.

The CHAIRMAN: Three short minutes.

Mr. MACKASEY: What prompted that question is that in the section entitled "Scope" you have a warning: "Conformity with this standard, as judged by any purchaser, is not to be construed as a guarantee of quality of products, or as evidence of products of any manufacturer are superior to those of others. This standard does not apply to the skill used in developing, designing or manufacturing these products, to the hazards of their use, or to their stability in storage."

It seems to me, however, that these are important factors which should be considered by purchasing agents, such as the stability in storage.

Mr. SHOWALTER: Well, there are two ways in which the purchasing system in government deals with that problem. One is the specification to which the product is bought in the first place, and the other is the demerit system in the standard itself, which is a sort of "after the fact" assurance.

Mr. MACKASEY: Well, I would like to see, in your correspondence with other bodies, a little more emphasis on the warning, particularly about stability, because some of these purchasing agents may, in good faith, buy on the strength of a name such as Immuno, and overlook the fact that the goods they purchase may not conform to their stability requirements because of their usage and so on.

I have one last question. Perhaps someone else will answer it, but I would appreciate it, Dr. Showalter, if you could.

I compliment you on the fact that in every case the lowest tender has been awarded the contract, which I think is healthy. Nevertheless, do you get cases, for example, in a D.V.A. hospital where a doctor has prescribed a medicine and refuses to accept what he gets? In other words, he may require Stelazine or Librium. Do you run into cases where he refuses to use a substitute, if there is a substitute?

Mr. SHOWALTER: I think this is a question that the user department ought to answer.

Mr. MACKASEY: If anyone could answer this, I would appreciate it.

Dr. K. S. RITCHIE (*Assistant Deputy Minister, Department of Veterans Affairs*): Mr. Chairman, we have had instances where members of the attending staff who have, in their original requisition, specified that they wanted a brand name product, and, it is being the practice to order by generic name and to go to tender, they have been supplied with a product from some other firm. We have had instances where a doctor has refused to use the product because he was completely familiar with the properties of the product he had originally ordered. He had probably tested the other product informally, either in his own private practice or within the department, and had found that the name product was a better product.

We do not attempt in the department to regulate the actual drugs that a physician may use. If he feels that a particular product is better for the care of a patient we accede to his judgment unless we feel that the generic name drug from another manufacturer is equally good. We try wherever possible to accede to the request of the practitioner.

Mr. MACKASEY: You made one significant qualification. You said "—if we think... that the generic equivalent is as good". Is this not the prerogative of the physician?

Mr. RITCHIE: Well, there have been instances where a product has been quite acceptable under the generic name in one hospital and with a practitioner of probably equally good standing, but it is not acceptable in that community.

Mr. MACKASEY: I leave it to the doctors in the committee to follow this up. If they will follow up on that one, I am not going to bother. What prompted this is

that in reviewing the Restrictive Trade Practices bible, as I call it—which is a very good reference book—I see this paragraph at page 488:

> The prescribing physician's first aim should be to select—

And I emphasize "the prescribing physician's first aim"—

> —the most suitable drugs for the treatment of his patient. Only when two or more drugs are approximately equal in their treatment value, or when the physician has a genuine doubt as to which drug will be most effective, should economic considerations be taken into account.

It seems to me that the one weakness in our system—and perhaps it is a desirable one—is that purchasing agents may have a tendency to substitute a generic drug, or vice versa, despite the fact that the original requisition coming in from the doctor is more specific.

Mr. RITCHIE: Well, where the product is requisitioned by the hospital under a no substitute title, then this is ordered for that hospital in particular.

Mr. MACKASEY: I have one final question, Mr. Showalter. Some publicity was given in the press a few weeks ago to drugs being flushed down a basin. Have you any comments on this? Do you know of any such instances since these regulations have been in force, or is this something which took place prior to their establishment?

Mr. SHOWALTER: I would not know about any of those cases.

Mr. MACKASEY: Why would you not know, if they exist?

Mr. SHOWALTER: I receive reports, but I have received very few from the user departments indicating that a material has failed to meet the purchase description when bought on contract. In those cases, it is my function to see to it that the Board decides on the application of these demerit points provided in the standard, if they are appropriate.

Mr. MACKASEY: Mr. Chairman, I have a few other questions, but perhaps I should leave the discussion to someone else.

The CHAIRMAN: Gentlemen, before we move on to Dr. Rynard, I think we should print Canadian Government Specifications Board Standard 74-GP-1b as part of today's record. Is that agreed?

Some hon. MEMBERS: Agreed.

The CHAIRMAN: With reference to Mr. Mackasey's question, as a practising physician I can tell you that I do receive mail from several drug companies saying: "We are proud to announce that we do meet these specifications".

Mr. RYNARD: Mr. Chairman, it appears to me, from the complexity of all the data we have, that we are rapidly being locked up in a prison of bureaucratic controls, and that it is operating at about the lowest level of efficiency. The question is asked: What is done to correlate health standards? There are no standards. There are no X-rays, there is no checking to see what the skin conditions are or whether the person is fit to work there. This is a ridiculous situation, after all the reams of printing that we have done, and with all the regulations and all the orders. I have to reiterate, that we are becoming locked up in bureaucratic controls, in a prison of our own. We are operating at the lowest level of efficiency. I think it is pitiful to see us get into this situation. I say this with a spirit of kindness, because it is quite evident, from the questions

which have been asked here this morning, the mass of material with which we have been furnished and the answers we have received, that we do not know what is going on. We have pointed a lot of standards, and we still do not know what is going on. What sort of efficiency is that? I am not criticizing anybody.

The CHAIRMAN: Dr. Showalter did say that the inspection services were up to the Food and Drug Directorate. I do not think his knowledge—

Mr. RYNARD: This is not the point at all. We have not got the answers. He has not the answers. He did present the regulations to us, but he has no idea whether or not they have been carried out. This, as was very well put on the record by Mr. Mackasey, that it may take two or three years.

How do you know whether or not someone is working in that plant, who has tuberculosis or some skin condition?

You said the lowest tender was not always accepted. I was interested in that. I would like to know why the lowest tender is not accepted, and by what standards you judge when you refuse the lowest tender?

Mr. ERSKINE: If the lowest tenderer has met the requirements of 74-GP-1 he would be awarded the contract. He would be invited to tender and unless we had an adverse report it would not occur until after the user had carried out his inspection. At that time the remedies provided in the terms and conditions of the contract would be implemented.

Mr. RYNARD: Do you run any tests on the drugs before you purchase them?

Mr. ERSKINE: We do not ourselves; the users are responsible for the inspection.

Mr. RYNARD: In other words, you take a drug with a generic name, which has not been tested, as far as you are concerned, and you use it?

Mr. ERSKINE: No, that is not true. We do not use any drugs; we merely buy what the user—

Mr. RYNARD: You purchase it for the hospital?

Mr. ERSKINE: That is correct.

Mr. RYNARD: In other words, there is no chemical test on them, so far as you are concerned?

Mr. ERSKINE: No, the tests are run by the inspection agencies named in the purchase document.

Mr. RYNARD: You mean, you do have them tested?

Mr. ERSKINE: Well, tests are carried out. We do not do them in my department.

Mr. RYNARD: On every batch of drugs that you purchase?

Mr. ERSKINE: I cannot speak for the entire inspection procedures of the three major user departments. I am not familiar in detail with just how they inspect.

Mr. RYNARD: I wonder if we could have that answered, because I think that it is important? Have you found that any drugs which you have been using have clinically not come up to the standards that the doctors felt that they should, or with which they were not getting the response in the treatment of the patient? Did you have to discontinue any of these?

Mr. ERSKINE: I am afraid I can only answer by quoting what Dr. Showalter said, that since this new standard has created an environment for the manufacture of these drugs and pharmaceuticals the incidence of unacceptable drugs had dropped very sharply.

Mr. RYNARD: Yes; but I think you will agree with me that we are not given the answers on this.

Mr. ERSKINE: I am sorry; it is not within my—

The CHAIRMAN: Perhaps we should allow the user departments, who are here, to answer your question.

Mr. RYNARD: Let us ask them now, so that we can get the answers.

The CHAIRMAN: I am just pointing out that you are not asking the right person.

Mr. RYNARD: You direct it right, Mr. Chairman.

The CHAIRMAN: We have a representative from each of the three user departments.

Mr. RYNARD: I am overwhelmed by the staff.

The CHAIRMAN: Mr. Poyntz represents the Department of National Defence.

Mr. H. H. POYNTZ (*Director, General Requirements, Department of National Defence*): Mr. Chairman, we carry out a very stringent test procedure on all our bulk purchases of drugs. Before we actually accept them they are inspected by the quality control branch of Materiel Command, or, biologically, by the Food and Drug Directorate. Only after that test has been carried out are they accepted.

Mr. RYNARD: Have you any idea—and I do not know that you would have—what it is costing you to do this testing?

Mr. POYNTZ: No; it would be very difficult to define. The quality control branch of Materiel Command is involved in all types of testing for the Department of National Defence.

Mr. RYNARD: You have no way of separating the costs of this particular program?

Mr. POYNTZ: I would say it would be very, very difficult.

The CHAIRMAN: Can we ask each of the departments in order?

Mr. ELLIS: Mr. Chairman, as far as the Department of National Health and Welfare is concerned, we depend on our two suppliers, as I pointed out in my statement. We get all our drugs from either Department of Veterans Affairs or through the Surgeon General's Branch of the Department of National Defence. We depend on the testing procedures of those two departments.

I can make an unequivocal statement though that we have had not a single complaint of lack of efficacy in our drugs. This was borne out this past week by phone calls to four senior pharmacists across the country.

Mr. RYNARD: Mr. Chairman, it seems to me that there was an article in the press—of course, you cannot believe all of what appears in the press—that some of the drugs were being resold. I am wondering where this rumour started. I was

phoned on a couple of occasions and asked about it. If this is untrue, and government agencies have never resold drugs, then I think we should make the unequivocal statement that no drugs which have been used in any government agency have been found to be inefficient and have been disposed of in any way. If we could make that unequivocal statement I think it would do a lot to clear up some of our problems.

Mr. M. G. ALLMARK (*Assistant Director General, Drugs, Food and Drug Directorate, Department of National Health and Welfare*): Mr. Chairman, I would like to make it clear that the responsibility of the Food and Drug Directorate in this area is to test those drugs which are referred to them by user departments. During the last couple of years we have examined many, many drugs, and unfavourable reports are sent back to the user departments. It is up to those departments to dispose of those drugs as they see fit.

Essentially, this is our responsibility in this purchasing area.

The CHAIRMAN: Would you like to comment on the earlier statement. Dr. Ritchie, about what your department does when they buy a batch of drugs?

Mr. RITCHIE: If any product is supplied to us with which we are not familiar, if we do not know that this is a satisfactory supplier in our own minds then the drug is quarantined by our central medical stores, or, locally, by our district pharmacist, and the drug is tested by the Food and Drug Directorate. I may say that in all instances these tests have been reported satisfactory, and the drug has been released for consumption.

The CHAIRMAN: Perhaps we could ask the two gentlemen from the two main departments. In reference to Dr. Rynard's last question, has your department ever resold any drugs which it has purchased?

Mr. RITCHIE: We have returned drugs to the manufacturers.

The CHAIRMAN: But you have never resold them?

Mr. RITCHIE: No.

The CHAIRMAN: Could we ask Mr. Poyntz the same question? Has the Department of National Defence ever resold drugs?

Mr. POYNTZ: We do not resell. We declare to Crown Assets Disposal Corporation, in accordance with regulations.

If we have drugs which have become surplus, for one reason or another, which, after test—if the quantity is sufficient to justify testing—still prove adequate, they are then declared to Crown Assets Disposal Corporation, and they can sell them. These can be drugs of various types that we are no longer using. They are good drugs if they are declared; otherwise they are not declared, and therefore could not be sold.

Mr. RYNARD: Mr. Chairman, I am going to bring my questioning to an end. Unfortunately, I have to leave. However, there is one other question that I would like to have answered.

Do the doctors working in those hospitals under the Department of National Defence, or under any other government agency, have to use the stock drugs. They cannot specify the drug of their choice or the drug that they feel would do the best job?

The CHAIRMAN: I think Dr. Ritchie answered that question earlier.

Mr. RITCHIE: This is not true. Doctors may specify a particular drug for the treatment of his patients in that particular hospital, and indicate no substitute. If this is signed by the superintendent of the hospital this drug is ordered and supplied.

Mr. RYNARD: Does this ever happen?

Mr. RITCHIE: Yes, very frequently.

Mr. RYNARD: You have bills then? Thank you very much.

Mr. ORLIKOW: Mr. Chairman, first of all, I would like to commend you for helping us do our job. From what I know, as a one-time pharmacist, you have in your list a very good cross-section of drugs which are very commonly used.

I may be stupid or a little dense, but I would like a little more detail on what these things mean. For example, let us take Chloromycetin. We have a long list of the companies which were invited to tender. We have four companies which actually did tender. They were asked to tender on Chloromycetin, 250 milligrams, in quantities of 100 tablets. The prices range from $3.25, by the low tender, which was accepted, to $8.80. How were these supplied? Were they supplied in bottles of 100, or were they supplied in larger quantities? You bought 180,000 tablets. Did they come in bottles of 100, or did they come in larger quantities?

Mr. POYNTZ: That will be specified in the purchase description under which they are ordered.

Mr. ORLIKOW: In other words, they were supplied in bottles of 100 tablets?

Mr. POYNTZ: If they were called up in bottles of 100.

Mr. ORLIKOW: Now, I notice you say that the manufacturer is Parke Davis. You purchased the quantity you required from a different company, Laboratoire Pentagone Ltée. Did they purchase from Parke Davis the drug that they supplied, or is that a generic?

The CHAIRMAN: I am sorry; that confusion may be my fault rather than theirs. When I prepared the list I put in the trade name and the trade name manufacturer. They actually bought under a generic name, which is listed there. On that list it just means the manufacturer of the trade name drug. It was actually purchased under Chloramphenicol.

Mr. ORLIKOW: I understand that; but I wonder whether the department knows who was the actual manufacturer of the Chloramphenicol which it purchased? Is Laboratoire Pentagone a manufacturer, or a distributor, or does the department know?

Mr. SHOWALTER: I happen to know that Pentagone is not a manufacturer.

Mr. ORLIKOW: Therefore, they would purchase elsewhere? They would purchase in the United States or in Europe?

Mr. Chairman, I want to get this on the record, because we have been told again and again by the large companies who have been here that there is a danger that if the generic drugs are used the quality will not be satisfactory. Are the user departments satisfied that the Chloramphenicol which was purchased and used in the various government hospitals and so on was satisfactory? Have there been any complaints that the Chloramphenicol used was not up to the standard desired by the doctors who prescribed it?

Mr. ERSKINE: Mr. Chairman, this particular purchase was made by the Department of Veterans Affairs, and so far as I am aware there have been no complaints.

Mr. LAROCQUE: This drug was purchased by the Department of Veterans Affairs, on our own tender, prior to the Department of Defence Production taking over. It goes under the trade name of So Framycetin, and I believe the manufacturer is the Royal Dutch Fermentation in Holland.

This drug has been tested in various forms over the years, and this current purchase is now being tested at the Department of National Health and Welfare. I do not think that I have a report on it as yet.

Mr. MACKASEY: Are we talking about the top sheet?

Mr. LAROCQUE: That is right.

Mr. MACKASEY: You refer to it as what?

Mr. LAROCQUE: Chloramphenicol is the generic name. This firm, Laboratoire Pentagone is supplying it under a trade name of So Framycetin. Each drug, even although you ask for it by its generic name, generally has a trade name, on their own label.

Mr. MACKASEY: Is this trade name registered in another country?

Mr. LAROCQUE: I believe that it is the Royal Dutch Fermentation of Holland. I would not swear to that, however.

Mr. ORLIKOW: Mr. Chairman, just for the record, I would like to point out that the department was able to purchase at the price of $3.25 per 100, and that Parke Davis, which is the big manufacturer or distributor in Canada, offered them to the department for $6.39 per 100.

I made a phone call after we got this table. The list price which Parke Davis offers to retail druggists in Canada is $39.40 a hundred; the discount which the druggist gets is 40 per cent. The retail druggist therefore pays $23.64 for 100 of these capsules which Parke Davis offered to the department for $6.39 a hundred. I think it is an interesting comparison.

I would like to turn, Mr. Chairman, to the sheet on Librium. I notice that here again prices were asked for 10 milligram tablets in bottle sizes of 100 tablets. I notice that Hoffmann-La Roche, which tendered the lowest price, offered them to the Department for $2.60 a hundred, in bottles of 100 tablets. The price to retail drugstores by Hoffmann-La Roche is $12 a hundred, list price. We take the 40 per cent off, and the price which the retail druggist pays is $7.20 a hundred.

Mr. Chairman, I am very interested in item 7—Meprobamate. I noticed 400,000 tablets were purchased. This is a very commonly used tranquilizer. I notice that the department was able to purchase them for roughly 35½ cents a hundred tablets. I wonder if we could be told whether the company from which they were purchased make them in Canada, or whether they purchase them elsewhere?

Mr. ERSKINE: I would not have any information on this.

The CHAIRMAN: This was for the Department of National Defence. Do you have any idea, Mr. Poyntz or Mr. Friesen? Where would the Meprobamate have been originally manufactured? Is that your question, Mr. Orlikow?

Mr. ORLIKOW: Yes.

Mr. ERSKINE: Bell-Craig Pharmaceuticals.

Mr. A. R. FRIESEN (*Department of National Defence*): That would be manufactured in Canada.

Mr. ORLIKOW: I would like to get on the record whether the department is satisfied that the products they purchased is satisfactory and that there have been no complaints from the doctors who prescribed it that they did not get the results they expected, or that there were any adverse results.

Mr. FRIESEN: We have had none.

The CHAIRMAN: There is one point I would like to put on the record for your information, Mr. Orlikow. You asked if they were buying them in 100 tablet containers. It depends on what it says in the tender. As an example here, I have two tenders before me, one covering Meprobamate; those were not purchased in bottles of 100, but in bottles of 500. One other example is Sulfisoxazole—Gantrisin; the total purchase was 500,000 tablets, and those were purchased in bottles of 5,000 rather than in bottles of 100.

Mr. ORLIKOW: Mr. Chairman in the case of the Meprobamate I notice that the department was able to buy them for 35.6 cents a hundred. John Wyeth, which is the biggest distributor of the brand name, Equanil, offered them at $1.44 a hundred, whereas the list price to retail druggists, which Wyeth quotes, is $3 for 50, and with 40 per cent off that is still a very substantial amount more than the $1.44 for which the department was able to purchase them.

Mr. Chairman, I wonder whether anyone from the various departments would care to make any further statement. I think we need to emphasize the point—and I do not want to put words in their mouths that throughout the record of these hearings we have constantly heard the suggestion by the large companies that if users use drugs which are generic drugs imported, or made by smaller companies, there is a distinct possibility—and I wish I had looked through the record, because I do not want to misquote them—that they will get a drug which is inferior in quality. I wonder whether the departments would like to make any further statement on their experience in the purchase of generic drugs. Obviously, they are purchasing these very commonly used drugs listed. Have they—particularly the users—any further statement to make on these generic products?

The CHAIRMAN: What you are asking is if they have any examples of drugs that have been rejected because they were not safe?

Mr. ORLIKOW: Yes; and, if they have, what is the percentage of the cases, and so on. What is the experience of the hospitals operated by the Department of Veterans Affairs?

Mr. LAROCQUE: We have bought many generic drugs and in each case we have attempted to have them tested by the food and drug laboratories. We have had very few rejections, on the whole. Since 74-GP-1 came into effect, I think there is only one I can recall, offhand, our hospitals have used these drugs and no one has said that they were not medically effective.

Mr. ISABELLE: May I interject, Mr. Chairman? Are you speaking about the Department of Veterans Affairs?

Mr. LAROCQUE: The Department of Veterans Affairs only, yes. In the case of the Gantrisin or Sulfisoxazole tablets we bought 500,000. This is a fair quantity, and enough to make it a special run. A normal drug store is well stocked if they have 500 or 1,000. In the case of Chloromycetin by Parke Davis, the normal drug store will have perhaps 16 to 32 capsules on hand, and perhaps up to 100 in the bigger stores. We buy, or we will use 50,000, a month, which, I think, is our requirement. This is one reason, I think, for the considerable difference between the retail drug store price and the departmental price.

Mr. MACKASEY: On a point of order, and only because of Mr. Orlikow's mention of librium. I want to be accurate. It is not that I want to ask questions. He mentioned librium as selling for $7.20 to the druggist, but I notice that there were 15,000 capsules bought on this tender, and I have been informed that for the same quantity sold to a drug store it would be $4.86 and not $7.20. It does not change the principle, but for the press it could—

Mr. ORLIKOW: I said the list price was $7.20—no; I said $12.

Mr. MACKASEY: You said $12 less 40 per cent, which brings it to $7.20.

Mr. ORLIKOW: Yes.

Mr. MACKASEY: But you did not mention the quantity; and in the identical quantity, the price would be $4.86 for librium.

The CHAIRMAN: I think we interrupted in midstream here. Would Mr. Poyntz and Mr. Friesen like to comment on Mr. Orlikow's question about the safety and the rejection of drugs?

Mr. POYNTZ: Yes, I think we can say that, with the introduction of GP-74-1, and the further protection which National Defence has called up on its requirements—which is a guarantee or warranty under which the goods are warranted to meet the specification for a period of three years, or are returnable for full credit—we are almost assured of better quality, particularly when the drug is tested before we even accept it; and there have been very few instances of drugs being rejected after they have been accepted, since the introduction of this standard and this guarantee.

Mr. ORLIKOW: Mr. Chairman, these are all the questions I want to ask now.

It seems to be obvious from what we have heard this morning, that, providing there is adequate inspection of all drugs, including generic drugs, by some government agency the public could be assured that the drugs they get are of high quality and meet all the standards of the medical professions and I think it is obvious from the figures provided that they could save a substantial amount of money.

I think this goes a long way to answering the questions which this Committee was set up to inquire into.

Mr. ISABELLE: I am a bit confused, but I am trying to understand. I want to know how you proceed when you are buying drugs. Do you go after quality first, before asking for tenders, or do you go for quality after your pharmaceuticals are bought? In other words, how do you proceed when you buy drugs? Do you invite tenders first?

Mr. ERSKINE: Mr. Chairman, we follow our standard buying practices. We receive a requisition from the user department, which specifies the particular

drug or pharmaceutical required, the quantities and the delivery date, and we go to all the known sources of supply that have met the requirements of 74-GP-1. When the tenders are received, providing the company is in good standing and has met the requirements of the specification, and we have no adverse reports on their products, the contract is awarded to the lowest tenderer.

Mr. ISABELLE: As you said before, you do not do the research, nor do you test anything you buy.

Mr. ERSKINE: Not before, no. The test takes place after the user gets it. He checks it before he puts it into service.

Mr. ISABELLE: In other words, you buy drugs in the same way that you would buy potatoes for the department?

Mr. ERSKINE: That is correct.

Mr. ISABELLE: There is no question of quality before; that only comes after.

Mr. ERSKINE: The same as I would do myself in going into a drug store. I simply rely on the integrity of the man who sells it.

Mr. ISABELLE: On the doctor.

The CHAIRMAN: If I may interrupt, with one exception; they invite tenders only from people who have already passed the Specifications Board.

Mr. ERSKINE: I think I mentioned that, Mr. Chairman.

Mr. ISABELLE: If I understand correctly, you buy drugs in the same way as you buy tomatoes and potatoes, and those who are buying them are the Department of Defence Production, the Department of Industry, the Department of National Defence, Department of National Health and Welfare and the Department of Veterans Affairs. There is no one buyer. There are four different buyers.

Mr. ERSKINE: No; actually there is ony one buying department now, and that is the Department of Defence Production. The Department of Defence Production buys for the Department of National Defence, and the Department of National Health and Welfare's requirements are normally supplied out of the Department of National Defence stocks, or are purchased by D.V.A. for the Department of National Health and Welfare. This is a private arrangement between them. The major customer is the Department of Veterans Affairs.

Mr. ISABELLE: But there is only one buyer—

Mr. ERSKINE: One purchasing department.

Mr. ISABELLE: —who buys, and you have a special arrangement for D.V.A.

Mr. ERSKINE: If I may, Mr. Chairman, there are exceptions, in that all departments are granted small, local authority to make emergency purchases within the locality where the medical unit is located, whether it be a hospital or a treatment centre; they are allowed to buy things themselves under the authority granted by the department. These are small purchases.

Mr. ISABELLE: How can you explain that in the Department of Defence Production, 95 per cent of the drugs are bought under generic names; in the Department of National Health and Welfare, 85 per cent of drugs are bought under the generic name; and in D.V.A.—in which department you said that you

did not have any trouble with them—65 per cent are generic drugs and 45 per cent are brand name drugs. What is your reaction to that, if you have one purchasing department?

Mr. ERSKINE: We have no reaction. Mr. Chairman. Our job is to give service to our customers. If the customers demand a particular product, or a particular brand-name product, and their deputy minister approves of this purchase, we will certainly buy it for them.

I also explained earlier that we have only recently started to buy for D.VA. and National Health and Welfare, and we really do not have any statistics as yet to show our percentage of generic purchases as opposed to trade names.

The CHAIRMAN: Before you go on, Dr. Ritchie wanted to comment on what you said.

Mr. RITCHIE: There is possibly one answer to this disproportion between what the Department of Defence Production is reporting as purchases by generic name and what we are reporting on. Actually, I think the information is identical, except that in many instances, there is only one supplier. The drug is therefore ordered by generic name, but it comes from the one supplier.

Mr. ENNS: I would like to ask a supplementary to the questions asked by Dr. Isabelle and Dr. Rynard earlier. I was out for a few minutes.

Even although the request is made in the generic name, is it not true that in the list of the 12 drugs, the suppliers have not always been generic drug manufacturers; they have been actual members of P.M.A.C. This does not reflect the fact that they are all copiers. Is this correct?

I think this is the wrong line of questioning which came up earlier, when we tried to give the impression that the department was using only the supplies or products of the copiers, as we have come to call them. This is not so.

Mr. ISABELLE: Mr. Chairman—

The CHAIRMAN: I was going to say that the government buys from the lowest tenderer the cheapest and on page 6, with reference to librium, the actual tenderer got the contract at a cheaper rate than one of its so-called copiers.

Mr. ISABELLE: Did you have any trouble recently with phenylbutazone?

Mr. RITCHIE: No, we have had no difficulty.

Mr. ISABELLE: I think I have finished. I find it amazing, and very interesting, to know that we buy drugs as we buy potatoes.

Mr. BRAND: I have been impressed by the protestations of innocence by everyone who has spoken today. It reminds me of that Shakespearian line about "Methinks he doth protest too much". Apparently everything has been sweetness and light in all the departments, and we have had no difficulty with any drugs.

Is it not a fact that several D.V.A. hospitals received Paul Maney's trifluorin when they had ordered S.K.F. stelazine, that at least three D.V.A. hospitals returned this product and that the department received a covering letter from the Drug Committee of St. Marys' hospital—which is a vererans' hospital in Montreal—saying that they had no intention of supplying patients with untested drugs from a questionable source. Is this not a fact?

Mr. LAROCQUE: This is an area where the drug asked for was stelazine. There was no substitute clause, and it was not countersigned by the chief of medicine. D.D.P. exercised their right to go out and buy this drug by competition.

Three months ago there was only one source of supply so the name "stelazine" covered it completely. About two months ago a competitive drug came on the market, and D.D.P. exercised their right to go and get it competitively.

Only one hospital that I know of returned the drug right away. We are now investigating this matter, and it is an internal policy of the department that is involved.

The CHAIRMAN: They returned it because of a name rather than quality? Is this what is being investigated?

Mr. LAROCQUE: They did not have testing facilities themselves, and they felt that they did not want to use a drug that was not tested. This drug that we are referring to is now at the Food and Drug laboratory being tested.

Mr. MACKASEY: May I ask a supplementary? You have twice used a phrase which intrigued me—"exercised their right" to substitute something or other for stelazine. Is this right spelled out in our directives or regulations? It seems contrary to the original premise that we established earlier that in the final analysis, the doctor has the right to prescribe for his patient. What right are you talking about when you say "exercise their right"?

Mr. LAROCQUE: The only time a drug is bought on a no-substitute basis is when the requisitioning hospital writes on their requisition, after the drug, "no substitute" and this is countersigned by the chief of service medicine or the senior treatment medical officer. Then only is that brand purchased, and nothing else.

The fact that they put down a trade name on their requisition, does not mean that they want that drug and nothing else, and D.D.P. realizes this. The name there to begin with is merely there as an identification.

Mr. BRAND: Obviously everything is not sweetness and light, and, in fact, there have been returns for some of the reasons that have been suggested.

I trust that the witnesses will be as frank as possible in the future, because I think it is very important in view of the tremendous amount of money going into tranquillizers.

This Committee recently requested, and has received, a comparison of stelazine and trifluoperazine tablets. I noted in going over it that one of them was this Paul Maney drug.

These were very interesting studies made by an independent laboratory, the Warnock Hersey Company Limited, and they showed that trifluoperazine, rather than meeting the standard base, which would be 100, varied, on the average,—and I want to be fair about which one this is—from somewhere around 70 to 80 per cent base instead of 100 per cent; therefore, you are not getting your money's worth. They varied considerably in changes in disintegration time and things of this nature.

Had these particular trifluorins to which I have referred, and which apparently were returned been tested by anyone in any of the departments?

Mr. LAROCQUE: The first shipment which was received by the central medical stores here in Ottawa has been sent over to the Food and Drug laboratories for testing. I have had no report on it.

Mr. BRAND: You mean that it was first sent to the hospital to be used by them, and only when they returned it did you send it over to be tested? Is that right?

Mr. LAROCQUE: No, I did not supply these hospitals; they were supplied directly from the firms.

Mr. FORRESTALL: How would this happen?

Mr. LAROCQUE: It is standard procedure in the department.

Mr. BRAND: Do you mean to tell me that when you order in this way, if the area of consignment is indicated, they go directly to the hospitals concerned and they do not go through to be checked and looked over as we have heard so piously explained this morning—that this is, in fact, not true?

Mr. RITCHIE: I think one has to understand the present requisitioning authority for departmental hospitals. They now raise their own requisitions for most of their drugs and these are processed through D.D.P. I would ask to have this verified.

Mr. LAROCQUE: This is a program that has been goind on for years. We purchase somewhere in the neighbourhood of $3.5 million worth of pharmaceuticals in a year. I cannot possibly stock all these and bring them into medical stores and ship them out. Any large quantities requisitioned are requisitioned directly for that hospital, and shipped directly to them.

In the other areas that I supply I bring them into my medical stores, and I do the checking there.

At one time all the generic products were brought into the medical stores and I reissued, them, but with D.D.P. taking over the purchasing this control became almost impossible, and, therefore, each hospital is responsible for the products which it receives now.

This problem of trifluoperazine, or any other tranquillizer, is very similar to meprobamate. When it first came out we got requests for equanil and no substitute, or miltown and no substitute, but for the last five or six years they have been buying the generic products and been using the generic products, and I have had no reports of any one that is not being used.

Mr. BRAND: May I interject at this point. We have already had evidence before this Committee that all the meprobamate comes from one firm.

Mr. MACKASEY: I am not hearing you, Mr. Brand.

Mr. BRAND: I am sitting directly on top of the microphone.

Mr. MACKASEY: I am not going to apologize for deafness. I depend very much at all these meetings on the amplificiation, not the translation. It is not your fault. I am just not getting it. I noticed that you tried to help and I appreciate it. I would like to sit close to everyone, including the pious witnesses, because I am quite impressed by them.

Mr. BRAND: I will get a bit closer. Does that come through all right now?

Mr. MACKASEY: Yes, that is much better.

In effect, then, what you say is that the hospitals will do their own testing, and with the new method of purchasing drugs they go directly to the hospital, as in this case. Therefore, the statement that was made—and which was denied—earlier this morning, that some of these are bought, and you never see them and they go right to the patients is probably true, in some instances at least? I find it difficult to believe that the average small hospital, or even the large hospital, has available to them sufficient testing facilities to test the quality of these drugs. I just do not believe this, and I would like to be convinced otherwise, if you can do this and are willing to try.

Mr. RITCHIE: I think one has to agree that if a drug is supplied to a hospital and they accept it and issue it to their patients they are accepting the responsibility of doing this. If they are in any doubt they have the facility to have this drug tested. They are under no obligation to put it into use until such testing has been carried out.

Mr. BRAND: Where is this testing carried out?

Mr. RITCHIE: At the Food and Drug laboratory.

The CHAIRMAN: Could we go back for one moment? I think Mr. Allmark wanted to comment on this.

Mr. ALLMARK: Dr. Brand has mentioned stelazine. I would like to put on record that we have not been able to confirm the analytical findings in that report. We have assayed these several brands of stelazine and at the moment we have not been able to find anything wrong with them.

Mr. ORLIKOW: If I could interject, does that include, the Paul Maney products?

Mr. ALLMARK: Yes; we have assayed them all—Paul Maney, Mowatt & Moore, S.K.F. and one other brand—and we have not been able to confirm the results in this report.

Mr. BRAND: This last report, dated November 1?

Mr. ALLMARK: Yes, this last one. I should point out that the reason for our not having been able to assay some of the products that are mentioned is that we have not been able to secure them. We are trying to do this at the present time. We have assayed lots that precede these batches and also those that come afterwards, and, as far as we can find out, there is nothing wrong with these. They meet existing standards.

Mr. BRAND: That is fine. Perhaps, while we are talking to the Food and Drug Department, I should ask about phenylbutazone. I notice that some has been bought. That is on page 9. Have you been testing any phenylbutazone?

Mr. ALLMARK: Yes; over the years we have tested many lots of phenylbutazone. I cannot give you the exact numbers because I have not got them here.

There have been some brands that have been unsatisfactory, but there have been many, many of them that have been satisfactory.

Mr. BRAND: I do not suppose that you have the facilities for testing every batch that has been purchased?

Mr. ALLMARK: You mean by the various departments?

Mr. BRAND: Yes.

Mr. ALLMARK: As I pointed out before, we test only those batches which we are asked to. We do not set the program. They simply submit to us products for assay, and we carry out these assays and report back to them what our findings are.

Mr. BRAND: Are you familiar, sir, with the paper on phenylbutazone produced by Dr. Pernarowski.

Mr. ALLMARK: I would like to point out that these results have not being published yet. I know Dr. Pernarowski, and I think that before these—

Mr. BRAND: I do not know what you mean by "published", sir, but surely it was presented to the Committee in Halifax.

Mr. ALLMARK: It was presented to the meeting in Halifax, but they have not been published in an official publication as yet.

Mr. BRAND: What has that got to do with what is in it?

Mr. ALLMARK: I think it may have quite a bit to do with it before it is finally published.

Mr. BRAND: I am afraid I do not follow you. You have left me somewhere around the last corner.

Mr. ALLMARK: I think you will agree that papers are presented at scientific meetings, but very often by the time they go to press they have been altered considerably.

Mr. BRAND: By whom?

Mr. ALLMARK: By the authors themselves, and very often by the editor.

Mr. BRAND: Do you mean that he presents a scientific paper to a scientific assembly and then decides, after chatting with some people, that he is not satisfied with his results and he changes them so that they will sound a bit better? Is this what you are intimating?

Mr. ALLMARK: Not exactly.

Mr. BRAND: I have never heard of anything quite like this. Certainly, in my profession, if I present a paper to a meeting and it is then published in a scientific journal it will be the same as I presented to the meeting. I am not going to change it unless there is new evidence to warrant changes; but I am not going to take the basic paper and change it. Are you trying to intimate that this is not a valid paper that was presented?

Mr. ALLMARK: No, I am not intimating that at all. What I am intimating is that the paper has not yet been published and that there may be some additions to the work that he is already doing, which might change, to some extent, the views that he expressed at the Halifax meeting.

Mr. BRAND: Let us change the subject because that is in the field of conjecture! I wonder if we could get back to the D.D.P. In the D.D.P. invitations to tender these is an equivalency clause, is there not?

Mr. ERSKINE: Not necessarily, no.

Mr. BRAND: But you do have it, though.

Mr. ERSKINE: Well, it all depends. If we have an adequate purchase description we have no equivalency, because the description covers anything in that general area. You are thinking of the "or equal"?

Mr. BRAND: Yes; that where equivalent products are offered proof of the equivalence shall be submitted with the tender and shall be sufficient to establish to the satisfaction of the surgeon general that the product offered is professionally acceptable and is, in fact, equal to the product named in all respects including potency, therapeutic effect, physical characteristics and stability during storage. Such proof shall include reports of clinical trials, results of stability studies, assay results of previous batches or lots, standard tests, test methods and the supplier's record of production and sales for the relevant product.

Would that be a fair approximation of the clause?

Mr. ERSKINE: The clause contained in our invitation to tender?

Mr. BRAND: Yes.

Mr. ERSKINE: It could be contained in some, yes.

Mr. BRAND: I do not quite understand when you would use it and when you would not use it. I understand that if you ask for one specific thing, as has been pointed out, and they say "no substitution" you would not ask for it then.

Mr. ERSKINE: Or if there was a generic name that was descriptive and covered a wide field of similar products we probably would not use an equivalency.

Mr. BRAND: You would not use.

Mr. ERSKINE: It would be very unlikely that it would be necessary.

Mr. BRAND: I think your understanding of the equivalency clause and mine are two different things.

Mr. ERSKINE: Well they may be; they could well be. You are suggesting that if we had a requirement for a drug from one of our customer departments and they asked specifically for a trade name, or a generic name, drug we would add this probably to introduce something else, or something that might do the job.

Mr. BRAND: What I am suggesting is that if you ask for something—and I think the evidence here today is certainly that most of it is asked for by generic name—with which you are not familiar, then, perhaps, in the case of some of the companies this sort of material should come along with the tender on the drug, to show the stability studies, clinical files and things of this nature, if it is not familiar to the department. Would not that be a fair assessment?

Mr. ERSKINE: I am looking at some of the invitations to tender that I have here. None of them contains this equivalency clause. There are times, I presume, when it is used, I do not see all these orders myself. We have a good many tens of thousands of them in a year, of all commodities. I am really not in a position to tell you at the moment when this equivalency clause is used in them.

Mr. BRAND: I have one here which has it in.

Mr. ERSKINE: You have one?

Mr. BRAND: I have a photostat of one here that has it in.

Mr. MACKASEY: Mr. Chairman, once again I must record my protest. I cannot follow the hearing. Obviously it is not your fault. Probably you are all, including Dr. Brand, speaking well into the microphones but every few seconds we get too much amplification and then the sound disappears as though somebody was playing with a switch, or a knob, or something.

The CHAIRMAN: I would ask every member to speak up. I would like to carry on because we might finish by noon.

Mr. BRAND: If chloramphenicol, let us say, had been purchased from Parke Davis on one of these orders, would they have been tested, as apparently these from this Dutch fermentation lab are being tested, or would they have been accepted at their face value because of the reputation of the company?

The CHAIRMAN: Would you care to comment, Dr. Ritchie?

Mr. RITCHIE: They would be accepted on their reputation at that time.

Mr. BRAND: Then I think it is fairly important—this question was brought up before—to know how much these testings add, in actual fact, to the cost of tender of these drugs? Do you know what I mean? If it is going to be cheaper in the long run to accept one from a firm that is trusted is it not better to buy in that way rather than to buy a drug on price alone, and then, as has certainly been the evidence here today, having to have it tested to make sure that it is all right, or having to test it after it has been sent back because it is not up to standard?

The CHAIRMAN: Perhaps we could ask Mr. Allmark of the Food and Drug Directorate to ascertain whether Dr. Chapman could give us what percentage of the total budget of the Food and Drug Directorate is represented by the testing of drugs?

Mr. MACKASEY: Mr. Chairman, I cannot follow Dr. Brand's question. Am I right in assuming there is no differentiation on what the source is? Whether it is Smith Kline and French, or Paul Maney, you still test? Is this not the least protection we should afford to the patient?

Mr. BRAND: The reason I asked how much it would cost is that I noticed one tender here for chlordiazopoxide in which the difference between the two tenders and the one accepted, which was the lower one, from a firm that is certainly not as well known as the other, is $7.50, and I was wondering whether you can test drugs for $7.50. I very much doubt it?

Mr. ENNS: Yes; but you would also have to test the drugs supplied for $7.50 and add the cost to that figure. This is Mr. Mackasey's argument, that the testing is required whether it is from an innovator or from a copier.

Mr. BRAND: I asked a question, as you recall—and I am sure Mr. Mackasey heard that portion because the equipment was working then—and the answer was that they would not have checked Parke Davis because they were aware of the background of this firm. Therefore, they would not have checked their drugs because they accept them as being of high quality.

Mr. ENNS: I would like that question answered. This is my point.

Mr. BRAND: That was answered, and it was answered in that way.

Mr. ENNS: I did not hear it. Would you repeat it?

Mr. BRAND: Would you answer it again, sir?

Mr. RITCHIE: I am sorry, Dr. Brand.

Mr. BRAND: My question was this: If you bought chloramphenical—trade name chloromycetin—from Parke Davis, would they be tested, as has the one accepted on tender here from the fermentation lab, which is now being tested, I understand, for adequacy and potency and so on?

Mr. RITCHIE: The answer given previously was that it would not have been tested if it was supplied by a known, reputable supplier.

Mr. ORLIKOW: I accept that answer, but I wonder if the department should not give some thought to whether that is a valid position. I have not got the information here, but I can certainly bring evidence of reports from the United States, where the biggest companies have had to withdraw drugs. I can think of one specific one, William Merrill, which is a very big firm, who, when they first produced the polio vaccine, were in real trouble. I am speaking from memory now, but there were deaths.

Mr. BRAND: I think you are speaking from memory. It certainly was not the William Merrill company.

The CHAIRMAN: You have the wrong firm.

Mr. BRAND: You have the wrong firm.

The CHAIRMAN: The firm that had trouble with the polio vaccine was, I think, the Cutter Laboratories.

Mr. ORLIKOW: I am sorry, Mr. Chairman; nevertheless, it happened to a big company. The big companies have had difficulties too. Within the last couple of months the Food and Drug Administration in the United States has ordered some of the big companies to withdraw drugs for various reasons.

The CHAIRMAN: Perhaps it would be reasonable to ask the Food and Drug Directorate to review their findings over, say, the past six months or a year. Perhaps they could give us a list of the drugs that have been tested and those rejected, and the reasons for rejections.

I can see that I will have to speak to Dr. Chapman in some detail.

Mr. ALLMARK: Mr. Chairman, I can tell you there have been about 500 recalls in the United States during the past year.

The CHAIRMAN: And in Canada?

Mr. ALLMARK: No, not in Canada; in the United States.

Mr. MACKASEY: May I ask a supplementary question. Do you know how these 500 are divided? What intrigues me, and what concerns me, is that someone is deciding which firms should be tested by the purchasing agent and which should not. It seems to me that you have a double standard, which is perhaps unfair in view of the fact that everybody tendering has already met your 74-GP standard.

Mr. ALLMARK: In the case of the United States firms I think it was about a 50-50 proposition.

Mr. MACKASEY: In other words—

Mr. ALLMARK: It involved just about as many brand name products as generics.

Mr. MACKASEY: Then why do you not test the batches coming in from brand names?

Mr. ALLMARK: That has nothing to do with us.

The CHAIRMAN: The Food and Drug Directorate test what they are asked to test; is that right?

Mr. ALLMARK: What they are asked to test.

Mr. MACKASEY: If it has nothing to do with you, whose responsibility is it? The purchasing department, obviously—

The CHAIRMAN: I think the answer is the user's rather than the purchaser's.

Mr. BRAND: Perhaps what Mr. Allmark is referring to is that article in Drugs News Weekly of November, which said that there is a 45-50 per cent chance that drug firms' manufacturing facilities will fall short of government standards. Is that what you are referring to?

Mr. ALLMARK: No; I was actually referring to the recalls.

Mr. ORLIKOW: Mr. Chairman, if there have been 500 recalls in the United States and 50 per cent of them have involved the big companies, by population comparison, and since we use a lot of drugs manufactured in the United States. There probably have been 50 recalls in Canada of which 45 would be from the big companies. Now, if there were not, then the question I think we have to ask ourselves is: Are our testing standards as good as those in the United States?

Mr. MACKASEY: I would supplement that by saying that it is not a question of whether our testing standard is good, but of why it is not being applied uniformly. Why is there a requirement that certain firms have to be tested, and other firms are not, in view of the fact that this is supposed to be a standard which one attains? Everybody is supposed to be equal before the law. Why give Parke Davis an exemption from testing and pick on someone like Paul Maney, or Empire?

Mr. ALLMARK: I might say something to this.

As someone suggested, it is just impossible to test everything. After you have been dealing with a particular firm for a number of years and know something about their quality control facilities you rely on their being able to do a good job. This is my own personal opinion, but I think probably it is what some of the user departments actually do. They have tested drugs from some of these companies, probably as many as 25 or 50 batches over the last few years, and they have found them satisfactory, so they feel at this point in time that they can purchase the drugs without their being tested.

Mr. MACKASEY: Of course, it follows that if they keep testing some other small firm and find, to their pleasant surprise, that their quality meets the standard, they will eventually develop the same type of confidence in the product?

Mr. ALLMARK. Yes, I think so.

Mr. FORRESTALL: I have one or two questions and then I would like to let Dr. Brand continue. I am a layman, so that there will be no great difficulty with my questions.

Could any of the witnesses, Mr. Chairman, tell me approximately how many people in Canada are being serviced by drugs through the government? Are there a million, perhaps, or half a million, annually?

Mr. ELLIS: About 300,000 for National Health, Mr. Chairman.

Mr. ORLIKOW: D.V.A.?

Mr. RITCHIE: We have a large veteran population, and to say what proportion of them are being serviced, I cannot readily answer.

An hon. MEMBER: The potential market?

Mr. RITCHIE: I cannot give you a figure. I can obtain a figure if the Committee would like one.

Mr. FORRESTALL: If we take ten of the 12 sample drugs submitted by the Chairman as a bit of a breakdown on recent purchases, because two were composite tender blocks, we find that there were some 6,437,500 dosages, either injections, or tablets or something. I am curious about what is happening to all these drugs. Would that be a year's supply, or is it a six months' supply, or what?

Mr. ERSKINE: Mr. Chairman, in some cases it is a year's supply.

Mr. BRAND: Ask them what they are using the contraceptives for?

Mr. ERSKINE: In some cases, Mr. Chairman, it is a national emergency stockpile which is actually being held. Over $1 million a year goes into that alone.

Mr. FORRESTALL: In E.M.O.?

Mr ERSKINE: Well, into Emergency Health Services.

Mr. FORRESTALL: So that roughly one-third of your purchases would be stockpiled.

I wanted to pursue that a little bit later on but we might follow it up now.

What happens to these drugs? How long are they kept, and what happens to them? Certainly there must be a life expectancy, not necessarily in terms of the dosage of the drug, but of how long you keep them. I would assume this is what is turned over at some point to Crown Assets for disposal.

Mr. ELLIS: They are under constant surveillance. Every depot has its own program. They have it classified according to their shelf-life—from long shelf-life to very short shelf-life—and they are under constant surveillance. There is a program with D.V.A. and National Defence whereby, if National Defence require a certain drug such as chloromycetin, they take it out of the national stockpile and replace it with new drugs which they purchase on the market.

Mr. FORRESTALL: What would they do, for example, with the chloromycetin? Would they offer that to Crown Assets for disposal?

Mr. ELLIS: No, they are never offered to Crown Assets. There is a constant turn-over of all these drugs by user departments. They draw out of the national stockpile and replace with new drugs.

Mr. FORRESTALL: And destroy?

Mr. ELLIS: No, no: they take them to use them. D.V.A. takes them out of the national stockpile—

Mr. FORRESTALL: No; I am sorry. I am speaking of E.M.O.

Mr. ELLIS: These are the drugs that they take out of the national stockpile. If D.V.A. wants aspirin they will take it out of the national stockpile, and replace it with new drugs that they buy that day to put in the national stockpile. The national stockpile has a constant turn-over.

Mr. FORRESTALL: We do not, then, have a stockpile of drugs, for example, at a place like Debert in Nova Scotia? There is not a stockpile of drugs there that would, simply because of the passage of time—

Mr. ELLIS: No, no. This is a constant program. It costs a lot of money to keep this program alive, too.

Mr. FORRESTALL: I expect it would. You have suggested that it is one-third of your total purchases, and that is a substantial amount of money.

I am a little puzzled about some of the questions—

The CHAIRMAN: Could you speak up a little, Mr. Forrestall?

Mr. FORRESTALL: I will try.

Mr. ELLIS: Mr. Chairman, I have suddenly remembered the phrase I was thinking of, it is "rotation program". That is the phrase. There is a constant rotation program of the national stockpile.

Mr. FORRESTALL: Would these 12 drugs that the Chairman has listed, constitute perhaps half of the drugs you buy, or 95 per cent? Would these 12 generally cover the great bulk of your purchasing?

Mr. RITCHIE: Which 12 are you speaking of?

Mr. FORRESTALL: I am sorry.

The CHAIRMAN: The user departments are not aware of the list of 12 that I gave to D.D.P. I just picked out 12 common drugs.

Mr. FORRESTALL: Then if I may direct the question to the proper house, what percentage of your purchases would these 12 samples cover?

Mr. ERSKINE: Mr. Chairman, in total dollar value I could not tell you. Certainly it is a very small percentage of individual types of drugs; but we have not yet any statistics for the two departments that are fairly new customers of ours. We have some estimates of their total requirements in a year. I think around 3½ million is what we expect. The Department of National Defence would run anywhere from $750,000 to $1 million, and National Health and Welfare would be relatively small, perhaps $100,000. I am speaking only from memory.

Mr. ELLIS: Of these 12 drugs?

Mr. ERSKINE: No; I am talking about total drug purchase.

Mr. ELLIS: I am forecasting that for the current year you will buy $200,000 worth of brand name drugs for us.

Mr. ERSKINE: We would have to put the total against the grand total to find out what percentage this is. We have not done this.

Mr. FORRESTALL: I thought perhaps there might have been a ready answer.

I had just one other question for the time being. I am concerned, for example, about people working for Canada outside of Canada, such as our armed

forces, who may happen to be in Cyprus, or wherever the case may be. How are these people supplied with drugs?

Mr. POYNTZ: As far as we are concerned they are just another area we service as we do the units in Canada.

Mr. FORRESTALL: The corps that is there is a unified, or self-contained, unit, and they would take their medical supplies with them?

Mr. POYNTZ: And they would requisition as they—

Mr. FORRESTALL: They would requisition. In short, they would be supplied out of the national tendering?

Mr. POYNTZ: Out of our National Defence stocks.

Mr. FORRESTALL: Yes, and this is true in all cases? Would it be true of our bases in Europe, for example—the more permanent ones that we used to have and still have?

Mr. POYNTZ: That is right. I am not sure to what extent it would apply to small, isolated units, but it is certainly available for them.

Mr. FORRESTALL: That is all I have for the time being.

The CHAIRMAN: Dr. Isabelle, did you have a supplementary question?

Mr. ISABELLE: Yes, Mr. Chairman.

I am going to quote an official answer I received from the Secretary of State of Canada to questions I put on the order paper, which read: Do hospitals and medical centres under federal jurisdiction buy drugs under their generic names or under their brand names? My second question was: What is the percentage of each. I received an answer as follows: Generic names, 95 per cent and brand names 5 per cent.

Now, in light of the answers up to now it means that generic drugs are cheaper, because in the way the purchaser is buying the drugs if they go to tender it means that they have a lower price; therefore, they buy 95 per cent of the drugs under the generic name because they are cheaper.

Now, because of what I have heard, and what has been said, do you not think that it would be very interesting to know how much it is going to cost to test those drugs, because I think, in the long run, we are going to have a cheaper quality for a high price—a higher price than the brand names. We do not test the brand names, because as you said, you rely on these important companies. Do you not think that this is so? In the long run, you have to pay to test them, and, therefore, the cheap price that you pay may turn out to be the highest price for drugs of the cheapest quality.

The CHAIRMAN: I think that is a very difficult question to ask anybody. It is a hypothetical question. The government will not stop testing drugs. Perhaps someone would like to attempt to answer it, however.

I will ask Dr. Chapman when he comes before us to see if he can break down the expense of testing that is done in his directorate. Mr. Mackasey?

Mr. MACKASEY: Are there any generic firms whose quality standards you accept without question?

The CHAIRMAN: Are you directing the question to Dr. Ritchie?

Mr. MACKASEY: They are all interesting people. It does not matter who answers it, as long as it is answered.

Mr. RITCHIE: There is no such thing as a generic firm.

Mr. MACKASEY: Well, obviously, according to an earlier witness, there is a certain competence in particular firms as opposed to other firms. Now, we have had the bad habit here of talking about innovators, copiers, brand names, generic firms, but I think we all know what we are talking about. The industry has a tendency to divide itself, and the presumption is that if you are supplied by the "in" group, or the brand group, or the innovators, you are automatically getting a certain standard of safety. I think it is justifiable when one sees their premises. What I am asking is, are there any firms that we usually call copiers or generics, who are also, in your opinion, entitled to the same degree of confidence?

Mr. LAROCQUE: In this case, each part will be considered individually. If we bought one product from the same firm, they being the successful tenderers over a period of, say, two or three years, supplying six, seven or eight requests—and perhaps supplying a dozen or more batches in those requests—without any indication that this product has ever been of a questionable nature, then we may eventually accept this particular product the next time without testing.

That does not mean, however, that when they tender on another product entirely we would not test the new product. Each case is dealt with individually.

Mr. MACKASEY: Is this generally true whenever you are purchasing a new product for the first time?

Mr. LAROCQUE: Yes.

Mr. MACKASEY: This will be of all suppliers, or any supplier?

Mr. LAROCQUE: No; in the case of new drugs coming out the only test available is the test that the supplier makes. They are the originators. They supply the test, and we pretty well have to trust to its being accurate.

Mr. MACKASEY: Of course, you rely on the fact that the Food and Drug Directorate periodically visit that source of supply and inspect it.

Mr. LAROCQUE: If there is any doubt at all about any product, we will refer to the Food and Drug Directorate for their advice before we will use it.

Mr. MACKASEY: Am I right, Mr. Chairman, in assuming that the Food and Drug Directorate make periodical inspections and analyses anyway?

I am getting into another question now, Mr. Chairman. Do you have any restrictions this morning on the type of questions, or the area?

The CHAIRMAN: Perhaps we can wait and see.

Mr. MACKASEY: That is fine. You mentioned earlier a very large purchase of chloromycetin, originating in Holland. This leads me to another area, that of goods originating outside the country.

Am I allowed to get into that area, Mr. Chairman?

The CHAIRMAN: I am not sure that they will be able to answer the question.

Mr. MACKASEY: No; but the Food and Drug Directorate people could, and they are here; and it relates to safety.

What did you do with these goods coming from Holland? You say that you now have received these goods.

Mr. LAROCQUE: I believe we received some of these goods, yes.

Mr. MACKASEY: Well, you received a fairly substantial quantity of 180,000 tablets.

Mr. LAROCQUE: I cannot tell off hand how many we bought up against this. It has been on tender for a year.

Mr. MACKASEY: Did they come in in part shipment?

Mr. LAROCQUE: We request them that way.

Mr. MACKASEY: You request them in part shipment. Therefore, is every lot re-tested?

Mr. LAROCQUE: Yes.

Mr. MACKASEY: Every lot is re-tested. In other words, if they come in 15,000 at a time, in 12 shipments, is each one of these 12 shipments re-tested?

Mr. LAROCQUE: This is our policy if we are doubtful, yes.

Mr. MACKASEY: Now, what do the Food and Drug Directorate do about these goods at the border point when they are coming in from Holland?

Mr. ALLMARK: Are you speaking about the raw material, Mr. Mackasey, or the formulated product?

Mr. MACKASEY: Well, we will make it easier and stick with raw material. What do you do with raw material?

Mr. ALLMARK: Well, actually, as probably you know, every batch of raw material has to be accompanied by a certificate indicating the complete analysis of that raw material. This goes to the manufacturer, and at the point of entry our inspectors do not usually hold this up unless there is some previous warning. It goes to the manufacturer, and then the inspector may ask to see this certificate when he makes his inspection.

Mr. MACKASEY: Who issues this certificate?

Mr. ALLMARK: Well, the manufacturer of the drug—the originator of the drug. In some countries there will be a control laboratory within that country that will do the analysis for them.

Mr. MACKASEY: Have you found different standards in different countries?

Mr ALLMARK: Occasionally, yes.

Mr. MACKASEY: Could you give examples?

Mr. ALLMARK: No, I could not give you examples on that.

Mr. MACKASEY: Are there any countries that you view with more suspicion than others?

Mr. ALLMARK: I do not know that I would want to answer that either.

Mr. MACKASEY: Why not? That is the purpose of our hearings. Why would you not want to answer it?

The CHAIRMAN: He is thinking of our international relations.

Mr. MACKASEY: I am not interested; I am interested in the safety of Canadians.

Mr. BRAND: Mr. Chairman, may I point out that Dr. Chapman has already pointed out that he disagrees with Canadian laboratories, and surely if he is going to disagree with the results of Canadian laboratories he can certainly tell us which other one he disagrees with; and I would insist on an answer to Mr. Mackasey's question.

The CHAIRMAN: Mr. Allmark is here representing the department; I would remind you that Dr. Chapman himself will be back before the Committee at the end of January.

Mr. MACKASEY: Mr. Allmark is a very knowledgeable and intelligent witness in the few times that we have had dealings with him, and I am quite happy to accept his appraisal and perhaps Dr. Chapman could elaborate on it.

Mrs. RIDEOUT: Flattery will get you nowhere.

Mr. MACKASEY: No, it is not flattery; I think that is unfair to Mr. Allmark.

Mr. ALLMARK: Of course, Mr. Mackasey, I have my own views on many of these things, and they may not necessarily be the directorate's views. I think there really should be a directorate policy-decision on to naming the companies abroad that we do not like, or have found wanting. I would not wish to name them.

Mr. MACKASEY: The point is that some of these people who are supplying the lowest tender to a hospital could have their source of supply in a country in Europe, the standards of which are not perhaps exactly what you would suggest should be maintained. How early can you prevent that so that it does not get all the way to the hospital?

Mr. ALLMARK: Well, I think the testing program that has been set up will pick this up.

Mr. MACKASEY: Eventually.

Mr. ALLMARK: I think you have heard from the purchasing agents this morning that if they are at all suspicious of a new tenderer they would have this checked before it ever would go into any hospital.

Mr. MACKASEY: Yes; but the point, Mr. Allmark, is that it is only when it gets to the hospital that they are suspicious. Obviously if they are suspicious beforehand, they should not permit the firm to tender in the first place. I would imagine that, in the case of everybody on this very long list, surely before they are issued an invitation to tender somebody must know what is their source of supply, whether it is Canada, the United States, or Switzerland.

Mr. ALLMARK: As I understand it, the source of supply may change, actually, from one batch to another. They do not always purchase their raw materials from the same source. They may buy the raw material in Copenhagen at one point, and may go to Italy at another point, even during the year, or within three or four months.

Mr. MACKASEY: Are we not concerned where they get it from?

Mr. ALLMARK: I think we are.

Mr. MACKASEY: I know you are, and I am being polite about it. If you are concerned, what are you doing about it?

Mr. ALLMARK: I might tell the Committee this, that we are doing quite a lot of research on raw materials at the present time, and up to this point in time our research has not revealed anything to be alarmed about.

Mr. MACKASEY: Well, Dr. Morrell, when he was before this Committee in 1964, said—and now I am quoting from *Maclean's,* and you can say it is inapt if you care to:

> Our greatest concern is the raw pharmaceutical materials coming from abroad; from countries where production controls are not as good as they should be.

Do you feel that this is still a fair appraisal two years later?

Mr. ALLMARK: I think so, Mr. Mackasey. I think it is still a big concern.

Mr. MACKASEY: Now, could you verify, or deny, the fact that a committee representing the Food and Drug Directorate did tour Europe about a year ago on a fact-finding mission?

Mr. ALLMARK: Yes, I can verify that; I was a member of the team.

Mr. MACKASEY: Could your findings be placed at the disposal of this Committee, one of the functions of which is to investigate safety of drugs?

Mr. ALLMARK: Well, I think this still would be the responsibility of the minister. If he wants you to hear about our findings, I think it would be up to him.

The CHAIRMAN: I think we have already asked Dr. Chapman about that. They did not want to put the committee's findings before this Committee.

Mr. MACKASEY: Why?

The CHAIRMAN: I will have to go back and refresh my memory, but it seems to me that we discussed this point when the Food and Drug Directorate was before us at almost the first meeting. I will have to refresh my memory.

I am prepared to discuss this with Dr. Chapman.

Mr. MACKASEY: Mr. Chairman, I must go on record once again to say that it makes a mockery of our Committee if we are to be denied this type of information.

An hon. MEMBER: I am glad to hear you say that, Mr. Mackasey.

Mr. MACKASEY: The point is that either we are going through an exercise in futility, and our work is already being done at the same time by a government agency, or we are not. If we are to do a job we should be entitled to all sources of information, not only from the government but from private industry. I think this is very pertinent to safety and, eventually, to prices, of course.

The CHAIRMAN: You are talking about safety, and our terms of reference are actually cost; but there is no question that the two are related.

Mr. MACKASEY: I think we all agree, Mr. Chairman, that if safety was not a factor you could buy drugs even cheaper.

Would you say that our requirements, or our standards, are as good here as they are in England, for instance?

Mr. ALLMRK: As you probably know, our official standards for drugs are outlined in our regulations. The official text actually is the B.P. and the U.S.P. and a national formulary, and French codex, and one or two others. We have no reason to believe that these standards are not good standards. We use these every day in the week.

Mr. ALLMARK: As you probably know, our official standards for drugs are tion because the United Kingdom saw fit—according to this article—to remove Italy and Poland as suppliers of antibiotics. Should we have done the same thing, or are our standards a little lower?

Mr. ALLMARK: I do not know the particular circumstances of why they did this; I think probably they found it was an inferior quality material.

Mr. MACKASEY: Have we found it inferior quality material?

Mr. ALLMARK: Do you mean the raw material?

Mr. MACKASEY: Well, in the form in which they saw fit to refuse imports from those two countries.

Mr. ALLMARK: We do reject materials periodically, you know, in the formulated drugs from abroad, and also raw materials.

Mr. MACKASEY: Well, this article, of January this year—which is not too old—does not say that some suppliers in Italy and Poland were removed. It says that they were recently removed from the U.K.'s list of suppliers of antibiotics. I really just want to know whether we have done the same thing?

Mr. ALLMARK: No; we have not excluded drugs from Poland, although I have the feeling that there are none coming into Canada.

Mr. MACKASEY: Because when they get to the door here they are not acceptable?

Mr. ALLMARK: I would not say that we would object to them if they met our standards.

Mr. MACKASEY: In other words, we have no policy of discrimination against any country as a source of supply?

Mr. ALLMARK: No, no; as a matter of fact we made a survey of this situation within the last two years, and we were actually obtaining drugs from over 30 countries at that time.

Mr. MACKASEY: Well, Dr. Morrell, in the same article which I have dug out from some of the past hearings, goes on to say:

> For the first time...

He is talking about the new regulations, and I am glad to see, Mr. Chairman, that he says some of these have come out of our past hearings—it means we are not quite that useless.

> Now the FDD is going to plug that loophole. When a new regulation goes into effect, probably within the next few months, it should dramatically reduce the incidence of substandard drugs now being sold to the public.

"For the first time," said Dr. Chapman, FDD's new director, "we will know who is making and distributing drugs in Canada. With this knowledge, we will be able to plan a more effective inspection program to insure proper quality standards are being maintained and our requirements are being met regarding safety and effectiveness."

Mr. ALLMARK: I think that what is meant there is actually the drug notification scheme, which is under way now.

Mr. MACKASEY: Which would have an effect in registering and pinpointing our sources.

Mr. ALLMARK: Yes; importing companies, as well as Canadian companies, will have to notify us of the drugs they are proposing to sell on the Canadian market.

Mr. MACKASEY: Now, do you feel that your staff is adequate at the present moment?

Mr. ALLMARK: I think, Mr. Mackasey, that many of these questions could very well be answered when we meet with you in January, if you would not mind leaving them over until that time.

Mr. MACKASEY: Fair enough.

The CHAIRMAN: Dr. Brand, do you have any further questions?

Mr. BRAND: I certainly have.

The CHAIRMAN: Carry on.

Mr. BRAND: When I was questioning the last time, Mr. Chairman, I began to think you were running interference for the witnesses; I hope that was not the case.

Mr. MACKASEY: I think that is an unfair assumption. There are a few things that Dr. Brand has said today that I would like to disassociate myself from, and one was his reference to the witnesses, as pious. I think the witnesses have been refreshingly intelligent, and I would like to know a little more about their background. I am quite impressed by the knowledgeability of the gentleman who has been the spokesman for the purchasing agents. I do not know whether he has an Irish brogue, or what type it is, but he can twist his tongue around generic names better than anybody I have heard.

The CHAIRMAN: Dr. Brand?

Mr. BRAND: Well, now that all the pats on the back are over with, I think we should go on to a few more questions. I do not do this in an attempt, as Mr. Mackasey is suggesting, to denigrate in any way any of the gentlemen who are appearing before us; but I adhere to any point that some of the statements made this morning were quite pious; and I think if you look back over the record you will agree with me, particularly since some facts have come out as a result of questioning, which did not come out earlier, despite questioning to that effect.

Now, here is a sneaky one, perhaps. The statement was made—and I think Dr. Showalter made it—that by the standards and the purchasing methods used we try to encourage Canadian industry. It has occurred to me, as I look at this Dutch thing, that this is a peculiar way to encourage Canadian industry. As I look through some of the things I have here and I see where they come from,

it is going to be a pretty difficult thing to encourage Canadian industry when so much of the raw material seems to come from overseas, as I think Dr. Allmark pointed out. But that is by the by.

One thing that intrigued me was this bit about drugs going to Crown Assets Disposal. I would like to hear more about that. I would like to know when you decide that a drug is no longer any good, from the viewpoint of the armed services, but is still good enough to be given to Crown Assets Disposal. It is obviously going to be sold on some market other than Canada. I am interested in the criteria.

Having been in some service hospitals and having seen the age of some of the drugs that have been there—I am not speaking about recently; I hope the situation has changed—I am a little curious about this.

Mr. POYNTZ: Well, I think I did say, Dr. Brand, that these drugs had to be good if they were declared; we were not getting rid of drugs that had not been tested.

Mr. BRAND: Why were you getting rid of them?

Mr. POYNTZ: There are various reasons. Treatments may change, the usage may change; a good example would be the fact that, up until about three years ago, we were supplying certain drugs for dependents. This was terminated, and these drugs that had been procured for dependents were no longer required; therefore they were declared surplus after they were tested. They were not necessarily poor drugs.

Sometimes there is no sale for these drugs. A recent case was where we had to dispose of a large quantity of R.C.N. seasickness tablets that were procured during the last war and which are no longer used for that purpose.

Mr. BRAND: They were procured over 20 years ago and were they still useable and still in good shape?

Mr. POYNTZ: No, they were not saleable; they had to be destroyed.

Mr. BRAND: Oh, they had to be destroyed. In the matter of destroying drugs, I think there was mention in this Committee a few years ago of something that happened overseas, where they were quietly flushing drugs down the toilets of service establishments. Now, this is a statement, or, let us say, a rumour—I think that is a much better word for it—that has recurred frequently. I wonder if we could set the bogey at rest, or resurrect the ghost, or something of this nature.

The CHAIRMAN: I may say that it was put on the record by yourself.

Mr. BRAND: This is correct. I am sure that the gentlemen have read the records of the Committee and have noticed that—

The CHAIRMAN: I am saying this because the Committee records are running far behind.

Mr. BRAND: That is true. That was some time ago.

Do you know anything about this?

Mr. POYNTZ: No, I do not. I have heard the rumour, but we have no evidence of it. I think you will probably agree that a doctor may say: "I do not want any of that stuff".

Mr. BRAND: If you do not know anything about it you can hardly speculate. Do you know of anybody who does know anything about this?

Mr. POYNTZ: I would have to have something more concrete than a rumour of evidence—

Mr. BRAND: I can give you a name—Lt. Col. Thurwell.

Mr. POYNTZ: When was this supposed to have happened.

Mr. BRAND: I am merely seeking information. I am not making suggestions, except for the name, at the moment. Do you think there is any possibility that he might have something which could contribute to the clarification of this problem?

Mr. POYNTZ: He might have. As I say, I do not deny that this sort of thing could happen at a particular unit where a doctor—and we use civilian doctors as well as military doctors—favours a particular drug and does not use what is supplied. However, these would be very small quantities in relation to what we procure for the armed services.

Mr. BRAND: You left me somewhere. What does this have to do with the problem of flushing them down the toilet. Surely, if you do not like a drug you do not do that. I know lots of drugs that I do not like as a physician and I do not flush them down the toilet.

Mr. POYNTZ: If a drug is not satisfactory to the person who is using it, particularly if it has been issued to him against prescription, you have to flush, burn or bury. I would say that it was a normal disposal method for unsatisfactory drugs.

I think it was agreed earlier that some doctors do specify "no substitute", and if they do not find it acceptable this could happen. But I reiterate that it would happen with only a small proportion of the drugs that we use.

Mr. BRAND: In view of the fact that the witness has said that Lt. Col. Thurwell may have something to offer, I would suggest, Mr. Chairman, if at all possible, at some time Lt. Col. Thurwell be asked to appear before this Committee.

The CHAIRMAN: Rather than have him appear, I was wondering if we could have Mr. Poyntz's approval that the Chairman talk with Lt. Col. Thurwell and perhaps have it put on the record in writing. It would then become part of the record. Is this satisfactory?

Mr. BRAND: I object strenuously, Mr. Chairman. I have asked to have the opportunity to chat with this gentleman in the Committee. I am not interested in records being lodged with this Committee, by people who are not witnesses. I think this is quite improper, and I do not think it should be done.

The CHAIRMAN: I will call this to the attention of the steering committee.

Mr. BRAND: All right.

Mr. MACKASEY: I might have a little more information perhaps to support Dr. Brand. Are we referring to the headlines I saw in the press a few weeks ago about drugs having been flushed down a toilet?

The CHAIRMAN: I saw an article in the press. I did not see any headlines.

Mr. MACKASEY: The article I saw did not mention that it was a rumour. It said that it was a statement in the Committee.

The CHAIRMAN: I think they were quoting Dr. Brand's statement in this Committee.

Mr. MACKASEY: Surely, in all fairness to Dr. Brand, he must have mentioned at the time that it was only a rumour.

Mr. BRAND: I most certainly did mention that it was only rumours. The Chairman can bear me out.

Mr. MACKASEY: Did the newspapers conveniently overlook the fact that this was only a rumour. There was nothing in the headlines saying: "Rumour that drugs flushed down toilet."

Mr. BRAND: I can think of some other newspaper headlines that sometimes are not quite—

Mr. MACKASEY: I am sure you would want to be fair to Dr. Showalter's department. The inference I got from that headline was that, despite the fact that his department had enough initiative to centralize buying and establish 74-GP-la, drugs were still being purchased and flushed down the toilet. This is the inference that a layman would have obtained from this irresponsible journalism; not, I am sure, from your question.

Mr. BRAND: It is a rumour, but it is a persistent one, and it was confirmed as a rumour by one of the witnesses who were here that day. I stand corrected, but I believe it was the president of Ayerst, McKenna & Harrison.

In view of this I think that in fairness to all concerned, including the gentlemen at this table, this matter should be clarified once and for all.

Mr. MACKASEY: I think we should have the witness here to exonerate the departments, if necessary. I concur in this.

Mr. POYNTZ: Dr. Brand, the reason I asked, when this is supposed to have occurred is that in Dr. Showalter's presentation he described the situation up to 1960 or 1961. I also explained that we have a guarantee now. Until 74-GP-1 and our guarantee came in, I believe that we may have received inferior drugs. We have taken corrective action, and if these are things which were rumoured over a year ago, then it is not reflecting the present status.

At the present time we do not know of any unsatisfactory conditions on drugs.

Mr. MACKASEY: What is the guarantee you are referring to?

Mr. POYNTZ: We call up a guarantee on our procurement documents. This guarantees that the product, on receipt, complies with our purchase description and that it will meet this purchase description for a period of three years afterwards, unless it is a shelf-life item. If it fails within that three-year period we get our money back.

Mr. MACKASEY: What happens to the dead soldier? I can understand a guarantee in the case of a defective can of peas or something, because I guess you can get ptomaine poisoning, but—

Mr. POYNTZ: Remember, I said we tested all our receipts.

Mr. MACKASEY: Mr. Chairman, may I ask another question which, I think, arose earlier?

Dr. Showalter, is there any particular reason why your department should not issue periodical bulletins, as is done in many areas in the United States, listing these firms who are—I will not say penalized, or punished—but whose goods are rejected and who violated the standards? Bad publicity is the greatest weapon at our disposal. Why the secrecy? Why are we protecting these people?

Mr. SHOWALTER: Mr. Chairman, there is no secrecy. That list of firms deemed acceptable under 74-GP-1 is now getting very wide distribution. A new list is circulated every three months, and during the three-month period amendments are sent out by special notice to all users of the list.

Mr. MACKASEY: You may send out a list tomorrow, and three months from now you will send out another list which may have certain names deleted.

Mr. SHOWALTER: That is correct.

Mr. MACKASEY: But you do not say why you have deleted them. In the United States they do.

Mr. SHOWALTER: So far that has not been done. I might say that our wide distribution of the list is a very recent development.

Mr. MACKASEY: But is it not possible that a firm could cease to be on that list because they simply intimated to you that they were no longer interested in quoting?

Mr. SHOWALTER: That is quite true.

Mr. MACKASEY: Therefore, would people not get the wrong inference from the fact that a firm was no longer on there, unless you explain why?

Mr. SHOWALTER: What you ask certainly could be done. It is not being done, if that is the question you are asking.

The CHAIRMAN: I would just like to mention that that recommendation that a list of infractions under the Food and Drugs Act be published by the Food and Drug Directorate was made by this Committee in 1964 and the government have never seen fit to implement it.

Mr. MACKASEY: A lot of our recommendations the government has not seen fit to implement. That is why I sometimes question our existence. When are they going to get around to implementing it.

The CHAIRMAN: I am merely pointing out that we have made this recommendation.

Mr. BRAND: I would like to ask again about this equivalent clause.

Do the departments do any testing of therapeutic effect. I know it is much easier to do physical characteristics, rate of disintegration, percentage of the base in the tablet, and things of this nature; this I understand. How about therapeutic effect and potency—whatever that means—unless that is referring to the percentage of base.

Mr. ALLMARK: As a rule we do not carry out clinical work, but occasionally we do a bit of it. I think our most recent work was done at a local hospital on tolbutamide. This work has actually been published. We actually studied a

number of different brands of tolbutamide, both from the laboratory point of view and clinically. This is the sort of work we do when the occasion arises.

Mr. BRAND: When you put the equivalent clause in a tender for drugs, such as in the one I have before me, and then you accept the tender of one of these firms in the 74-GP-1 list, such as the one Mr. Mackasey mentioned—

Immuno (Canada) Ltd. on Sherbrooke Street West, or some of these other distributing houses—do you insist, when you purchase, on the evidence—"proof of equivalent" as it says here—to show that the offered is professionally acceptable and is, in fact, equal to the product named in all respects including potency, therapeutic effect, physical characteristics, stability during storage, and so on. Do you insist on this? Do you always get this?

Mr. ERSKINE: Yes, we would, Mr. Chairman. This is a condition of the tender and the tenderer must comply with this; and the user department must be satisfied that what has been offered is acceptable to it as an equivalent.

Mr. BRAND: Mr. Mackasey made reference to one Nova Scotia that intrigued him. Presumably he was referring to Colonial Agencies. I know they sell tractors and snow plows, and apparently drugs to the government, as well. Under what seem to be these very fine, 74-GP-1b standards I am puzzled how you can go into a distributing house, which may be an office, let us say, with a few tractors standing around and things of this nature—how you can apply this and then give them a 74-GP-1 rating? I just do not understand how you do it.

If they import the drug, let us say, from some part of Europe, do you send a team of inspectors to the plant in Europe where they made the drug, because obviously if they are an agent it must come in in a capsulated or tabletted form?

Mr. SHOWALTER: It is true that we have listed, as being in conformity with the standard, some companies who do not manufacture in Canada. Some of the products that they supply are manufactured in Canada, and some elsewhere. If they meet the standard they will have in their possession quality control information about everything they provide—

Mr. BRAND: I was thinking of things like personnel, and how you describe the plants. This has to do with the manufacturing plant. You mean they supply this to you, saying that the toilets all have a sufficient amount of toilet paper in them? I understand this was the reason that one was turned down at one time not too long ago. How do you know that?

Mr. SHOWALTER: The company, if it is not a manufacturer, lists its suppliers, and it is under obligation to show that they are in conformity with the standard.

Mr. BRAND: That is exactly what I said, then.

Mr. SHOWALTER: Yes; that is correct.

Mr. MACKASEY: How do you know if they conform, other than from their testimony?

Mr. SHOWALTER: If it is a Canadian company, of course, we know; if it is a foreign company, of course, it is more difficult. But we do have a good deal of information about—

Mr. BRAND: Are you going to get rid of the inspectors?

Mr. SHOWALTER: I am sorry, I do not understand the meaning of that.

Mr. BRAND: I will make it clear then. If you are going to accept the written word from some of these firms about overseas ones, why will you not do the same thing for Canadian firms and get rid of your inspectors? Do you see what I mean? What is sauce for the goose is sauce for the gander, in other words. You are going to accept the written word from an agent. You get 1,000 pills of chlordiazopoxide, which the D.D.P. has just bought, and you are satisfied because they have sent with this a paper which says that the firm that manufactures these is clean in every way and meets the standards of 74-GP-1b. This is how you accept it?

Mr. SHOWALTER: No, that is not what I have said. We do not accept the word of the Canadian company to the effect that its foreign suppliers are in conformity with the standard. We have not asked for that.

Mr. FORRESTALL: You just do not ask for it. It is not a question of whether or not you accept it. You just do not ask for it. Is that what you are saying.

Mr. SHOWALTER: We try to get information on the foreign companies in order to support to this, but we are not always able to get it. We do have a good deal of information about foreign sources, but we do not have it all.

Mr. MACKASEY: Mr. Showalter, earlier you said that before a person could be invited to tender he had to satisfy certain standards which were enforced by the Food and Drug Directorate. Am I correct? Was it not your original testimony that before they can tender to your department, or to the government they had to satisfy your department that before they were invited to tender that they had lived up to the specifications of 74-GP-1, and that it was up to the Food and Drug Directorate to carry out the checks that are in this particlar formula.

Now, until Dr. Brand brought this point up I was under the impression that all the raw materials that were coming in from other countries because we do not manufacture them here—and the big companies cannot tell us differently, with a few exceptions—at least were being put into dosage form in Canada on premises that met this standard, and with the Food and Drug Directorate periodically making sure the standards did not deteriorate. For instance, in Section 5.2 it says that all ceilings, floors and walls of a building shall be reasonably dust-tight to the extent that dust cannot migrate through the floors or walls or from one room or operation to another.

> 5.2. All ceilings, floors, and walls shall be constructed, finished and maintained to prevent the introduction or migration of extraneous material into drug products.

This is an extract at random from "Premises and Equipment." How do you make sure that this is being carried out, if the source of the finished form is not in Canada?

Mr. SHOWALTER: There are undoubtedly many cases where we do not know; we do the best we can. This standard has provided an additional assurance, but there is no certainty, and there would be no certainty of the quality of a drug even if the drug were bought entirely from a Canadian manufacturer.

Mr. BRAND: Why include those where you have no certainty—no way of knowing at all—in the 74-GP-1 list?

Mr. SHOWALTER: This is partly based on history—the fact that government purchases has for a long time allowed non-Canadian products.

Mr. BRAND: Because of price alone?

Mr. SHOWALTER: No; because there has been—

Mr. BRAND: Surely if there is no check on quality it must be on price alone.

Mr. SHOWALTER: There have been benefits or, if you like to call it, handicaps for Canadian content in the purchasing; but it is also true that there are some Canadian manufacturers who offer, to Government purchase, products which are manufactured abroad. It was not felt by the Board that we wished to eliminate entirely firms who do not manufacture in Canada from the list of those that we would accept in accordance with this standard.

Mr. BRAND: But you do nothing in this to ensure the continuity of legal responsibility? In short, you do not ask the supplier, if he happens to be receiving his raw material or the package form from a foreign supplier, to guarantee, underwrite or accept responsibility for, the actual manufacturer. There is no legal responsibility. Your concern is only with yourself and the person who supplies you. You do not ask for the extension back?

Mr. SHOWALTER: Guarantees are a function of the purchasing activity, and I am not involved in purchasing activity. This is an accommodation, or a service and the list of companies was of purchasers.

Mr. FORRESTALL: We keep shopping around like this. It reminds me of Admiral Landymore's testimony and what eventually came out of that. Doctor, I do not think any one of us here is attempting in any way to do other than to put before the public all the information that is available. You gentlemen have come and donated your time, but all you are doing is answering questions. What if I were to ask each of the seven of you, for example, to tell the Committee what you think we could do usefully to achieve the purpose for which we are here? Would you feel free to comment frankly on that and give us the advantage and benefit of your experience, professional and otherwise? I suggest that you would be reluctant to do it. That is all.

Mr. SHOWALTER: Mr. Chairman, a hint of that was given in my original remarks, and I think it may be a valuable one; but in a way it is a sort of expression of opinion.

What I would like to say—because of some of the questions you have asked are about the standard and the list of people that we say conform to the standard—is that we are attempting to produce a system, and we think that the system is considerably better than the system that prevailed earlier. I am prepared to admit that it has imperfections. It would be ideal if we could run the same kind of inspection in all foreign suppliers to the Canadian drug market that we run in Canadian firms. I am afraid this is not possible at the present time. We still have created a system which, with some imperfections, has worked tremendous improvements in the purchasing of drugs in government.

Mr. BRAND: There is no argument about this. This is probably true.

Mr. MACKASEY: Why should a firm settle in Canada? Why do they not settle in some nearby point, such as Puerto Rico or even in Europe, and not have to meet with this standard?

I realize, as you mentioned earlier, that if there is any doubt on the part of the purchasing agent he can demand or request a test on the product, but it

seems to me we have two standards. I agree fully with your standard for Canadian manufacturers, in that they must conform to all this, and that the Food and Drug Directorate should be charged with the duty of inspecting the premises and of making certain that everything is there just as you outlined, but I did not quite realize that we do not really have any way of knowing whether products coming in from outside the country are meeting your standards, and I am rather surprised that we take a chance on these sources.

Mr. SHOWALTER: We have two ways of knowing. One is that the material is subject to inspection, as received by the user, and the other is the system of demerits applied in the standard. All I can tell you is that this standard has been used in government purchasing since, I believe, the end of June, 1964, and I have had in that time probably not more than about four or five reports of unsatisfactory material received by users.

Mr. MACKASEY: Is all material coming in from Europe checked automatically?

Mr. SHOWALTER: It is given the same kinds of checks as the others.

Mr. MACKASEY: That is not quite the answer to the question, because with the others you can check the premises; you can check the source of material; you can check the plant; you can check the physical assets by the Food and Drug Directorate dropping in unexpectedly. You cannot do this to the European firms. Therefore, do we get goods in from Europe that are not necessarily checked, or are they subject only to spot check, or is every batch checked?

Mr. SHOWALTER: Are you referring to the check of the factory operation, or the check of the product?

Mr. MACKASEY: The product.

Mr. SHOWALTER: The products coming from Europe are given the same check as products coming from any Canadian source.

Mr. MACKASEY: You are going to adhere to that. Tell me what it is. What is the check?

Mr. SHOWALTER: I am not the inspection authority here. I am afraid I cannot answer this question.

Mr. MACKASEY: Are you sure they can?

Mr. SHOWALTER: I think they can.

Mr. MACKASEY: Will someone answer it, then?

The CHAIRMAN: I think what Mr. Mackasey would like to know is if you get a product from the United Kingdom or France, you automatically check every batch.

Mr. LAROCQUE: Yes. If it is a new product and we have never had it before, we will check it. We will even check any product that we have checked many times before if we are suspicious that the source of the raw material has been changed from time to time.

Mr. MACKASEY: That is not quite the answer I am looking for, Mr. Chairman, but I guess it is the only answer available.

It strikes me—and Dr. Showalter is right—that if we are buying a product from, say, Empire, or from Smith, Kline and French, or from Hoffmann-LaRoche, these firms are situated and exist in Canada, and in addition to having them meet this standard they also have to face the psychological possibility of the Food and Drug Directorate walking in unannounced on a Wednesday morning and checking the lights; checking the fluorescents to make sure that there is no dust on them; checking sanitary facilities; and making sure that the tableting machine is properly cleansed when it switches from one ingredient to another. These are all things that guarantee or safeguard our health in Canada.

Now, for particular reasons, such as shortage of staff and other logical reasons, we cannot make that type of on-the-spot check on all the sources of products in Europe. Nevertheless, we do accept these products from Europe, and I just want to know why we do not check each and every batch, for that particular reason.

Now, if we are talking basically of food and drugs, we can ask that because of the general concern. But I am talking about these drugs that are bought according to the specifications of the Department of Industry. We have a very progressive section 5 pertaining to premises and equipment which we cannot enforce in many instances because the particular factory in which it should be enforced is situated thousands of miles away. Therefore, what protection do we have? What safeguard do we have, or what alternative do we have to section 5?

Mr. SHOWALTER: Mr. Chairman, I began by answering that there are two safeguards here.

Mr. MACKASEY: One is the demerit system.

Mr. SHOWALTER: One is the demerit system and the other is the inspection of the product when it is received.

Mr. MACKASEY: The demerit system is quite obvious. If you get a bad batch constantly you are going to eliminate the supplier; but I would like to know more about the inspection. Is it an automatic inspection, or is it only because someone requests it, or is it automatically all the time on every batch, or every purchase coming in?

Mr. SHOWALTER: If you are referring to inspection of the product, I think the department should answer. If you are referring to inspection of the source and the operation in which the material is made, then I am responsible, because I am the Chairman.

Mr. MACKASEY: Would you answer in your area of responsibility, then, and we will get the answer from the others.

Mr. SHOWALTER: I explained that we realize that this is an imperfect system, and yet it has brought benefits. It is imperfect partly we cannot inspect all companies throughout the world. We do have a good deal of knowledge about the many sources throughout the world, partly because Food and Drug has travelled very considerably in those areas.

Mr. MACKASEY: I have been reading about that.

Mr. SHOWALTER: Further, we have knowledge about the performance of those sources, and that knowledge is officially conveyed into the list of acceptable

firms through the medium of the demerits; and the reason I raise that again is that the experience with demerits over the last two and a half years has justified the system.

Mr. MACKASEY: When the price variation is very little, such as in the case of penicillin—$1.21, $1.22½, $1.35—do we take into consideration then, Dr. Showalter, that one of the firms—it may not be the lowest but very close—exists in Canada, and as a result of that has to be subject to the physical inspections, as I think it should be, as outlined in section 5. Is there any advantage given to these companies?

Mr. SHOWALTER: I am afraid I do not quite understand this question.

Mr. MACKASEY: Well, suppose that $1.21 is the price quoted by a firm with a source in Poland, which has an office, suite number such and such, and not subject to demerit; his price is two cents cheaper than that of a firm that is situated in Cooksville, or in an Ontario location, which is at least packaging the raw material and so on, but it is a few cents dearer; and incidentally, is subject, as it should be, to the periodical inspection of the Food and Drug Directorate. Does this second firm, which is a couple of cents dearer, get any advantage by the fact that it is Canadian?

Mr. SHOWALTER: Mr. Erskine might like to answer with respect to the effect of Canadian content on purchasing, but if the company's name is on the list, normally it would be question of lowest tender.

I should explain that the several departments, which participate in what we call the Interdepartmental Advisory Board, are independent in their own authorities. Each reports to the House through its own minister. I, as Chairman, am just a sort of co-ordinator in a bull-pen; that is to say, we are a bunch of gentlemen—

Mr. MACKASEY: But they are not independent to the point that they can ignore this standard?

Mr. SHOWALTER: They can ignore the standard, and we are only around the table as a board on a basis of mutual agreement; because each department may do what it wishes, and on some occasions it must, because it may be buying something for which there is no source approved under this.

Mr. MACKASEY: Will the purchasing agents of the departments perhaps answer my question?

Mr. ERSKINE: I will, Mr. Chairman. We do pay a premium for Canadian content, but usually when you get into a price which is as close as this one the foreign content of the total price would be a very, very small percentage, and when we use the factor that we use for the Canadian portion of it it would probably make no difference in the award of the contract. The foreign content would probably be represented by the actual ingredients that came in. All the rest would be Canadian. The customs duty is paid, the clearance, the sales tax, and so forth.

Mr. MACKASEY: I was not talking about Canadian manufacture; I was really talking about packaging firms, where there is no real manufacture. I am talking about people who bring in raw material. At least they are under the supervision of the Food and Drug Directorate when they are transferring the raw material

into dosage form. I am comparing them to a firm who imports it, already in dosage form, we will say, from Poland or Italy, or England. Does the Canadian firm gain any advantage from the fact that it is Canadian?

Mr. ERSKINE: Yes; the foreign content is taken into consideration.

Mr. MACKASEY: Is it a formula?

Mr. ERSKINE: Yes, it is a formula.

Mr. MACKASEY: Is it a matter of judgment?

Mr. ERSKINE: No, it is a formula.

Mr. MACKASEY: Could you outline the formula?

Mr. ERSKINE: It is a policy which is applicable to all the products. There is a 10 per cent allowance, but only on that factor which is foreign.

Mr. MACKASEY: Only on the material?

Mr. ERSKINE: On whatever was involved in the foreign price. In the case of purchases in the United States, for instance, which were bought f.o.b. down in the south, the transportation costs that were incurred outside the country would also be a factor. That would be foreign content, too.

Mr. MACKASEY: It would be a factor in the final price of the submission would it not?

Mr. ERSKINE: That is right. But the proportion of the foreign content would include an element that was not really material. It would be a service charge in there, for freight in that case.

Mr. MACKASEY: In this source of supply in the deep south, do we have any type of agents—perhaps a United States government agency—whose word we accept that this source of supply meets the standards of the Food and Drug Directorate?

Mr. ERSKINE: No; I cannot recall our buying anything in the United States in the drug field; but the formula is used very, very generally, and if we are dealing with military supplies we use the same formula. I was merely using that as an illustration to show an element that was not directly material.

Mr. MACKASEY: I think you will agree that there is a different element here in drugs, however; that there is the safety factor, if nothing else.

Mr. ERSKINE: Well our formula, of course, is just that—a formula.

Mr. MACKASEY: Do any of the other departments make the distinction?

Mr. LAROCQUE: The Department of Defence Production are now doing the purchasing for us, but when we were doing our own purchasing we also used the same formula as D.D.P. used.

Mr. BRAND: I asked previously about inspection of these foreign companies. You said that this just was not done. At page 9 of your 74-GP-1b, under paragraph 15, Inspection, I read the following:

> When all or part of the inspection required by this Standard must be carried out in a foreign country, the necessary living and travelling expenses related to such inspection shall be provided by the supplier.

Now, if you do not do that, why do you not?

Mr. SHOWALTER: This is a Food and Drug Directorate problem, I believe, but—

Mr. BRAND: This is under the 74-GP-1, which I heard you say a few minutes ago is your baby.

Mr. SHOWALTER: That is true. This standard was drafted by a committee which contained representatives of various government departments and of industry. They wanted to have that provision in there in order that it would be already made clear to any supplier that he must allow this. It is optional on our part, but not on his.

Mr. BRAND: I still do not understand, though, why you have two standards, one for those from foreign countries and another for those in Canada, for inclusion in the 74-GP-1 list, and for the life of me, despite the historical references you mention, I do not understand why you do not delete from the 74-GP-1 list any foreign or other companies who do not comply, as Canadian manufacturers must, with the 74-GP-1b standards as amended 7 October, 1966. Or are these orders from higher up suggesting that it might be wise to buy from such-and-such a country?

Mr. SHOWALTER: No; I can answer quite frankly, Mr. Chairman, that I have no orders from higher up. Our Board is attempting to do a job. We think that we have done an acceptable job. We know that there are faults in the system, but it has brought about benefits.

Mr. BRAND: I agree; I have already said that this is a good standard. However, I do not necessarily agree that you are implementing it the way that you should. Why should you accept companies that you have not inspected, and then send inspectors into Canadian firms and turn one down, for example, because he does not have any toilet paper in the receptacle, as occurred not very long ago? I do not understand this; it just does not make sense to me. I do not know how it makes sense to you either.

Mr. SHOWALTER: If we turned down all imported material we would be turning down the supplies of many of the large Canadian manufacturers.

Mr. BRAND: You are avoiding the question. You just skidded around the corner. I am not talking about the bulk supplies that are brought in from Europe, that must be mentioned on the tender; the amount, in Canadian funds that are doing out to the United States or in United States funds—whichever it is—of stuff brought in from other parts of the country. I am talking about these other firms who are on this list whom you have not inspected according to the specifications laid out in 73-GP-1. That is what I am talking about; I am not talking about all imports or raw materials and things of that nature.

All I am saying is that if you are going to do this why not inspect them all and see if they are really good? If you were seriously ill would you like to take some medicine from some place in Poland? I know that we do not get any from Poland, according to the Food and Drug Directorate, so that I will use that as an example. Would you take something that comes in from Poland not knowing how it was made, or where, why, or when? You are lying in a veterans' hospital and the supplies go directly to the veterans' hospital. It is the weekend and it arrives

on Saturday. Nobody looks at it to make sure whether they like it or not, or whether they are going to send it away for testing. In the meantime you take some? Would you like to be in that position?

The CHAIRMAN: I think it is fair to point out that under D.V.A. I am sure this would not happen. They do not open—

Mr. BRAND: It is in evidence that it does happen. This is in evidence today, Mr. Chairman. I ask you to look back on the transcript of today. You will find that this indeed happened in connection with the trifluorin, the one I mentioned. The shipment was made directly to the hospital.

The CHAIRMAN: From a Canadian company. We are here talking about an overseas company.

Mr. BRAND: I do not care what company it is from. I want them to apply the standards everywhere. The fact is that it can happen. If it can happen from a Canadian company, what is going to stop it happening from one of those?

The CHAIRMAN: Because the gentleman have already told you that they would test every batch before they released it. At least that was my interpretation.

Mr. BRAND: That is the idealistic approach.

Mr. LAROCQUE: In the three cases that were mentioned I do not think any of the three hospitals that received them have taken this material into use as yet. One hospital is sending it out and having it tested before they use it; one hospital returned it to the firm without even looking at it that closely; the other hospital is holding it for some decision some place.

Mr. BRAND: I am very pleased, Mr. Chairman, to hear that finally what I said was confirmed. It was one hospital a short while ago, now there are three. Thank you very much.

Mr. LAROCQUE: I said one returned it; three received it.

Mr. BRAND: Ah.

Mr. LAROCQUE: Another thing which is involved here is that our hospitals are not down to rock-bottom, we hope, when they re-order, and they should have at least a month's supply on hand when they receive a new product. This is our standard.

Mr. MACKASEY: If they are down to rock bottom, they do have permission to buy it locally. I understand there is a fund.

Mr. LAROCQUE: A veteran never goes short.

Mr. MACKASEY: Well, this is one of the reasons why he does not. You do have the right to run down the corner store if you run out of something, because of, say late shipment as the result of a shipping strike, or the longshoremen holding up the shipment. You do have the right to go down to the corner, and regardless of price, buy the product you need?

Mr. LAROCQUE: Treatment comes first; price comes second.

Mr. MACKASEY: Fine.

Mr. LAIDLAW: I have just one very brief question, Mr. Chairman, that happens to relate to prices.

Witnesses have appeared before this committee, Mr. Chairman, and one of the many reasons given for the lowest prices to hospitals was the fact—and I think several witnesses said this—that the companies like to get their products into the hospital so that the medical profession can become aware of their product, and they hope that the medical profession will, when they are prescribing to their own patients, use this particular product.

Now my question is this: if, for example, on an order placed by the Department of Defence Production for a Chloramphenicol, Parke, Davis & Company was the lowest bidder, does the product come into the hospital marked "Chloromycetin" or does it carry the trade name and the generic name. Or, if it carries both, does it carry the generic name in small letters compared to the trade name? This of course could apply to any order of a generic which has a trade name.

Mr. ALLMARK: According to the regulations covering this, both names have to appear on the labels, if there is a generic name. They both have to appear, and they have to be displayed prominently.

Mr. LAIDLAW: But my question would be: if Chloramphenicol is ordered, then it comes back marked "Chloromycetin" in the case where Parke, Davis & Company had been the successful bidder, then in small letters underneath would be the generic name which was ordered in the first place.

Mr. ALLMARK: Yes; it could appear that way. The brand name would take prominence in that particular case.

Mr. LAIDLAW: Thank you, Mr. Allmark.

The CHAIRMAN: Are there any other questions of the witnesses.

I am sorry to keep the Committee so long but I had hoped that we would perhaps finish this morning by, say, one o'clock.

Mr. FORRESTALL: There is one final question that I would like to ask, and perhaps they could all comment on it.

Is there any other group of people in Canada who can buy drugs as cheaply as the government?

Mr. ERSKINE: Apparently a number of the larger hospitals, Mr. Chairman, are able to buy drugs as cheaply as some of the ones we buy. We do not have a complete price comparison across the board, though.

Mr. FORRESTALL: Is this something that you perhaps are attempting to do, as a matter of your history.

Mr. ERSKINE: As a matter of fact we are trying to achieve an utopian goal in the new department of supply, as I guess it will be named, to have a total cost concept in all our buying, which will include all factors; so that in the case of many of the questions which have been asked today, about inspection and so on, these costs would be added until you got a total cost of an end product; and this will include all fields, not just drugs.

Mr. FORRESTALL: In light of your personal experience, would you make one comment and tell us whether or not you think the costs of drugs to the general public are too high? I am speaking very personally.

Mr. ERSKINE: Mr. Chairman, I can only say that about two or three weeks ago I, unfortunately, had to get a prescription from my doctor. I had it filled by a drugstore. It happened to be one of the drugs mentioned here. The price that I paid for twelve was certainly very different.

Mr. FORRESTALL: Dr. Showalter, would you care to just briefly comment for the Committee.

Do you think the costs of drugs for the Canadian public are too high. Personally speaking, as a Canadian citizen, taxpayer and resident?

Mr. MACKASEY: I should warn Mr. Forrestall and the doctor that whether he says yes or no I am going to ask him on what he bases his argument.

Mr. FORRESTALL: I would be interested, because, Mr. Chairman, these are responsible Canadians who have some understanding, and I wonder if, just as Canadian citizens, and very personally speaking, they could just briefly comment.

Mr. SHOWALTER: I am afraid I do not have a very good opinion here, Mr. Chairman. I wonder if, when we say, "Too high," we are thinking about economics or ethics. I am not quite sure that I understand the question.

Mr. FORRESTALL: Now, that is an excellent answer.

An hon. MEMBER: The best answer we have had today.

Mr. FORRESTALL: Would the other gentlemen care to comment briefly.

Mr. POYNTZ: Only when I have to pay for a prescription.

Mr. FORRESTALL: Thank you.

Mr. FRIESEN: I think all prices are too high, including food and drugs.

Mr. ELLIS: It has not been mentioned, Mr. Chairman—I am bashful—but I must admit that I am a pharmacist. A doctor in Ottawa attends my family when any of us is sick. I pay the retail drugstore price for prescriptions. I do not feel hurt.

Mr. FORRESTALL: You are not unhappy.

Mr. ELLIS: I know what goes into it, and I am not unhappy.

Mr. ALLMARK: I must say that I am not unhappy either. I do not buy too many drugs.

Mr. RITCHIE: I think you have to have a personal opinion. We are all concerned with the cost of treating our patients, and certainly the cost of drugs contributes in no small way to this.

I think there are too many factors involved to be able to express any firm opinion on whether the prices are too high or not.

Mr. FORRESTALL: Thank you, doctor.

Mr. LAROCQUE: It depends on what side of the dispensing counter I am working on at the moment. I would like to say, however, that when a doctor

writes a prescription I am much happier dispensing a trade name drug than a generic one. If he puts down the generic name, with the cheapest beside it, I do not like filling that prescription.

Mr. FORRESTALL: Thank you, very much.

The CHAIRMAN: May I thank the committee and the witnesses for persevering until one o'clock. I would like to thank the gentlemen for appearing.

There will be no meeting this afternoon. There will be two meetings next week.

The meeting is adjourned.

APPENDIX "A"

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
1. Chloromycetin	Chloramphenicol	240 mgm.	Parke Davis Co.	100 tabs

LAST PURCHASE—DDP Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
				Per 100				
GH51051-6-0307	180,000 tabs	Ciba Co. Ltd., Dorval, P.Q. Burroughs Wellcome & Co. Lachine Bristol Laboratories, Candiac, P.Q. Abbott Laboratories, Montreal Ayerst, McKenna & Marrison, Mtl. Pfizer Co. Ltd., Montreal Merck Sharp & Dohme, Montreal Laboratoire Nadeau, Ltd., Mtl. Cyanamid of Canada Ltd., Mtl. Charles E. Frosst & Co., Mtl. Smith-Kline & French, Mtl. 9 E. R. Squibb & Sons, Mtl. Laboratoire Pentagone Lte., Mtl. Frank W. Horner Ltd., Mtl. Nordic Biochemicals Ltd., Mtl. Neo Drug Co., Montreal 28 Schering Corp. Ltd., Pte Claire Sandoz Canada Ltd., Dorval, P.Q. Winley-Morris Co. Ltd., Mtl. Connaught Medical Res. Lab., Tor. Bell-Craig Pharmaceuticals, Tor. British Drug Houses, Toronto Glaxo-Allenburys, Toronto John Wyeth & Brother, Windsor Intra Medical Products, Tor. Eli Lilly & Co., Toronto Pitman-Moore of Canada, Don Mills Parke, Davis & Co. Ltd., Brockville Winthrop Laboratories, Aurora The Upjohn Co. of Canada, Toronto Mowatt & Moore Ltd., Pte Claire Baxter Laboratories of Can., Alliston Webber Pharmaceuticals, Rexdale Warner-Chilcott Lab., Toronto Paul Maney Laboratories, Toronto Aerosol Custom Pharms., Toronto Strong Cobb Arner of Can., Fort Erie Canada Duphar Ltd., London Rexall Drug Co. Ltd., Cooksville Empire Laboratories Ltd., Toronto Hoechst Pharmaceuticals, Montreal	Laboratoire Pentagone Ltee..... Parke, Davis & Co. Ltd Frank W. Horner Ltd... Canada Duphar.....	$3.25 $6.39 $8.50 $8.50	Laboratoire Pentagone Ltee. Montreal 38, P.Q.	16/9/66	$5,850.00	D.V.A.

NOTE: This was a composite tender covering the supply of 51 items of Pharmaceuticals for delivery to various D.V.A. Hospitals across Canada.

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
2. Achromycin	Tetracycline	250 mgm.	Lederle (Cyanamid)	100 tabs

LAST PURCHASE—DDP Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
				Per 100				
GH51051-6-0307	850,000 Caps.	Ciba Co. Ltd., Dorval, P.Q. Burroughs Wellcome & Co. Lachine Bristol Laboratories, Candiac, P.Q. Abbott Laboratories, Montreal Ayerst, McKenna & Harrison, Mtl. Pfizer Co. Ltd, Montreal Merck Sharp & Dohme, Montreal Laboratoire Nadeau, Ltd., Mtl. Cyanamid of Canada Ltd., Mtl. Charles E. Frosst & Co. Mtl. Smith-Kline & French, Mtl. 9 E. R. Squibb & Sons, Mtl. Laboratoire Pentagone Lte. Mtl. Frank W. Horner Ltd., Mtl. Nordic Biochemicals Ltd., Mtl. Neo Drug Co., Montreal 28 Schering Corp. Ltd., Pte Claire Sandoz Canada Ltd., Dorval, P.Q. Winley-Morris Co. Ltd., Mtl. Connaught Medical Res. Lab., Tor. Bell-Craig Pharmaceuticals, Tor. British Drug Houses, Toronto Glaxo-Allenburys, Toronto John Wyeth & Brother, Windsor Intra Medical Products, Tor. Eli Lilly & Co., Toronto Pitman-Moore of Canada, Don Mills Parke ,Davis & Co. Ltd., Brockville Winthrop Laboratories, Aurora The Upjohn Co. of Canada, Toronto Mowatt & Moore Ltd. Pte. Claire Baxter Laboratories of Can., Alliston Webber Pharmaceuticals, Rexdale Warner-Chilcott Lab., Toronto Paul Maney Laboratories, Toronto Aerosol Custom Pharms. Toronto Strong Cobb Arner of Can., Fort Erie Canada Duphar Ltd., London Rexdale Drug Co. Ltd,. Cooksville Empire Laboratories Ltd., Toronto Hoechst Pharmaceuticals, Montreal	Empire Laboratories Ltd.	$3.14	Empire Laboratories Ltd., Toronto 3, Ontario	16/9/66	$27,200.00 (Est.)	D.V.A.
			Mowatt & Moore Ltd.	$3.70				
			Frank W. Horner Ltd.	$3.75				
			Charles E. Frosst & Co.	$3.90				
			Pfizer Co. Ltd.	$5.95				
			Bristol Laboratories	$7.13				
			Cyanamid of Canada Ltd.	$13.047				

NOTE: This was a composite tender covering the supply of 51 items of Pharmaceuticals for delivery to various D.V.A. Hospitals across Canada.

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
3. Gantrisin	Sulfisoxazole	0.5 Gm.	Hoffman-La Roche	100 tabs

LAST PURCHASE—DDP

Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
GH51051-6-0525-7	500,000 tabs	Hoffman La Roche Limited, Montreal 9, P.Q. (Only source)	Hoffman La Roche Limited, Montreal 9, P.Q.....	$1.66 per 100	Hoffman La Roche Limited, Montreal 9, P.Q.	27/7/66	$8,300.00	D.V.A.

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
4. Pentids	Penicillin G potassium	600,000 units	Squibb	100 tabs

NOTE: No purchase of 600,000 unit strength. Prices below are for 500,000 units strength purchased under generic name.

LAST PURCHASE—DDP

Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
				Per 100				
GH51051-6-0307	1,200,000 tabs.	Ciba Co. Ltd., Dorval, P.Q.	British Drug Houses....	$1.21	British Drug Houses, Toronto, Ontario.	16/9/66	$14,500.00	D.V.A.
		Burroughs Wellcome & Co. Lachine	Pfizer Co. Ltd.....	$1.225				
		Bristol Laboratories, Candiac, P.Q.	E.R. Squibb & Sons....	$1.35				
		Abbott Laboratories, Montreal	Mowatt & Moore Ltd...	$1.45				
		Ayerst, McKenna & Harrison, Mtl.	Charles E. Frosst & Co.	$1.57				
		Pfizer Co. Ltd., Montreal	John Wyeth & Brother..	$1.632				
		Merck Sharp & Dohme, Montreal	Glaxo-Allenburys.....	$1.65				
		Laboratoire Nadeau, Ltd., Mtl.	Ayerst, McKenna & Harrison.....	$1.70				
		Cyanamid of Canada Ltd. Mtl.	Canada Duphar.....	$1.723				
		Charles E. Frosst & Co. Mtl.	Frank W. Horner Ltd...	$1.80				
		Smith-Kline & French Mtl. 9	Winley-Morris Co. Ltd..	$2.12				
		E. R. Squibb & Sons, Mtl.						
		Laboratoire Pentagone Lte. Mtl.						
		Frank W. Horner Ltd., Mtl.						
		Nordic Biochemicals Ltd. Mtl.						
		Neo Drug Co., Montreal 28						
		Schering Corp. Ltd., Pte. Claire						
		Sandoz Canada Ltd., Dorval, P.Q.						
		Winley-Morris Co. Ltd. Mtl.						
		Connaught Medical Res. Lab. Tor.						
		Bell-Craig Pharmaceuticals, Tor.						
		British Drug Houses, Toronto						
		Glaxo-Allenburys, Toronto						
		John Wyeth & Brother, Windsor						
		Intra Medical Products, Tor.						
		Eli Lilly & Co., Toronto						
		Pitman-Moore of Canada, Don Mills						

Parke, Davis & Co. Ltd. Brockville
Winthrop Laboratories, Aurora
The Upjohn Co. of Canada, Toronto
Mowatt & Moore Ltd. Pte. Claire
Baxter Laboratories of Can. Alliston
Webber Pharmaceuticals, Rexdale
Warner-Chilcott Lab., Toronto
Paul Maney Laboratories, Toronto
Aerosol Custom Pharms. Toronto
Strong Cobb Arner of Can. Fort Erie
Canada Duphar Ltd., London
Rexall Drug Co. Ltd. Cooksville
Empire Laboratories Ltd. Toronto
Hoechst Pharmaceuticals, Montreal

NOTE: This was a composite tender covering the supply of 51 items of Pharmaceuticals for delivery to various D.V.A. Hospitals across Canada.

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
5. Decadron	Dexamethasone (methylprednisolone)	0.75 mgm.	Merck Sharp & Dohme	100 tabs

LAST PURCHASE—DDP

Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
				Per 100				
GH51051-6-0252-30	2,000 tabs	Schering Corp. Ltd. Pointe Claire, P.Q. (Only firm invited)	Schering Corp. Ltd..... Pointe Claire, P.Q.	$3.59	Schering Corp. Ltd..... Pointe Claire, P.Q.	26/5/66	$71.80	D.V.A.

NOTE: Prices quoted on a previous purchase were: Schering Corp. Ltd..... $17.95 per 500
Merck Sharp & Dohme..... $36.50 per 500
Considering the dollar value involved Schering Corp. Ltd. was the only firm requested to quote.

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
6. Librium	Chlordiazopoxide	10 mgm.	Hoffman-La Roche	100 tabs

LAST PURCHASE—DDP

Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
				Per 100				
GH51051-6-0950-4	15,000 Caps.	Hoffman-LaRoche Limited, Mtl. P.Q. Elliott Marion Co. Ltd., Mtl. P.Q. Canada Duphar Ltd., London, Ont.	Hoffman-LaRoche..... Elliott Marion Co. Ltd.. Canada Duphar Ltd.	$2.60 $2.80 $2.97	Hoffman LaRoche Ltd. Montreal 9, P.Q.	2/10/66	$390.00	D.V.A.

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
7. Equanil	Meprobamate	400 mgm.	Wyeth & Co.	100 tabs

LAST PURCHASE—DDP

Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
				Per 100				
CB20–430215/ Req. 12–1	400,000 tabs.	Bell Craig Pharmaceuticals, Tor. Intra Medical, Tor. John Wyeth & Brother, Windsor Ayerst, McKenna & Harrison, Mtl.	Bell Craig Pharmaceuticals..... Intra Medical..... John Wyeth & Brother.. Ayerst, McKenna & Harrison.....	$0.356 $0.53 $1.44 $1.86	Bell Craig Pharmaceuticals, Toronto 9, Ont.	13/7/64	$1,424.00	D.N.D. (Meds)

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
7. Enovid	Norethynodrol with Mestranol	5 mgm.	Searle	100 tabs

LAST PURCHASE—DDP

Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
GH51051–6–0697–11	25,000 tabs	G. D. Searle & Co. of Canada Ltd. Bromalea, Ont. (Only source)	G. D. Searle & Co. of Canada Ltd..... Bromalea, Ont.	$7.826 per 100	G. D. Searle & Co. of Canada Ltd., Bromalea, Ont.	24/8/66	$1,956.50	D.V.A.

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
9. Butazolidin	Phenylbutazone	100 mgm.	Geigy	100 tabs

LAST PURCHASE—DDP

Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
				Per 100				
GV20–430203–11	260,000	Paul Maney Laboratories, Tor. British Drug Houses, Toronto Mowatt Moore Ltd., Montreal Intra Medical, Toronto Geigy Pharmaceuticals, Mtl.	Paul Maney Laboratories..... British Drug Houses.... Mowatt Moore Ltd..... Intra Medical..... Geigy Pharmaceuticals.	$0.33 0.58 0.40 0.673 2.62	Paul Maney Laboratories, Toronto, Ont.	9/4/64	$858.00	DND (Med)

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
10. Mobenol	Tolbutamide	0.5 Gm.	Horner	100 tabs

LAST PURCHASE—DDP

Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
				Per 100				
GH51051-6-0930-18	7,500 btls. of 50	Hoechst Pharmaceuticals, Mtl. Frank W. Horner, Toronto	Hoechst Pharmaceuticals Frank W. Horner.....	$2.465 $2.48	Hoechst Pharmaceuticals Montreal 16, P.Q.	20/10/66	$9,243.75	D.V.A.

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
11. "222"	(Acetylsalicylic acid phenacetin, caffeine & codeine phosphate gr. 1/8)		Frosst	1,000 tabs

LAST PURCHASE—DDP

Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
				Per M				
GH20-657030 Req. 238	3,000,000 tabs.	Chas. E. Frosst & Co., Mtl. H.K. Wampole & Co., Ltd., Perth Bell Craig Pharmaceuticals, Tor. Druggists Corp. Toronto John Wyeth & Brother, Windsor	Chas. E. Frosst & Co... H.K. Wampole & Co. Ltd..... Bell Craig Pharmaceuticals..... Druggists Corp..... John Wyeth & Brother..	$2.60 $3.282 $3.35 $4.528 $4.60	Chas. E. Frosst & Company. Montreal, P.Q.	26/10/66	$7,800.00	DND (Med)

TRADE NAME	GENERIC NAME	STRENGTH	MANUFACTURER	ORIGINAL SIZE
12. Premarin	(Estrogenic substances)	1.25 mgm.	Ayerst, McKenna & Harrison	100 tabs

LAST PURCHASE—DDP

Purchase File	Quantity	Firms Invited to Tender	Firms Tendering	Unit Price	Contractor	Date	Lot Price	User Department
GH51051-6-0177-14	5,000 tabs	Ayerst Laboratories, Division of Ayerst, McKenna Harrison Limited, Montreal, P.Q. (only source)	Ayerst Laboratories, Division of Ayerst, McKenna Harrison Limited, Montreal, P.Q.	$3.59 per 100	Ayerst Laboratories, Division of Ayerst, McKenna Harrison Ltd. Montreal, P.Q.	8/6/66	$179.50	D.V.A.

APPENDIX "B"

CANADIAN GOVERNMENT SPECIFICATIONS BOARD

Standard
for

MANUFACTURE, CONTROL AND DISTRIBUTION OF DRUGS

1. *SCOPE*

1.1 This standard applies to the manufacture, control and distribution of drugs for supply to agencies of the Government of Canada.

1.2 It applies to primary manufacturers of drugs, primary distributors of drugs, importers and commercial testing laboratories. (See par. 19.1.)

1.3 *Warning*—Conformity with this standard, as judged by any purchaser, is not to be construed as a guarantee of quality of products, or as evidence that products of any manufacturer are superior to those of others. This standard does not apply to the skill used in developing, designing or manufacturing these products, to the hazards of their use, or to their stability in storage.

2. *GLOSSARY*

2.1 *Supplier*—Any person or firm that undertakes to contract for the supply of a drug.

2.2 *Drug*—Any substance or mixture of substances manufactured, sold or represented for use in:

2.2.1 The diagnosis, treatment, mitigation or prevention of disease, disorder, abnormal physical state or symptoms thereof in man or animal.

2.2.2 Restoration, correction or modification of organic function in man or animal.

2.3 *Bulk Drug*—Loose, unpackaged material, usually in lots larger than the largest commercially available package size; material in a semifinished form, or material in other than its final dosage form.

2.4 *Quarantine*—Status of material isolated and not available for use until released by a designated authority.

2.5 *Lot*—A portion of any drug distributed under a specific lot number, of which the character and quality are uniform within specified limits.

2.6 *Lot Number*—Any distinctive symbol or combination of letters or numbers, or both, by which any drug can be traced in manufacture and identified in distribution.

2.7 *Batch*—A portion of any drug manufactured according to a single manufacturing order as attested by the signatories of the order. A batch will be smaller than a lot except in the case of continuous procedures.

3. *APPLICABLE ACTS AND REGULATIONS*

In addition to complying with this standard, the manufacture, testing and handling of all drugs shall conform to the relevant provisions of the following:

3.1 Food and Drugs Act and Regulations.

3.2 Proprietary or Patent Medicine Act and Regulations.

3.3 Narcotic Control Act and Regulations.

3.4 Pest Control Products Act and Regulations.

3.5 Animal Contagious Diseases Act and Regulations.

3.6 Municipal and provincial regulations that apply in the area where the plant of the supplier is situated.

4. *INSPECTION AND CRITERIA OF CONFORMITY*

4.1 Anyone wishing to supply a drug may request through the purchaser an inspection of the system of manufacture, control and distribution of the drug.

4.2 *Rating System*

4.2.1 The degree of conformity with each of the detailed provisions within Sections 5 to 14 shall be indicated by a figure based on the figure shown in the right-hand column of this Standard, which represents full compliance with that requirement. The final rating is obtained by expressing the aggregate of all such individual figures as a per cent of the maximum. Where parenterals are not manufactured, the rating for Section 7 will not be included in the computation.

4.2.2 The supplier shall be deemed to have conformed with the Standard if the final rating obtained in the manner described in 4.2.1 is:

4.2.2.1 Not lower than 90 per cent of the total rating for all the requirements of the Standard.

4.2.2.2 Not lower than 90 per cent of the indicated individual rating for the requirements in each of Sections 7, 9, 10 and 11.

4.2.2.3 Not lower than 70 per cent of the indicated individual rating for the requirements in each of Sections 5, 6, 8, 12, 13 and 14.

5. *PREMISES AND EQUIPMENT* 50

5.1 All processing, packaging, testing, storage and distribution areas shall be of material, construction and finish that will permit the ready and efficient cleaning of all surfaces.

5.2 All ceilings, floors and walls shall be constructed, finished and maintained to prevent the introduction or migration of extraneous material into drug products.

5.3 Drains shall be of adequate size and suitable type; and where connected directly to a sewer, they shall be equipped with traps.

5.4 Adequate light and ventilation shall be provided in all working areas.

5.5 All processing, packaging and finishing equipment shall be:

5.5.1 Suitable for the operations carried out in accordance with accepted pharmaceutical manufacturing practice.

5.5.2 Designed so as to permit ready and thorough cleaning, and shall be of materials and construction that will not contaminate or add extraneous materials to drugs for which it is used.

5.5.3 Maintained in a manner that will prevent contamination of drugs with extraneous materials.

5.5.4 Subject to clean-up procedure following the manufacture of each lot of drug.

6. *SANITATION* 100

6.1 The premises shall be clean, sanitary, orderly and free from accumulated waste and debris, vermin and pets.

6.2 A written sanitation program shall be available.

6.3 Toilet facilities and sanitary supplies shall be provided and maintained in satisfactory condition at all times.

6.4 An adequate number of sanitary wash basins near working areas, with a satisfactory supply of hot and cold water, liquid or powdered soap, air dryers or single-service towels, shall be provided. Handwashing shall be carried out before commencement of work and after each absence from duty.

6.5 No eating, smoking nor spitting shall be permitted in working areas.

6.6 Only material required for the particular manufacturing operation in progress at any one time shall be stored in the immediate working area.

6.7 Clean working garments shall be worn over, or in place of, street clothing for work in processing and packaging areas.

7. *PARENTERALS* 300

7.1 *General*

7.1.1 Every parenteral drug shall be terminally steam sterilized, except when such sterilization may cause harm to the drug, or it has been shown that the drug is self-sterilizing.

7.1.2 Nothing in this Standard shall be taken as an indication that terminally sterilized drugs may not be aseptically filled.

7.1.3 No clinical nor diagnostic procedures, and no other unrelated operation, shall be carried out in the filling area for parenteral drugs.

7.1.4 Distilled water used in parenteral solutions, or when used in the final rinsing of the ampoules, vials or components thereof, shall be produced by a still that is not operated beyond its rated capacity; the body of the still shall be emptied and cleaned periodically, and the distilled water storage tanks shall be emptied at least every 24 hours, unless suitable precautions are taken to prevent bacterial growth.

7.1.5 Nonpyrogenic distilled water shall be used in all aqueous parenteral drugs, Pyrogen tests shall be conducted on this water unless the final dosage form is so tested.

7.1.6 The manufacture and testing of parenteral drugs shall be the responsibility of personnel complying with the requirements of 8.2, provided such personnel have had training in microbiology.

7.2 *Aseptically Filled Drugs*

7.2.1 All aseptic processes shall be carried out in an aseptic processing area that shall be a separate and enclosed area designed for the processing, filling and closing of the drugs and operated in a manner that will prevent contamination of the drugs.

7.2.2 The asceptic processing area shall be designed and equipped to ensure the safety and the sterility of drugs compounded and filled; the area shall be provided with a supply of filtered "sterile" air under positive pressure, subject to disinfectant sprays or disinfectant wipe-downs; and the area shall be subject to limited access of personnel through an airlock.

7.2.3 Immediately before entering the aseptic processing area, the operators shall scrub with liquid antiseptic soap and be dressed with sterile outer garments, rubber gloves, face mask, and coverings for the head and shoes (or the shoes shall have been subjected to an effective sterilizing procedure).

7.2.4 The aseptic processing area shall be checked routinely by performing bacterial counts on the air in the room.

7.2.5 The aseptic filling operation shall be proven by testing the efficiency of sterilizing procedures used and by carrying out normal filling operations with sterile thioglycollate medium or other means suitable for dry-powder fills.

7.2.6 Records shall be prepared and retained of the processing, filling and sterilizing procedures used, including recording sterilizer charts, or exposure time and temperature details, for the component parts of the finished drug.

7.3 *Terminally Sterilized Drugs*

7.3.1 All processing and filling shall be carried out, and all units shall be filled or closed, in a separate and enclosed area designed for the processing, filling and sealing or closing of such drugs and operated in a manner that will prevent contamination of the drugs.

7.3.2 The filling, processing and sealing or closing area shall be designed and equipped to ensure safety of the drug, and the area shall be provided with a supply of filtered air under positive pressure, subject to disinfectant sprays or disinfectant wipe-downs; the area shall be subject to limited access of personnel.

7.3.3 Before entering the filling and processing area of parenteral drugs, the operators shall scrub with liquid antiseptic soap and be dressed with clean outer garments and covering for the head.

7.3.4 The sterilizing operation shall be checked routinely for the efficiency of the sterilizing procedures used.

7.3.5 Records shall be prepared and retained of the processing and filling, and of the sterilizing procedures used, including recording sterilizer charts.

7.3.6 The time lapse between the preparation of the distilled water or other solvent and the terminal sterilization of the drug shall be reduced to a minimum and shall not exceed 24 hours, unless suitable precautions are taken to prevent bacterial growth.

8. *PERSONNEL* 125

8.1 *Health of Personnel*—No person known to be affected with a disease in a communicable form or to be the carrier of such disease, and no person with open lesions on the exposed surface of the body, shall be employed in the processing, packaging, testing or storage of drugs.

8.2 *Qualified Personnel*

Technically qualified personnel shall be:

8.2.1 Graduates in Science from a university of recognized standing, with a degree requiring the study of chemistry, biochemistry, pharmacology, pharmacy, microbiology, chemical engineering, medicine or veterinary medicine, with adequate practical experience after graduation in the formulation, processing, packaging, labelling or testing of drugs.

8.2.2 Persons qualified by training or experience to carry out the supervision of formulation, processing, packaging or testing of drugs, who are directly responsible to one of the persons complying with the requirements of 8.2.1.

8.3 *Maintenance Personnel*—Personnel in charge of all equipment, machinery and sanitation shall be suitably qualified and shall be responsible to a person complying with the requirements of 8.2.

9. *RAW MATERIAL TESTS* 100

9.1 Each raw or bulk material shall be:

9.1.1 Sampled after receipt on the premises and then tested to ensure indentity and to distinguish it from chemically or therapeutically related materials.

9.1.2 Tested to ensure compliance with applicable specifications; all analytical reports shall be signed and dated by the Control Department.

9.2 The tests carried out shall be of pharmacopoeial (or equivalent) status and the records available shall be in a lucid form and include disposition of rejected raw materials.

10. *FINISHED PRODUCT TESTS* 200

10.1 Each lot of drug in dosage form shall be:

10.1.1 Tested in dosage form to ensure identity, potency and purity for its recommended use. Where necessary to ensure the quality of the finished product, in-process testing may be required.

10.1.2 Checked in packaged dosage form, under recognized statistical procedure, to ensure identity.

10.2 Records of these tests shall be in a lucid form and signed and dated by the Control Department.

10.3 All finished products shall be covered by detailed written specifications including the limits of variability and methods of analysis of pharmacopoeial or equivalent status, or, where such standards do not exist, the standards established by the originator of the drug entity.

10.4 All finished products shall be released for distribution only over the signature of the head of the Quality Control Department or his superior.

11. *QUALITY CONTROL* 350

11.1 *Raw Materials*—All raw materials used in processing shall be:

11.1.1 Covered by detailed written purchase specifications.

11.1.2 Identified by a lot number, receiving number, or laboratory control number.

11.1.3 Generally kept in an area separate from immediate manufacturing areas.

11.1.4 Held in quarantine until released by the Control Department.

11.1.5 Stored in such a way as to preserve potency and quality.

11.1.6 Adequately labelled as to identity.

11.2 *Manufacturing*

11.2.1 Master Formula Cards shall be available and prepared by, and subjected to independent checks by, personnel complying with the requirements of 8.2.1.

11.2.2 The formulation and processing shall be supervised by personnel complying with 8.2.1.

11.2.3 All processing operations shall be perfomred in accordance with individually numbered manufacturing orders issued by personnel complying with 8.2.1 or 8.2.2.

11.2.4 All raw materials shall be precisely described on manufacturing orders.

11.2.5 All raw materials dispensed for processing shall be labelled as to identity and quantity and, where possible, grouped for batch.

11.2.6 The raw material lot number, receiving number or laboratory control number shall be recorded on the manufacturing order.

11.2.7 All processing operations shall be performed according to comprehensive and detailed written procedures.

11.2.8 Each ingredient added to a batch shall be subjected to one or more checks for identity and quantity by personnel complying with 8.2.1 or 8.2.2.

11.2.9 Addition of each ingredient to a batch shall be confirmed by personnel complying with 8.2.1 or 8.2.2.

11.2.10 The initials of personnel performing each step of the process shall be recorded on the manufacturing order.

11.2.11 All containers of semi- or fully processed bulk shall be adequately labelled as to identity.

11.2.12 All bulk drugs shall be held in quarantine until released by the Control Department.

11.2.13 Bulk drugs shall be stored under conditions approved by the Control Department of preserve potency, quality and safety of the drug.

11.3 *Packaging*

11.3.1 All labels, printed materials and packaging materials shall be quarantined upon receipt from the supplier and shall be subject to release by the Control Department only after inspection.

11.3.2 Printed packaging materials and labels shall be:

11.3.2.1 Stored in limited access area (preferably fully enclosed).

11.3.2.2 Restricted to designated personnel.

11.3.2.3 Supervised by a person complying with 8.2.

11.3.2.4 Withdrawn against packaging order.

11.3.2.5 Issued and checked by personnel complying with 8.2.

11.3.3 The packaging and labelling processes and withdrawal of bulk drug in dosage form shall be supervised by personnel complying with 8.2.

11.3.4 All packaging operations shall be performed following the issue of individually numbered packaging orders, or of manufacturing orders as described in 11.2.3, where packaging standards and procedures are provided.

11.3.5 All packaging operations shall be performed according to comprehensive and detailed written operating procedures or specifications, which shall include disposal procedures for unused printed packaging materials.

11.3.6 The initials of personnel supervising the packaging operation shall be recorded on the packaging order.

11.3.7 Every package of drug shall be identified by a lot number.

11.3.8 All packaged drugs shall be held in quarantine until released by the Control Department.

11.3.9 Packaged drugs shall be stored under conditions approved by the Control Authority to preserve potency, quality and safety of the drug.

11.4 *Quality Control Department*

A manufacturer shall have a Control Authority on the premises responsible only to the Management and such Control Authority shall:

11.4.1 Have personnel and functions separate and distinct from Processing, Packaging, Finishing and Sales Department.

11.4.2 Be supervised by personnel complying with 8.2.1.

11.4.3 Have a Control Laboratory, or have true and effective access to adequate equipment and facilities for inspecting and testing, to ensure the quality, identity, potency and safety of all ingredients and materials used in the production of drugs as well as the finished drugs.

11.4.4 Be responsible for drawing all samples for their use.

11.4.5 Be responsible for determining the stability of the finished drug.

11.4.6 Be responsible for checking to see that all processing, packaging and storage specifications are met.

11.4.7 Check the theoretical yield against actual yield on the Manufacturing and Packaging Orders.

11.4.8 Be responsible for the maintenance of a formal written record of every complaint on each finished drug distributed, during or after its distribution. Such records shall include the action taken in dealing with the matter.

11.4.9 Be responsible for inspection of all returned drugs.

11.4.10 Be responsible for checking to see that disposal procedures are followed.

11.4.11 Be responsible for maintaining Quality Control records in a lucid form.

12. *RECALL SYSTEM* 35

The supplier shall have a written procedure, capable of immediate implementation, for the complete and rapid recall of any lot or batch of a drug from the market.

13. *PRODUCTION RECORDS AND SAMPLES* 20

13.1 Records required to be maintained in respect to a finished drug shall be kept until the expiration of five years from the date of the testing of the drug, or the expiration date of the drug, whichever occurs first.

13.2 A sufficient sample of each lot of the finished drug in dosage form shall be kept by the manufacturer under suitable conditions of storage until the expiration of five years from the date of the testing of the drug, or the expiration date of the drug, whichever occurs first.

14. *PRODUCT INFORMATION RECORDS* 20

Adequate records relating to the drug shall be maintained showing all information received pertaining to the quality or hazards of any drug. This sahll include letters from all Regulatory Agencies and the action taken on this information.

15. *INSPECTION*

When all or part of the inspection required by this Standard must be carried out in a foreign country, the necessary living and travelling expenses related to such inspection shall be provided by the supplier.

16. *PENALTY FOR NONCONFORMITY OF SUBMITTED MATERIALS*

16.1 If a drug submitted to a purchaser is found either before or after delivery not to conform with the requirements of the contract, the following demerits shall apply to the rating arrived at in accordance with 4.2:

16.1.1 *First Rejection*—Four percentage points shall be deducted from the rating established.

16.1.2 *Second Rejection*—shall constitute noncompliance with this standard.

16.2 If as a result of rejections described in 16.1 the rating obtained by a supplier falls below the required 90 per cent, the supplier shall be deemed not to comply with the requirements of this standard.

17. *REINSTATEMENT*

A supplier whose rating is inadequate, either as computed under par. 4.2 or because of penalties imposed under par. 16.1, may apply for reinstatement after 90 days by presenting to the purchaser a submission indicating appropriate corrective action.

18. *ENQUIRIES*

18.1 Any correspondence or negotiations regarding the application of this Standard shall be directed to the purchaser.

18.2 Applications for qualification or for reinstatement under the conditions of this standard should be addressed to:

The Chairman

Interdepartmental Advisory Board on
Standards for Pharmaceutical Manufacturers,
Distributors and Agents

Third Floor, Gillin Bldg.
Laurier Ave. West, Ottawa 4.

19. *NOTES*

19.1 The supplier is responsible for ensuring, and for demonstrating to the satisfaction of the purchaser, that material he supplies is manufactured, controlled and distributed in conformity with this Standard. The decision as to conformity with the requirements of this Standard rests with the purchaser.

19.2 The publications referred to in 3.1 to 3.5 inclusive are available as follows:

The Food and Drugs Act and Regulations—The Queen's Printer, Ottawa.

Proprietary or Patent Medicine Act—The Proprietary or Patent Medicine Division, Food and Drug Directorate, Department of National Health and Welfare, Ottawa, Canada.

Narcotic Control Act—The Narcotic Control Division of the Food and Drug Directorate Department of National Health and Welfare, Ottawa, Canada.

Pest Control Products Act—Plant Products Division, Canada Department of Agriculture, Ottawa, Canada.

Animal Contagious Diseases Act—Health of Animals Division, Canada Department of Agriculture, Ottawa, Canada.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 24

TUESDAY, DECEMBER 6, 1966

WITNESSES:

Representing the Canadian Wholesale Drug Association: Mr. C. M. Peel of Winnipeg, President; Mr. Geoffrey C. Pitcher of Fredericton, N.B., Vice-President, and Mr. Douglas R. Weston, of Montreal, Secretary-Manager.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1967

25324—1

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

MINUTES OF PROCEEDINGS

TUESDAY, December 6, 1966.
(34)

The Special Committee on Drug Costs and Prices met this day at 9.50 a.m. The Chairman, Mr. Harry C. Harley, presided.

Members present: Mrs. Rideout, and Messrs. Asselin (*Richmond-Wolfe*), Brand, Enns, Harley, Howe (*Hamilton South*), Howe (*Wellington-Huron*), Isabelle, Mackasey, MacLean, Orlikow, Tardif (12).

In attendance: *Representing the Canadian Wholesale Drug Association*: Mr. C. M. Peel of Winnipeg, President; Mr. Geoffrey C. Pitcher of Fredericton, N.B., Vice-President, and Mr. Douglas R. Weston, of Montreal, Secretary-Manager.

Also in attendance: Mr. A. M. Laidlaw of Ottawa, Legal Counsel for the Committee.

The Committee proceeded to the consideration of the brief of the Canadian Wholesale Drug Association.

The Chairman introduced the officials of the Association.

Agreed,—That the brief, the 1965 Operating Survey and the Service Survey be printed as appendices to this day's proceedings (*See Appendices "A" "B", and "C"*).

Mr. Weston made a short opening statement.

Messrs. Weston, Peel and Pitcher were questioned by the Members and by Mr. Laidlaw.

The Chairman thanked the representatives of the Association for appearing before the Committee, and at 12 o'clock noon the Committee adjourned to 9.30 a.m. Thursday, December 8th.

Gabrielle Savard,
Clerk of the Committee.

25324—1½

EVIDENCE

(Recorded by Electronic Apparatus)

TUESDAY, December 6, 1966.

The CHAIRMAN: Mrs. Rideout and gentlemen, I think we might start the meeting this morning. I would like to introduce to you the representatives of the Canadian Wholesale Drug Association. They have presented a brief with two appendices. Representing the association, on my immediate right is Mr. Douglas R. Weston, the Secretary-Manager from Montreal, next to him is Mr. c. m. peel, president of the association and next to Mr. Peel is Mr. Geoffrey C. Pitcher from Fredericton, the vice president of the Canadian Wholesale Drug Association. Is it agreed that we print today's briefs as part of the minutes?

Some hon. MEMBERS: Agreed.

The CHAIRMAN: I think in all fairness to the association we should print all three. Is that your wish?

Mr. Douglas R. WESTON (*Secretary Manager, Canadian Wholesale Drug Association, Montreal*): Yes.

The CHAIRMAN: That is fine.

There are two surveys, one is an operating survey and the other one is a service survey. The other document is the brief itself. Do you have a statement to make, Mr. Weston?

Mr. WESTON: Thank you very much, Dr. Harley.

Ladies and gentlemen, we of the Canadian Wholesale Drug Association are pleased to have the opportunity of appearing before this Committee and we hope that our submission and answers to your questions will be of value to you in your deliberations. Our board of directors is composed of drug wholesalers from all across Canada. Unfortunately they could not all be with us. However, Dr. Harley has introduced Mr. Peel, our president and Mr. Pitcher, our vice president. Our immediate past president, Mr. Raymond Dupuis, general manager of Pharmacie Moderne, one of the major wholesalers in the province of Quebec, unfortunately could not be with us today. We also appear to have lost our legal adviser, who was supposed to come in from Montreal this morning.

We would like to make a few brief comments regarding our submission. Firstly it is our belief that Canada's drug wholesalers are doing, and will continue to do, an efficient and economical job of distributing pharmaceuticals and other health aids. Secondly, it is not economically practicable or feasible for all retail pharmacies, hospitals and government institutions—between 6,500 and 7,000 dispensing outlets—to carry the complete pharmaceutical line. Wholesalers have a duty and a moral obligation to have the right drug at the right place at the right time. Thirdly, we believe there is unnecessary duplication of effort

where manufacturers maintain their own warehouses or depots. Drug wholesalers are stragetically located all across the vastness of Canada and can provide maximum overnight service, which is not always possible for manufacturers. Fourthly, it has been said that you can eliminate the wholesaler, but you cannot eliminate his function. Someone has to perform his job, and his essentiality is recognized by leaders in manufacturing pharmacy and retail pharmacy. Fifthly, we believe that in performing his vital and necessary function, the drug wholesaler is instrumental in keeping down the cost of drugs. Distribution by wholesale druggists does not add to the cost of drugs. By efficient and rapid distribution the wholesale druggist can keep costs down.

The CHAIRMAN: Thank you, Mr. Weston. The meeting is now open for questioning.

Mr. HOWE (*Hamilton South*): To start off, I hope this is basic to the intent of the wholesale druggist. As I understand it, retail drug stores purchase shares in your companies or company, as the case may be, in order to participate in buying from you. Is this correct?

Mr. WESTON: I believe you are referring here to what are known as mutual houses. It is not necessary, to the best of my knowledge, for any pharmacist to have shares in a mutual drug wholesaler in order to purchase from that particular drug wholesaler. If he is a shareholder he does get the advantage of dividends and certain rebates. If that right, Mr. Peel?

Mr. HOWE (*Hamilton South*): I got this information from page 28, and actually it is the dividends or the kick-back that the druggist gets by being a shareholder in that wholesale outlet, and it says:

> We are informed by one company that dividends are set at 10 per cent per annum . . . . . .

Could you tell me 10 per cent of what?

Mr. WESTON: I will have to direct this to Mr. Peel.

Mr. C. M. PEEL (*President, Canadian Wholesale Drug Association, Winnipeg*): In most instances it is 10 per cent of their purchases. I believe that most mutual houses have two columns on their invoice, a net column and a usual column, and they receive 10 per cent on merchandise which is priced in the usual column.

Mr. HOWE (*Hamilton South*): In other words, they get their wholesale price less 10 per cent on each purchase they make, rather than an over-all amount for the year's work in one lump sum, and this is deducted as an additional 10 per cent from the usual wholesale price?

Mr. PEEL: Yes, usually, though, the 10 per cent rebate is taken off every six months. It is credited against their account, it is not a cheque. It is a credit note against their purchases.

Mr. HOWE (*Hamilton South*): But no matter how you add it up, it is another 10 per cent on the wholesale price of the drug. At one time or another when they quote a wholesale price or list less 40 per cent, there is an additional 10 per cent added to it, or it may be 40 per cent less 4 per cent less another 10 per cent, or whatever the case may be. It could even be 50 per cent less another 10 per cent.

So that in some instances druggists are buying drugs at somewhere between 40 and 50 per cent of their retail selling price?

Mr. PEEL: Yes, if they are shareholders in a mutual house.

Mr. HOWE (*Hamilton South*): I will quote one example. The other day librium was brought up, which sells at $12 a hundred by the retail druggist if bought in 100 lots, that is, if they do not have to break their 100's down into a lesser quantity, and I was able to find out from retail druggists that they actually purchase at $4.68 when they buy in 5,000 lots. Would they get an additional 10 per cent to this too?

Mr. PEEL: This all depends on the mutual with whom they are doing business. For instance, in the company which I represent, Hoffman-La Roche merchandise is priced in what we call the net column. There is no further rebate on Hoffman-La Roche products in the company I represent.

Mr. HOWE (*Hamilton South*): In other words, within this price is included the kick-back from the wholesale distributors?

Mr. PEEL: Excuse me, I did not quite understand that.

Mr. HOWE (*Hamilton South*): I said within the wholesale price that the druggist buys from you is included the additional rebate they get from being a shareholder in your company?

Mr. PEEL: Not in the case of Hoffman-La Roche or librium.

Mr. HOWE (*Hamilton South*): May I ask what company it is?

Mr. PEEL: I am with National Drug in Montreal.

Mr. HOWE (*Hamilton South*): It was National Drug I was interested in. You sell to the retail druggist who buys in 5,000 lots; does it work out to $4.68 a hundred?

Mr. PEEL: We sell librium at list less 44 per cent net.

Mr. HOWE (*Hamilton South*): List less 44 per cent. This would involve doing a bit of arithmetic, but this would come to higher than $4.68. How could one explain how a druggist could get it for $4.68, then?

Mr. PEEL: It could be that we are talking about different lots, because librium comes in 100's, 500's and 1,000's.

Mr. HOWE (*Hamilton South*): You mean there is a different retail price on 5,000?

Mr. PEEL: The list price on 5,000.

Mr. HOWE (*Hamilton South*): What is the retail list price on 5,000, do you know offhand?

Mr. PEEL: I do not know, I am sorry.

Mr. ORLIKOW: I wonder if I could ask a supplementary. Is it not fair to say that the price charged by the wholesale druggist will usually be a little higher than the price charged—and I think you deal with this in your brief—by the manufacturer if a retail store buys directly from the manufacturer? Usually for standard prescription items the retail druggist buys from the wholesaler in relatively small quantities?

Mr. PEEL: That is correct.

Mr. HOWE (*Hamilton South*): If I may ask, then, what is your price off list when you buy from the manufacturer? If you give 44 per cent off, what per cent do you get off list when you buy from the manufacturer?

Mr. PEEL: I stand to be corrected, but I believe our price on librium is 40 per cent and 16⅔ per cent.

The CHAIRMAN: I think this is important. Just for the record, what quantities would you buy in? Do you buy 5,000, 10,000, or what?

Mr. PEEL: Normally we buy in 100's, 500's and 1,000's.

Mr. HOWE (*Hamilton South*): Surely as a wholesale distributor you are not going to be buying single bottles of 100. What quantity would you buy at a time to get this discount?

Mr. PEEL: What I am trying to suggest is that the manufacturer makes the product in several sizes and we, as wholesalers, carry it in all the sizes that they list, 100, 500, 1,000, or whatever. The reason we would have it in 100's is that some retail pharmacist might just simply order 100.

Mr. HOWE (*Hamilton South*): Does the man who buys a single bottle of 100 from you have to pay a higher price than he would if he were to buy 500 or if he were to buy 5,000?

Mr. PEEL: That is right.

Mr. HOWE (*Hamilton South*): In other words, the small man who does not require the large quantity, is being penalized in a sense for the fact that he cannot handle large quantities?

Mr. PEEL: That is correct.

Mr. HOWE (*Hamilton South*): Therefore, if the druggist were to come up with the idea of selling at a cost plus basis, the cost is going to be such a variable factor that this would not be an equitable way to sell drugs from one drug store to another; this price would vary because their cost varies. Is this correct?

Mr. PEEL: It would appear that way, yes.

Mr. HOWE (*Hamilton South*): This is not an answer, then to what some of the druggists are doing, selling drugs at a cost plus, because the cost varies and so you are going to get an even greater variance of price between drug stores. This is really a repetition of the same question. You are not going to get something constant by dispensing on a cost plus basis, such as some drug stores are attempting to do?

Mr. PEEL: I am not personally familiar enough with the retail set-up of pricing to answer that question.

Mr. HOWE (*Hamilton South*): But as it stands at the moment the larger drug store, if he is selling at the same price as the smaller drug store, is making a larger profit?

Mr. WESTON: If I may interject here, I think it is true that in the purchases of many product lines the greater the quantity you buy—not always mind you—the less your per unit cost. I think that is what you are driving at, sir.

Mr. HOWE (*Hamilton South*): It is what I am driving at, and what I am trying to prove is that instead of this being a discount for the large store I feel it is a penalty for the small store.

Mr. WESTON: On the other hand, the wholesaler purchases from the manufacturer and the manufacturer has set the price on his different sized units. Is this not true, Mr. Peel?

Mr. PEEL: That is correct.

Mr. HOWE (*Hamilton South*): I agree with you. I am not disputing this fact, but it is still a penalty to the small man that he has to buy his drugs at a higher cost and compete against the other stores that are buying at a lower cost, and selling either at a greater profit or marking his profit down and selling a larger quantity at a lower price.

Mr. WESTON: As we have pointed out ourselves, the wholesaler has very little to do with the setting of prices. He is quite literally the man in the middle. The manufacturer says, "Here is the product and here is the price." The wholesaler figures in his discount, whatever it is, and goes to the retailer and says, "Here is the product you ordered and this is the price." We have nothing to do, in a sense, with setting prices, we have no control over prices.

Mr. HOWE (*Hamilton South*): From your point of view, could this be equalized between the stores so that the varying quantities sold at the same amount per unit, and in this way one could arrive at a cost plus basis of selling drugs that would be equitable throughout the retail drug business?

Mr. WESTON: I think you are in a sense entering into the field of multiple pricing.

Mr. HOWE (*Hamilton South*): I think we are multiple pricing now.

Mr. WESTON: Well, you are but, as we have said, the price for 100 is X, the price for 500 is Y and the price for 1,000 is Z. The wholesaler simply takes this and if someone's pharmacy calls up and says, "Send me 100", Mr. Peel or Mr. Pitcher may be the wholesaler in this case and they simply ship that over and say, "This is the price". The pharmacy on the next corner wants 1,000 and this, of course, is more or less in bulk and therefore the price is less.

Mr. HOWE (*Hamilton South*): I was really asking you if the feasibility of it was such that they could make all the prices Y, which is halfway between X, Y, and Z, and therefore have a more equitable pricing for everyone so the drug pricing could be the same and profits could be equal through the retail trade?

Mr. WESTON: I think in this particular case—

Mr. HOWE (*Hamilton South*): I realize your position but it is an opinion I am asking for.

Mr. WESTON: —that this is something the manufacturers are going to have to determine, because it is the manufacturer who sets the original price, not us.

Mr. HOWE (*Hamilton South*): Do you think this is feasible?

Mr. WESTON: Quite frankly, I do not know. Do you know, Mr. Peel?

Mr. PEEL: I do not really know.

Mr. WESTON: What about you, Mr. Pitcher?

Mr. GEOFFREY C. PITCHER (*Vice President, Canadian Wholesale Drug Association, Fredericton*): Yes, I would say it was feasible.

Mr. HOWE (*Hamilton South*): You are into a standard set-up now, and what I am asking you is something that is aside from the standard set-up that you now have, but it was the feasibility of it that I was interested in.

The CHAIRMAN: Could I ask a question on a point of clarification. Your function is really to take the product as it is already packaged and sell it as it is packaged. In other words, just because you sell in any year 100,000 tablets of a certain drug, this does not mean you can buy 100,000 in one bulk package and re-package it and re-label it yourself. You do not do this at all, you really take a package of 100 and sell it as labelled and as already packaged by the originating company?

Mr. PEEL: The wholesale druggist does not re-package, because on any pharmaceutical product there is a lot number and a control number and the wholesale druggist does not re-package merchandise. He sells it in the original package in which it is purchased.

I would like to correct one thing, if I may, Mr. Chairman, in fairness to librium. I indicated the wholesale cost was list less 40 per cent and 16 per cent. That is incorrect. I have reminded myself of a change recently made by this company, and they now have net pricing. What I said, therefore, was incorrect in that it is 40 per cent and 16 per cent. They charge us a flat amount for a given size of a given product and we add a mark-up to it. In other words, there are no list prices on Hoffman-La Roche.

Mr. HOWE (*Hamilton South*): Do you get any additional discounts for quantity buying of these packagings?

Mr. PEEL: No.

Mr. HOWE (*Hamilton South*): This is set whether you buy 10 of them or 100 of them or 1,000?

Mr. PEEL: That is correct.

Mr. HOWE (*Hamilton South*): Therefore you get yours at roughly—if my arithmetic is anywhere near correct—50 per cent off and you sell at 44 per cent off, therefore you retain roughly 6 per cent. Am I correct?

Mr. PEEL: Right.

Mr. HOWE (*Hamilton South*): Do you get any additional discounts for 6, projects undertaken by your association, and it mentions tele-tips. What would that be?

Mr. WESTON: Pardon our levity, sir, but we were just discussing that, and it occurred to me that we should have brought one of these along.

This is simply a small plastic easel which sits on a telephone order clerk's desk and it has 6 plastic envelopes. The manufacturers—regardless whether thy are drug manufacturers, proprietary, cosmetic, toiletry or sundry—supply small cards, which are 5 by 8, and these fit in the clear plastic envelopes and 12 cards can be fitted in. There may be a special deal on Scotch Tape—which comes to mind—and when the order clerk is talking to the pharmacist she will have this in front of her and she will say "By the way, we have a special on Scotch Tape,

you get one free with 12." This is really all it is. There is no cost to the manufacturer or the supplier beyond the supplying of these cards. We supply the tele-tip easels to our wholesale drug members, and, if I am not in error, we have something like 170 to 180 of them out across the country at the moment. We provide these at cost price to our wholesale drug members and the associate members supply the cards which are inserted in there.

Mr. HOWE (*Wellington-Huron*): Do you charge the firms that supply the cards anything for getting their inserts in those tele-tips?

Mr. WESTON: No. This is simply a service which we provide so that the retail pharmacist may be aware of new products, of any special deals, or anything of this nature.

Mr. HOWE (*Wellington-Huron*): How is your association supported, by fees, dues, or what?

Mr. WESTON: Yes, we are a non-profit organization incorporated under the Dominion Companies Act, and 99 per cent of our revenue is from annual fees received from our members.

Mr. HOWE (*Wellington-Huron*): I notice you have active members and associate members at the back of your brief. I would like you to define those two types of membership for me.

Mr. WESTON: This, sir, is on page 1 of our brief. The active members are any full service wholesale druggist who has been in business for five years and whose application shall be endorsed by at least two active members in the same trade area.

Our associate members are entirely composed of suppliers. As you will probably notice by the list, this includes pharmaceutical houses, proprietary houses, sundry houses, toiletries and cosmetic houses.

Mr. HOWE (*Wellington-Huron*): Do they pay a fee to be an associate member of your organization?

Mr. WESTON: Yes, they pay a flat fee of $200 a year. The active members are based on a sliding scale, ranging from $125 to $500 a year.

Mr. HOWE (*Wellington-Huron*): And do your organizations refuse to buy from anyone else except associate members?

Mr. WESTON: Oh no, definitely not. We have a representative of a company here today who is not a member of our association and who deals with all our active members.

Mr. HOWE (*Wellington-Huron*): What percentage of the drug business is done through your wholesalers?

Mr. WESTON: It has been estimated that roughly 40 per cent of the drug business in Canada moves through drug wholesalers. As we have noted, this compares with about 60 per cent in the United States and Great Britain. We are hoping to improve this by encouraging our wholesalers to do a far more efficient job and also to encourage manufacturers and suppliers to make greater use of the wholesalers' facilities.

Mr. HOWE (*Wellington-Huron*): Does this mean that more of the drug business in Canada is going through the big drug chains, who buy direct from the manufacturers, than through the smaller operators?

Mr. WESTON: Not necessarily sir, because some of the manufacturers in Canada sell direct. To the best of our knowledge, there is no such thing as a complete, 100 per cent, direct house. All direct houses do sell, to some extent, through drug wholesalers, but there are certain companies which say, "no, we do not wish to deal with the drug wholesaler, we will sell direct." We naturally believe this is wrong. We think this is a costly way of doing business. We think the wholesaler can do it cheaper, faster and more efficiently.

Mr. HOWE (*Wellington-Huron*): I agree with you that the wholesaler does a job for the small man, particularly where he cannot buy full cases, and in reply to Dr. Howe in regard to the costing of an article, the small man may get a special order for a certain product that he does not want to stock and does not stock and he can take a smaller mark-up because he does not have to put it into stock. Is this not true?

Mr. WESTON: Yes, I would say so, but you must remember that some direct houses, for example, have minimum orders. In other words, if the pharmacist calls up a house and tells them he wants a dozen or two X, Y, Z, this may only amount to $6 or $7. The manufacturer says that this is under their minimum order and will have to charge for this. But if he calls up his wholesaler and says that he needs this, that and the other thing, it still may only amount to $6, $7 or $10. To the best of my knowledge no wholesaler in Canada has a minumum selling order.

Mr. HOWE (*Wellington-Huron*): As long as the druggist's credit is good?

Mr. WESTON: Yes. Then, of course, there is also the point which we make that it is not always possible to get same day delivery from a manufacturer, particularly if the manufacturer is in one city and the retailer is in another city, but with the wholesaler I think we can safely say there is maximum overnight delivery.

Mr. HOWE (*Wellington-Huron*): Have you found in the drug trade many wholesale drug firms who have been in this phase of the drug business for quite a number of years who decide to go directly into the retail business themselves? What I am referring to is what happened to Gordon MacKay in Toronto, who were in the general dry goods business for a great many years, and they went out of this wholesale business but went into their own chain stores, which are the Walker stores. Another big wholesaler in Toronto started that last weekend. I understand. Do any of the drug wholesalers do this?

Mr. PITCHER: I know on one company in Newfoundland that has gone this way, yes.

Mr. HOWE (*Wellington-Huron*): That is the only one in Canada that has?

Mr. PITCHER: I would not say that, but it is the only one that I know of.

Mr. WESTON: I might say, sir, that there is a firm in Montreal—one of our members—Leduc and Leduc, which do have retail outlets, but they do a great deal of their business with other drug stores which are not part of their chain. The same applies on the west coast where there is a company which has retail

outlets, but I understand the larger part of their wholesale business goes to stores which are not part of their retail outlets.

Mr. HOWE (*Wellington-Huron*): On page 7, under the heading "Projects Undertaken by the Association", number 8 is, "Code of Distribution Practices" and it indicates that it has under study:

> ...which is designed to discourage and prevent acts or practices which injure, destroy or prevent competition.

There is legislation which has been provided for that very same thing, I understand.

Mr. WESTON: This is true. Our sister organization in the United States, the National Wholesale Druggists Association—we have no direct connection with them beyond the fact we exchange information back and forth—came up with a code of distribution practices which we have looked at. It is not suitable for our members in Canada because of the difference in the legislation between the two countries. All I can say at the moment—and I do not have a copy with me—is that we are turning this over to our lawyer and saying to him, "What do you think of this? Do you think this is feasible? What shall we do about it?" We are dependent upon him for his advice in this particular case.

Mr. HOWE (*Wellington-Huron*): Have there been any cases where any charges have been laid because of infraction of the present legislation?

Mr. WESTON: Not to the best of my knowledge.

Mr. HOWE (*Wellington-Huron*): What disciplinary action are you considering to take through your organization?

Mr. WESTON: As you know, sir, we are a voluntary organization and, like any voluntary organization, the very most we could do would be to write a stiff letter of reprimand to any company who did not conform to the code of distribution practices.

Mr. HOWE (*Wellington-Huron*): It might depend on the size of the organization, too, would it not?

Mr. WESTON: This is true.

Mr. HOWE (*Wellington-Huron*): The big fellow would not get his knuckles wrapped quite as badly as the little fellow?

Mr. WESTON: I do not think that is true, sir. We try to be very impartial on this and try to treat all members alike, whether they are large or small. I must say that our board of directors have given me their complete confidence and left matters of this nature in my hands.

Mr. HOWE (*Wellington-Huron*): I was rather interested in what you say at the bottom of page 27:

> The pharmacist pays 60 cents, thus providing him,the pharmacist, with 40 cents or a 40 per cent mark-up.

Now, this is not true.

Mr. PEEL: I suppose that should read 40 per cent discount.

Mr. WESTON: A discount of 40 per cent.

Mr. HOWE (*Wellington-Huron*): Well, if it was 40 cents on a 60 cent article, he would be making 66 per cent on it, would he not?

Mr. WESTON: Not necessarily. That is mark-up, not profit. He has to take his other costs into consideration.

Mr. HOWE (*Wellington-Huron*): Well, if he gets 40 cents on a 60 cent purchase, his mark-up is not 40 per cent.

Mr. PEEL: Forty cents on a $1 purchase is your retail list.

Mr. HOWE (*Wellington-Huron*): It says, "The pharmacist pays 60 cents" and that is providing him with 40 cents or a mark-up of 40 per cent. If he pays 60 cents and makes 40 cents on it, it is more than a 40 per cent mark-up.

Mr. WESTON: What we are saying here is the suggested retail price of a product is $1. The pharmacist pays 60 cents, thus providing the pharmacist with 40 cents. Oh yes, I see what you are driving at.

Mr. HOWE (*Wellington-Huron*): If he gets 40 cents on a purchase of 60 cents he makes more than 40 per cent profit.

Mr. WESTON: Yes, I am sorry, that is our error. It should be 66 2/3 per cent.

Mr. HOWE (*Wellington-Huron*): Yes. This Committee was set up to find ways and means, if possible, to reduce drug prices to the consumer. How can we do it? You are in the business and have made a study of it. What are your suggestions to this Committee of ways and means of doing this, other than by a reduction in the 11 per cent sales tax?

Mr. WESTON: One point we have made is that we think there is unnecessary duplication of effort on the part of many, many manufacturers. As we point out, there are three drug wholesalers in Vancouver. To the best of our knowledge—and I do not doubt there are more—seven of our associate members retain either warehouses or depots in Vancouver, and to us this is unnecessary duplication of effort. If I am a pharmacist in Vancouver and I wish to purchase products from seven of these companies, I have my choice. I can call a wholesaler and place my complete order with him, get one invoice, one delivery, one cheque when I am paying it, and this is it. Or I can call the seven manufacturers, get seven deliveries, seven invoices, make out seven cheques and, believe me, most of the time they make these deliveries at the busiest time of the day, which, of course, takes me away from my more important work of dispensing pharmaceuticals and looking after my customers. We believe this is one way that costs can be reduced or, at least of keeping costs down. In Winnipeg we have two drug wholesale members and, again to the best of my knowledge, there are seven manufacturers that we know of with depots or warehouses there. I understand there are at least another 10 which make use of a company—Mr. Peel, will you refresh my memory?

Mr. PEEL: Midwest Storage.

Mr. WESTON: Midwest Storage. Here again this does not make sense to us. It is one way of reducing costs. We have wholesalers in every province of Canada with the exception of Prince Edward Island, and the only reason we do not have wholesalers there is that there are not enough pharmacists to support a wholesale house and therefore these pharmacists get their supplies from wholesalers in New Brunswick or Nova Scotia.

Mr. HOWE (*Wellington-Huron*): In other words, you maintain that by having a co-operative effort by the manufacturers and wholesalers in one great big warehouse to distribute all the drugs that are used by the retailers, that this would cut down the cost of drugs?

Mr. WESTON: We believe so. For example, we know of one house in Montreal which is a direct house. This company's products are well known right across Canada. They have a fairly wide range and they deal direct. This means that they must invoice—I do not know how frequently perhaps once a month, perhaps more or less frequently—5,500 pharmacists. Every time they sell a pharmacist they have to invoice him. They have to ship to 5,500 pharmacists, they have to handle returns from 5,500 pharmacists, they have to receive 5,500 cheques from the pharmacists, whereas if they dealt through a wholesaler they would only be invoicing a maximum of—what would you say, Mr. Peel?—45 or 50 wholesalers across the country. Consider the amount of paper work involved here.

Mr. HOWE (*Wellington-Huron*): What percentage of that would reduce the cost of drugs to the consumer?

Mr. WESTON: This is something that would have to be worked out very carefully. We do not know what it costs this particular company to invoice and ship from warehouses. On page 35 it states:

> ...according to the submission to this Committee by the Pharmaceutical Manufacturers Association of Canada, 41 member companies of PMAC reported total sales (Federal Sales and Excise Taxes not included) aggregated $148,053,720. Distribution (including warehousing) expenses totalled $6,322,984. This works out to 4.33 per cent.
>
> If we include warehouse expenses in the CWDA figures, the total is 4.17 percent.

On this basis alone our figures are less than the manufacturers. We do not have comparable figures with the manufacturers. We have asked for them and they have informed us that they are not available. I understand from Mr. Guy Beauchemin, their vice president, that this will be taken up with their statistical committee.

Mr. HOWE (*Wellington-Huron*): You do not see any area in the present set-up where there can be reduction in the price of drugs to the consumer?

Mr. WESTON: In the distribution area, yes. We are not in the manufacturing of drugs. We have nothing to do with the merchandising of drugs and, as you are aware, you cannot promote prescription drugs. All the wholesaler can do is to accept the orders from the pharmacists and fill them. He cannot promote librium, which was named a few minutes ago.

Mr. HOWE (*Wellington-Huron*): Would you like to name a figure that you think could be saved by this plan?

Mr. WESTON: Not unless we knew what it was costing the manufacturers, and we do not know.

Mr. ENNS: Mr. Chairman, I have been wondering why there is a reluctance on the part of the manufacturers to use the wholesalers. Has there been an

approach or some canvassing done by your association to channel all the marketing of drugs through wholesalers? What is your explanation why more manufacturers are not using your services?

Mr. WESTON: As we have pointed out, there appear to be four major factors involved. Many suppliers in Canada—and when we say suppliers we include manufacturers, manufacturers' agents, distributors, and so forth—are subsidiaries of United States firms which have long established policies of direct selling. Now, these companies have moved into Canada, they have set up subsidiaries, and these subsidiaries or affiliates have just continued the practice of their parents.

Mr. ENNS: Yes, but why is it to their advantage to keep selling directly, when you can say—

Mr. WESTON: It is not. We have argued this point and said it is not to their advantage. It is to their advantage to deal through the wholesaler.

Mr. ENNS: I agree with you. It seems to me this is an eminently logical way of marketing, but it is surprising therefore that 60 per cent of the trade in this country is still not handled in this way.

Mr. WESTON: As we have pointed out, the geography of this country certainly works in favour of the wholesaler, but for some reason some of the major manufacturers have not seen fit to agree with us and they have continued to sell direct. We have said, "Why go to the trouble and expense of erecting or leasing a warehouse, staffing it and shipping goods when there is a wholesaler right on the spot?" It does not cost any more for that manufacturer to ship, let us say a $25,000 inventory from Montreal to a wholesaler in Winnipeg than it does to ship to his own warehouse in Winnipeg. This does not make sense. It has to go out there any way and he might as well place it in the hands of a wholesaler who will do his selling for him, who has a sales force and, where possible,—and, of course, as you realize, it is not always possible in the case of non-drugs or non-prescription items—he can do merchandising for him.

Mr. ENNS: Is it correct to read into this reluctance of the manufacturer to merchandise through the wholesaler the fact that he may lose his promotional ability of promoting his own brand product?

Mr. WESTON: He will not.

Mr. ENNS: This is not—

Mr. WESTON: No, because if a pharmacist calls up and says, "Please send me a dozen X,Y,Z, the wholesaler cannot say, "Do not take X,Y,Z, take A,B,C". He cannot do this because the X, Y, Z has been specifically requested by the retail pharmacist. It is a prescription drug. It may be a bit different in the case of a retailer calling up and saying, "Send me two dozen Paper-Mate pens". The wholesaler very well may say, "I am sorry, I am out of Paper-Mate pens, will you take Northrite?" There is no harm done here. But not in the case of a prescription drug; it cannot be done.

Mr. ENNS: Can some generic product be substituted in the event the other one is out of stock?

Mr. WESTON: No, not to the best of my knowledge. The wholesaler must supply the drug as requested. Am I right, Mr. Peel?

Mr. PEEL: This is his moral obligation.

Mr. ENNS: Do some of the so-called generic manufacturers use the services of the wholesale houses?

Mr. WESTON: It is our understanding that most of the generic houses are direct sellers. The drug wholesalers must provide the drug of choice. In other words, when the pharmacist calls up and specifies a certain drug the wholesaler is both morally and legally obligated to provide this particular drug. The drug wholesalers do support the manufacturers in this respect. Quite frankly, we have looked at this generic problem, and from our point of view it is one of economics. We only have so much shelf space, we only have so much storage space, and if we get to the stage where one drug is being duplicated by six or seven generics, with their various sizes and potency, the drug wholesaler is in the position of having to increase his capital investment and his facilities with no commensurate return on his investment. It is our understanding that most prescriptions that are written call for so-called brand name drugs. The wholesaler is certainly not going to keep drugs in stock that he cannot move. This is equally true of non-drug items. A very poor quality thermometer which does not move, the wholesaler is not interested in storing it because there is no money in it for him as long as it sits on a shelf, and if there is no demand for generic products the wholesaler is not going to stock them. If we get to the stage where generics are more frequently prescribed than they are at present, I think you will find that the wholesalers will probably only stock such quantities as they think they will require. In other words, they will not keep large stocks of them on hand.

Mr. A. W. LAIDLAW *(Legal Counsel for the Committee)*: Mr. Chairman, in the case of the manufacturer who sells directly to the retail pharmacist, who gets the benefit of the 16⅔ per cent which otherwise would go to the wholesaler, the manufacturer?

Mr. WESTON: No one, because he has performed the wholesale function, and the party who performs the wholesale function has to pay for it.

Mr. LAIDLAW: But is he performing the wholesale function to the extent of 16⅔ per cent of the sale prices of all the products?

Mr. PITCHER: This again is a question which we cannot answer. We do not know what it costs the manufacturer to do business and to perform this function. We do know what it costs us but we do not know what it costs the manufacturer.

Mr. LAIDLAW: My assumption would be that it is an enormous amount of money that the manufacturer is absorbing if it is 16⅔ per cent of the final sale price.

Mr. WESTON: You must remember, sir, that if a retail pharmacist calls a manufacturer, he is only going to order that manufacturer's particular line. When he places an order with a manufacturer he tells him to send this, this and this. Now, this is only going to be the manufacturer's particular line. But the pharmacist who calls the wholesaler will say I wants this, which is one company's line, I want that, which is another company's line, and I want this, which is another company's line. There may be a dozen or more companies involved in this, and consequently our costs will be spread over all these companies. This makes for lower distribution costs. By comparison, the manufacturer only has to

spread his costs over his particular line. We think this is a more costly way of doing business.

Mr. LAIDLAW: Mr. Weston, just following along, do you think it is practical for the government to legislate how a manufacturer should conduct his business?

Mr. WESTON: No, sir. We think this intrudes into the field of free enterprise.

Mr. LAIDLAW: Then, the suggestion set out in your brief is, in your own view, not practical?

Mr. WESTON: Why?

Mr. LAIDLAW: Do you think it is practical for the government to legislate against drug manufacturers to say that you must use wholesalers, you must no longer sell directly. This, in effect, is what you are asking, is it not?

Mr. WESTON: We believe it is more efficient and cheaper to do business through the drug wholesaler, but if a company wishes to distribute direct, that is their prerogative. We would love to see every manufacturer in Canada going through wholesalers, that will be the day of the millennium and we know that will never happen, but we would like to see far more manufacturers making use of the wholesalers. Many manufacturers who are direct sellers do make use of the wholesalers, not deliberately but simply because the pharmacist will call up and say, "I want so and so and so and so." These are direct selling items, but the wholesaler who is making a small margin on these particular products, simply says, "Yes, fine" and he sells them to the pharmacist.

Mr. MACLEAN (*Queens*): This Committee is interested in the price of drugs to the consumer, and I have a letter here which was received by a member of Parliament and passed on to me as a member of this Committee, and I wonder if you might have any comment on it. I know that you have no direct responsibility but perhaps, being concerned in the merchandising of drugs, you might be able to give the Committee some idea how this situation could arise. This is a letter from a veteran who was living in Montreal and became ill and went to his doctor, who prescribed a certain drug. He went to a drug store in Montreal with this prescription for certain tablets and he was charged $12.50 for 25. The retail price of these tablets was $50 for 100. Later on he moved to Ontario and had another attack of his ailment, went to the local doctor—he had the previous prescription with him—and the doctor sent to a drug company in Ottawa for 100 of these tablets and the price again was $50 for 100.

Later on this man went to California on a trip and while there he once again became ill. He went to a local doctor who prescribed the same drug, and he then sent at the place he happened to be in California, to a drug store for 25 tablets. The price there was $2.75.He thought there was a mistake, so he went to another drug store and the price was the same. Then he discussed the matter with the druggist and he said that the druggist in California told him that their suggested retail price for this drug was $10 for 100 or $2.75 for 25 tablets.

On his return to Canada he wrote to the Canadian manufacturer of the drug, who informed him that the suggested selling price for this drug in Canada is $12.60 for 100, although there might be added to this a professional fee for providing the prescription, but the Canadian suggested selling price was $12.60 for 100 and the suggested selling price in the United States was $10 for 100—that

would be American dollars, of course—and the manufacturer went on to say that it does not compare too unfavourably with the Canadian price when taking into consideration duty, federal sales tax, and so on. This man then sent to this same drug firm in Ottawa for another supply of 100 of these tablets and this time the price asked was $12.60, which was presumably for 100, although he does not actually say that. This man then goes on to say the manufacturer must have contacted the drug store by this time because the selling price was then $12.60. Have you any suggestion how this situation could arise?

Mr. WESTON: I have not the faintest, sir. Perhaps Mr. Peel or Mr. Pitcher could help.

Mr. PITCHER: There is always a possibility of error there on the part of the retailer, but it is hard to understand how the error would occur in two places, one in Montreal and one in Ottawa, and charging the same price. I cannot understand that.

Mr. HOWE (*Hamilton South*): If we could understand that we could arrive at the answer to some of our problems, could we not?

Mr. WESTON: Of course, we have no control over what any retailer does with the lines he sells. He simply has these products and we cannot dictate to him and tell him he must sell them at that price. We cannot do that. We simply hand the products over to him, deliver them to him, and tell him what it is going to cost. What he does from there on in we do not know. He may charge a professional service fee or he may have other methods of pricing. This we do not know because we do not enter into this area at all.

Mr. MACLEAN (*Queens*): I take it that your association does not follow this practice, but does any manufacturer follow the practice of having purchasers go to drug stores to price their product at the retail level to see what is being asked for it?

Mr. WESTON: Yes, I understand that they do have what might be called "comparison shoppers". I do not know this officially, but I understand that some manufacturer will go to probably their own medical director and have him fill out a number of prescription blanks and he will then take them to various drug stores and shop. This may not only be for price reasons, but also to ascertain that the pharmacist is filling the prescription as written. I only know this unofficially, not officially.

Mr. MACLEAN (*Queens*): May I just add that in the second case where the doctor sent on his behalf to a drug firm in Ottawa for 100 tablets which cost $50, that this man, being a veteran, was then having his medical expenses paid as he was a recipient of war veterans' allowance, and the Department of Veterans Affairs paid the second $50. To your knowledge does the Department of Veterans Affairs, or any other department of government that pays for drugs on the retail level in this fashion, do any checking to see whether they are paying the proper price?

Mr. WESTON: I do not know, sir.

Mr. MACLEAN (*Queens*): Thank you very much.

Mrs. RIDEOUT: Gentlemen, I must first tell you that I am very much a layman on this Committee and I have listened with a great deal of interest to

many witnesses and I must confess I have not any reasonable way to suggest how we might lower the cost of drugs. I am interested in your brief because you are in the wholesale industry and presumably, as you stated, you would like anyone who is interested in buying drugs to take advantage of your services. I notice in my own area a particular trend, which is really just beginning, where some larger businesses are getting into the drug business—department stores and shopping centres—and I would presume these people must be buying in bulk directly from the manufacturer because their prices are indeed cheaper.

On the other hand, take the case of the smaller drug stores who have been servicing the communities for years, in many cases on credit. A lot of people go to their druggist and get their prescriptions filled and charge their drugs, and I am sure that in some form, whether by service charge or some other way, the druggist has to charge these people for the use of credit because it is not reasonable to think that he could carry on without doing so.

Here we have the larger businesses being able to take advantage of the lower price from the manufacturer and the smaller drug stores still almost committed to buying from the wholesaler and not able to compete. What do you say about this?

Mr. WESTON: This is not necessarily true, Mrs. Rideout. There are some manufacturers who will not sell direct regardless of the size of the account. They will simply say to the account, "You must purchase this through the wholesale house, we do not sell direct." Therefore the retail account must go to the wholesaler. If the particular drugs are being sold by a direct house, naturally the retail account is going to go to the direct house. Nevertheless, the manufacturer again is performing the function of the wholesaler and someone has to pay that cost. It may not be as great or it may be more. We are inclined to think it is more than the wholesalers' cost. Now, what this small retailer does in handling his own accounts, whether he charges interest or has a monthly charge, this we do not know, this is an area in which we do not enter, but I think the only advantage the large account might have—and I think the drug librium was mentioned before—is that if the small store has a relatively small demand for this product he may only buy 100 tablets, but he will pay the 100 price. The larger store, which may be better financed and may be well able to afford a large inventory, may buy 1,000 and they then get the price on 1,000. This is very true, we do not deny this at all, but what we have to look at is the fact that the wholesaler simply has the products on hand and thus meets the demand for them as they come in, whether it is for 100, 500, 1,000 or 10,000. It is not quite true to say that the larger accounts will get it cheaper. They will get it cheaper if they are buying large quantities. This is not only true of drugs; it is true of other thing as well.

Mrs. RIDEOUT: This is exactly why I mentioned this to you because it seems to me that it is a trend now—just the same as the corner grocery store is a victim of the large supermarkets—and is this something in the foreseeable future that we are going to have large drug stores that can sell their products cheaper and put the corner drug store out of business in some cases?

Mr. WESTON: My personal opinion, Mrs. Rideout, is that they have been crying the death of the corner drug store for many, many years but the corner drug store is still with us. Some of them have sharpened up their practices and

are doing quite well. There is one just down the street from where I live and he is faced with a supermarket up the street, but this chap does very well for himself. He has sharpened up his merchandise and practice. I think the small druggist is going to have to do the same thing.

Mrs. RIDEOUT: In other words, are you suggesting that there is competition in drug prices and if they want to stay alive they have to compete? Would you think this is true? I do not know, I am not trying to query you on this, I am merely interested.

Mr. WESTON: Mr. Peel or Mr. Pitcher, would you like to answer that?

Mr. PITCHER: Mrs. Rideout, I would say as far as there being a definite trend in this direction is concerned that you are quite right. There is a trend in this direction. We, as wholesalers, are doing what we can to assist the smaller drug stores to stay in business. One of the things that could evolve from this trend is that two or more of the small drug stores will have to get together—or should get together, perhaps—and go into one large store together in competition with this type of operation. Certainly the small corner drug store is at a disadvantage and he will have to improve his mode of operation. He will have to bring his costs down as much as possible in order to compete with the large chains.

Mrs. RIDEOUT: Meanwhile the people who are used to going to this particular store and who probably have a charge account there will probably find it difficult to make the change. It is a vicious circle, really.

Mr. PITCHER: In the case where he has been carrying these accounts, no doubt he will have to get a bit tougher and shorten up his terms with these people.

Mrs. RIDEOUT: I am wondering if you would agree with me, then, that the person who is in the position of being able to go and buy his drugs and pay for them is more apt to get a better price than the person who may have to charge them for a month?

Mr. PITCHER: In some instances, yes. This does not hold true right across the board, but there are instances where they can buy better by going to one of these larger chains and paying cash for them.

Mrs. RIDEOUT: Well, I have particularly cold practical thoughts and I was wondering whether this would not play some part in the cost of drugs to the consumer. Thank you very much.

Mr. ISABELLE: If I understand, wholesale is a certain part of the distribution of pharmaceuticals throughout Canada to retail stores or retail druggists. Am I correct?

Mr. WESTON: That is right. We have estimated that 40 per cent of the drugs in Canada are distributed through wholesale druggists.

Mr. ISABELLE: Therefore, pharmaceuticals cost Canadians about $400 million a year.

Mr. WESTON: I have seen those figures, Dr. Isabelle, but quite frankly I cannot remember them. I have seen them in the Canadian Pharmaceutical Association brief, but as I say, I cannot remember them.

Mr. ISABELLE: If you take 40 per cent of that, you are doing quite a good business.

Mr. WESTON: We have estimated, according to our last survey, gross sales of 28 members—and I must point out to you that each company with branch houses, must take out a separate membership for each branch. For our 28 members, which cover 10 companies, our gross sales for 1965 were $137,351,000, as compared to $115,799 for 27 members for the previous year. The Dominion Bureau of Statistics has reported sales of $316 million, but their basis is not the same as ours. Our net sales were $127 million as compared to $113 million, the net sale figure being reached after returns, allowances and adjustments, and discounts deducted from gross sales.

Mr. ISABELLE: Would you say that if all the pharmaceuticals in Canada were distributed through a wholesale company, the price of drugs could be lowered, because companies are spending lots of money on all those depots and things of that nature, across Canada.

Mr. WESTON: As we have pointed out, Dr. Isabelle, we do not set prices of drugs.

Mr. ISABELLE: I know, but—

Mr. WESTON: But if we can go to the manufacturer and say to him: "It is costing you X to perform our function, we can do this and it will only cost you Y which is less than you are paying", if he wishes to reduce his prices, that is fine, we will reduce our prices correspondingly, but we are still bound by the fact that the manufacturer says to us: "Here is the product and this is the price." We must then turn around to the retailer and say to him: "Here is the product and this is our price", our price, of course, allowing for our gross operating cost, and our margin of profit. If we can reduce our distribution costs and the manufacturer says: "Fine you have reduced the distribution costs and we will reduce our price," we will go along with him.

Mr. ISABELLE: Did you not just tell the Committee that if drugs were distributed through wholesale companies, this would lower the percentage of the big companies by about 15 per cent in their expenditure?

Mr. WESTON: We do not know what it is, because we do not know what it costs the manufacturers. We have tried to find this out, and I think we came up with a figure of 4.33 per cent, but our distribution costs are less than the manufacturers'. I know of one company which is not an ethical manufacturer and is in the field of health products. At one time they distributed virtually all their products direct. They have now changed their policy, and, at last count, they had under 200 direct accounts. The majority of these accounts were wholesalers; very few retail accounts, and they are planning to decrease this even further, because they have said it does not pay to do this. "We just cannot be bothered in billing 5,500 pharmacists—" and their products are sold right across the country,—"or shipping to 5,500 pharmacists and having returns from 5,500 pharmacists. We do not want any part of it". Therefore, they turn it over to the wholesaler.

Mr. ISABELLE: Do you advertise and do you have a certain budget for advertising, or do you bother with advertising?

Mr. PEEL: No, we do not do any advertising, other than in trade journals.

Mr. ISABELLE: How could a druggist know that you are in a certain area?

Mr. WESTON: Our wholesale druggists do have salesmen.

Mr. ISABELLE: Salesmen?

Mr. WESTON: Yes; we have salesmen and we also have what are known as telephone order clerks, his sole duty being to sit down and take orders over the telephone. Of course, any pharmacist going into business, quickly finds out who the wholesale druggist is in his community. He can do this in a number of ways. He is probably informed by another pharmacist; he may call up a pharmaceutical house and ask to be provided with goods, and he is told that they only deal with the wholesalers and he is given a list of the wholesalers in the area, and then it is up to him.

Mr. ISABELLE: Are you a part of a big organization in the wholesale business as a whole, or are you just wholesalers in drugs?

Mr. WESTON: Are you referring to—

Mr. ISABELLE: Do you wholesale razors, perfume, candies and so on?

Mr. WESTON: Yes; but this again will vary. We have some of our wholesale druggists who will carry tobacco and confectioneries. We have others who will not touch it. We have wholesale druggists who will carry films and will not touch cameras. But the drugstore today has been evolving over the years to the point where it carries a great many non-drug items. They may carry these for competitive reasons, and they carry product goods which they would not have dreamed of a generation ago. Now, the average person walking into a drugstore may go in for a bottle of cough medicine or something, and while he is in there, he suddenly realizes that he needs cigarettes or a bottle of ink, or something like this, he needs some razor blades. He buys these things while he is in the drugstore. Now the drug wholesaler, knowing this, is going to try and encourage his retail drug account to purchase as many of these items from him as he possibly can. The drug wholesaler is not only competing with other drug wholesalers, he is also competing with wholesalers of tobacco, confections, sundries, and so forth. Where he has a retail drug account and he knows that this retail druggist will carry cigarettes, tobacco, chocolate bars, razor blades, electric razors, hot water bottles, and so on, he will try to sell these things.

Mr. ISABELLE: This is what I had in mind, because I do not see where the word "druggist" fits into this wholesale organization, because from National Drug you can get anything, except a car and a coffin.

Mr. PEEL: In our brief we say that 39.93 per cent of our business is pharmaceutical drugs and quite a high percentage is called O.T.C. items which would be cough mixtures, vitamins, and so on.

Mr. ISABELLE: Excuse me, 43 per cent of your own business is distributing drugs?

Mr. PEEL: It is 39.93 per cent.

Mr. WESTON: At page 15, you will see that 39.93 per cent of the sales are in prescription drugs.

Mr. ISABELLE: Yes, prescription drugs.

Mr. WESTON: Now, 24.10 per cent is over-the-counter drugs. Over-the-counter drugs are normally those drugs which do not require a prescription,

although there are certain over-the-counter drugs for which a doctor may write a prescription for one reason or another therefore. This would bring the total up to 64 per cent. It must be remembered, sir, that many of the other wholesalers cannot carry these products for a number of reasons. First of all, they have to have a pharmacist on the premises. The wholesale druggist is the only wholesaler who has to have a professional man right on the premises. There are certain matters dealing with security. If you are carrying—and all wholesalers to the best of my knowledge do—narcotic drugs, they must be kept very, very secure. There are certain drugs which must be kept under refrigeration; you have to have a refrigerator for this purpose; you have to have temperature control in your warehouse, which is not necessary for any other types of wholesalers. We call ourselves wholesale druggists with considerable justification.

Mr. ISABELLE: That will be all, but it is still not too clear in my mind.

Mr. ASSELIN (*Richmond-Wolfe*): Mr. Chairman, in the brief that is before us this morning, I find that you have suggested the elimination of the 11 per cent sales tax in order to reduce the cost of drugs. I believe this is the only suggestion you are making. Being really a layman, I would like to ask just one very plain, simple question. What would you recommend this Committee suggest in order to really help to reduce the cost of drug prices?

Mr. WESTON: We have said that the 11 per cent sales tax should come off. I think everyone is agreed on that.

Mr. ASSELIN (*Richmond-Wolfe*): But there is a certain variation of ideas on that, whether the consumer would really benefit by it or not.

Mr. WESTON: We believe the 11 per cent sales tax should come off.

Mr. ASSELIN (*Richmond-Wolfe*): I have my doubts, but I would like to know what you would suggest to start with.

Mr. WESTON: I do not think the government really gets that much money out of it, in comparison with other revenues. This is only a personal opinion and is certainly not the opinion of the association. I think if you took a look at the public accounts in Canada, and it was broken down, the amount they would get from taxing drugs, I think, would be a relatively small proportion of the whole thing.

The CHAIRMAN: I think it was about $20 million over the last year reported, roughly.

Mr. WESTON: We have estimated that the value of the inventories in wholesale drug houses in Canada is $12 million, on which the tax has been paid. Therefore, 11 per cent of that would be $1,300,000.

Mr. ASSELIN (*Richmond-Wolfe*): Besides this, what other suggestions would you put forward? In other words, this Committee has a duty to make recommendations to lower the cost of drugs, and I would like to know what you would suggest that we could consider?

Mr. WESTON: We think distribution costs can be lowered; we are quite honest in admitting this, but this is our own horse we are riding, if you wish. We think distribution costs can be lowered by the use of drug wholesalers, and we certainly believe that we operate more efficiently: we can do it faster; we can do

it more economically than can the manufacturer. If we can prove this to the manufacturer over a period of time and say: "Look, your distribution costs are not as great as they were when you were distributing, and if you wish to lower your cost of drugs, we will certainly pass this along." I cannot speak for each member of our company, and certainly this association will not enter into any discussion on prices; but it would seem to me only logical that if the manufacturer is getting the benefit of lower distribution costs, and if he wanted to consider lowering his costs, this is one area where he might come in. I think we have pointed out that:

> In 1964, the 10 largest manufacturers of ethical pharmaceuticals who distributed through drug wholesalers employed 455 salesmen and reported sales of $41,700,000. This works out to $91,646 per salesman. The 10 largest manufacturers who sold direct had sales of $52,969,000 but employed 701 salesmen. This works out to $75,562 per salesman—or $16,085 per salesman less.
>
> In other words, although the direct houses reported total sales $11,269,000 greater than the wholesale orientated houses it took another 266 salesmen to achieve this success.
>
> We think it is obvious that the wholesale orientated houses are getting invaluable assistance from their wholesalers in moving their product lines—assistance, I wish to emphasize again, at no direct cost to these firms.

The manufacturers, as you know, have detail-men who are continually on the road. They call at hospitals, they call on doctors, and they call on wholesalers. The wholesale drugs have salesmen also. The wholesale druggists have no interest in doctors and very little interest in hospitals. They can concentrate all their efforts on the pharmacist and we have our telephone order clerks. We think, by using these people, we are helping the manufacturer to promote his products. Through rapid, economical and efficient distribution, we can keep the cost of drugs down. We do not believe we can tell the manufacturer what he can sell his products at. This I think is a matter of competitive demand, of prices and of a number of factors.

Mr. ISABELLE: May I ask a supplementary question. You say in your brief that at present 60 per cent of the drug business is done on a direct basis. Am I correct?

Mr. WESTON: That is correct.

Mr. ISABELLE: This is contrary to the United States and Great Britain in the same business.

Mr. WESTON: That is right.

Mr. ISABELLE: But does the wholesale business in the United States and Great Britain operate in the same way as is done here?

Mr. WESTON: It is done in approximately the same way. On the other hand, you must remember that Great Britain is a much smaller country and this helps them a great deal. They have more wholesalers in Great Britain than we have in Canada. The United States have many more wholesalers than Canada. I would

suspect that in the New York area alone they have as many as we have in all of Canada. Their business—in the United States—is 10 times the amount of ours.

The CHAIRMAN: I wonder if I could ask a question. If I am a retail druggist in Toronto buying drugs, would I pay the same for a similar drug in 100 tablet lots as I would if I were a druggist in northern British Columbia? Do distribution costs change, or do you average them out across the whole country?

Mr. PEEL: I would say, for most pharmaceutical drugs, it would be the same in Toronto, as it would be in Vancouver.

The CHAIRMAN: Not Vancouver, but northern British Columbia or northern Saskatchewan?

Mr. PEEL: I would say that your price would be reasonably the same. Mr. Chairman, if I may say so, it occurs to me that the wholesale druggists in Canada have not done a very good job of selling themselves to the manufacturers with regard to their services and distribution facilities and I believe the formation of the Canadian Wholesale Drug Association, in getting the wholesalers together, will do much to strengthen their hand with the manufacturers for the manufacturer to recognize the wholesaler as the proper source of distribution.

Mr. HOWE *(Wellington-Huron)*: Mr. Chairman, I was rather interested in the statement made at the bottom of page 15. It would appear that your wholesale organization is not practising what you preach, because you maintain that the cost of distribution increases the cost of drugs, and you say:

> It must be stressed that not all drug wholesalers carry the same lines of non-drug merchandise.

But the non-drug merchandise which you sell amounts to 35.97 per cent of the sales. Have you done anything to get the people who sell the tobacco products and confectionery and the people who sell photographic supplies and films and flash bulbs to co-ordinate their business, so there will only be one? You said it was paper work and orders that increased the cost, and 35 per cent of your sales are non-drug merchandise. You are saying it is cheaper to have a one stop business, and yet some of your wholesalers refuse to carry certain lines of non-drug merchandise that are being sold by the druggist.

Mr. WESTON: The reason for this is that perhaps in some areas you will have tobacco wholesalers.

Mr. HOWE *(Wellington-Huron)*: Yes, but you could handle tobacco, too, as well as they can.

Mr. WESTON: Some of our wholesalers do, others do not. It is a matter of choice; it is up to the wholesaler himself to determine what he may wish to carry. He may estimate that the mark-up on carrying certain lines is not worth it. I can think of two wholesalers in Montreal who do not carry tobacco products, and I think the answer to that is that there are wholesale tobacconists in Montreal, and they just do not want to compete with these people.

Mr. HOWE *(Wellington-Huron)*: Mr. Chairman, in answer to a question I put to the witness some time ago on how we are going to reduce the cost of drugs was by using the wholesale outlets and by using these wholesale outlets, you

have one stop for all themerchandise. If you are going to say that your wholesalers do not carry the complete line to the druggists, what is the point?

Mr. PITCHER: I think Mr. Weston was referring to a complete line of drugs. How far a wholesaler wishes to go in the other direction, is a matter entirely for the wholesaler to decide.

Mr. HOWE (*Wellington-Huron*): Yes, but it still amounts to 35 per cent of the sales you make to the druggists.

Mr. PITCHER: Exactly.

Mr. HOWE (*Wellington-Huron*): These are non-drug items, and if you are going to service—and after all, his resale prices are estimated on what he makes out of his entire sales, whether they are drugs or non-drug items.

Mr. PITCHER: The druggist is not being penalized because the wholesale druggist does not carry tobacco and does not carry confectionery. The druggist can buy these products from his local distributor.

Mr. HOWE (*Wellington-Huron*): You maintain that the one stop sale will reduce the cost of drugs, if he can buy everything that he is going to use in his store in one area.

Mr. PITCHER: Right, but you are confusing drugs with the other sundry items.

Mr. HOWE (*Wellington-Huron*): The other items have something to do with the price he will sell his drugs at, though.

Mr. PITCHER: No, I do not think so.

Mr. HOWE (*Wellington-Huron*): You mean that if 35 per cent of his business is done with non-drugs that that percentage of his business does not affect the price of his drugs?

Mr. PITCHER: There are some wholesalers in the United States who handle pharmaceuticals alone. They handle nothing else but pharmaceuticals, because they are in the thickly populated areas where the pharmaceutical business itself will sustain their business. They are strictly in pharmaceuticals.

Mr. HOWE (*Wellington-Huron*): You maintain that most drugstores carry non-drug items. The amount of items which they sell has something to do with the profit they make on their drugs and what they sell the drugs at. Any type of business is operated this way, and if 35 per cent of the business in the drugstore is done on non-drug items, the profit that the druggist makes out of these has something to do with his over-all profit picture and what he can sell some of these drugs at. There are a lot of drugs which do not have the resale price marked on them and he marks them up according to what he figures he should make from them, and his profit picture is affected by these things.

Mr. PEEL: Of course, he is buying this 35 per cent of product—if he can not get it from his drug wholesaler—from another wholesaler at a pretty competitive price, I would think. I also say that if a wholesale druggist sees a volume of business there that he does not have in stock, he would be thinking very seriously of putting this into his inventory and promoting the sale of it.

Mr. HOWE (*Wellington-Huron*): What I am trying to point out is that if you are going to go for this one stop sale for the retail druggist, if he gets everything

and saves paper work and distribution costs, you have to consider the non-drug items, too, because they are part of his sales picture.

There is one other thing that I was interested in, and that is on page 37, where it says:

> As business becomes more complex, as demands by all levels of government increase, the retail pharmacist finds he has less and less time to spend on the professional aspects of his job.

Do you foresee some day when there will be drugstores without druggists in them; that they be licensed to such an extent, or computerized, that you will just call up a wholesale druggist and then will supply this specialized prescription without the druggist being in the store?

Mr. PITCHER: I do not think you could ever operate a drugstore without a druggist in the store. I do not think that will ever be possible.

Mr. HOWE (*Wellington-Huron*): I am just wondering, whether you are going to do away with him when, as you say, he has less and less time to spend on the professional aspects of his job.

Mr. PITCHER: Without his bookkeeping and other multiple tasks that he has to do.

Mr. WESTON: We have seen, over the years, the development of unemployment insurance, pension funds, and we have seen the food and drug people say that certain drugs have now been placed under control. This is no criticism of government, it is merely a statement of fact. This of course has necessitated more and more work on the part of the pharmacist. We cannot do anything about that, but we do say to the pharmacist: "Why do you place orders with 50, and up to 100 suppliers. You are going to have to receive from those suppliers their invoices and check them, and you are going to have to issue cheques to them. Buy it from your wholesaler and save yourself a lot of work and money." After all, the banks do charge for every cheque he writes, and it is a lot cheaper for him to write one cheque than it is to write 100 cheques.

Mr. MACLEAN (*Queens*): I would like to ask a question. What you are saying would seem to imply that the small drugstore is in an increasingly unfavourable competitive position with the large outlet. I say this because where you have a very small drugstore, with perhaps two or three of a total staff, you have to have a professional druggist. He is misemployed most of the time filling out forms and this sort of thing; whereas a large retail outlet would have a relatively small number of druggists compared to their total staff, would be fully employed in their profession, or nearly fully employed in their profession and the paper work and the merchandising of other articles, and this sort of thing, would be done by non-professionals who presumably would not command as high pay.

Mr. WESTON: Of course in the large retail outlet you probably would have one, two or three pharmacists; you would probably have a cosmetician, who would look after the ladies; you would probably have a couple of clerks who would be selling non-drug items, such as kleenex, or anything of this nature; you would probably have one or two people in the back who would be doing nothing but receiving goods and putting them on the shelves, checking stock and so on.

You would probably have a bookkeeper or an accountant, who would be writing cheques and doing the paper work. The small pharmacist would have to do all this himself, or he might be able to employ another pharmacist, or a clerk, who could look after some of these other things. He certainly cannot compete with the large pharmacist, the large retail store in manpower, no.

The CHAIRMAN: Are there any other questions of the witnesses?

Mr. BRAND: I have a couple of short questions. I was curious about this distribution question. I do not quite understand what you are getting at in saying that distribution that is carried out largely by the wholesale firms cuts down the costs. Is this right? We know that 39.93 per cent of your business now is in prescription drugs. We are concerned primarily with what it is costing the consumer. As a result of your distribution methods, as outlined on page 37, do you believe that the drugs that you handle are being sold cheaper to the public than the ones that are sold directly through the manufacturers? That is, in fact, what you are saying.

Mr. WESTON: What we are saying of course, is that we have no control over prices. I cannot emphasize this too strongly. A manufacturer, regardless of whether he sells direct, or sells through the wholesaler, has set the price at which he will sell either to us, or at which he will sell to the drugstore. In other words, some direct manufacturers will sell to us through the wholesaler at the same price as they sell to the retail pharmacy. There is no advantage there. The manufacturer who sells through a wholesaler does make provision in his selling cost for our cost, which includes our operating costs and what we would consider a reasonable margin of profit. We have no control over prices, there is nothing we can do about them, but we believe that if we can demonstrate, through efficient methods of distribution, to the manufacturer that our distribution costs are lower than his, if he wants to take advantage of this and lower his costs, that is up to him. We think we can do it faster, cheaper and more efficiently. We cannot persuade all manufacturers of this, but we hope we can get the majority over to our side eventually, up to the 60 per cent in the United States and Great Britain.

Mr. BRAND: You lost me somewhere there, because you did make the statement that you thought you could do it more cheaply.

Mr. WESTON: We believe we can. We cannot prove this, because—

Mr. BRAND: Then, on the other hand, you say you have nothing to do with prices; you have no control over them.

Mr. WESTON: We cannot prove this, Dr. Brand, for the simple reason that we have not got the manufacturers' figures. If the manufacturers would turn around and say to us: "Our distribution costs are X", we would then compare them with ours, and would then know if our distribution costs were lower or higher or at the same level. This is one thing we do not know.

Mr. BRAND: In other words, this is just a hunch on your part?

Mr. WESTON: We can spread our costs and they cannot. For example, if a pharmacist calls a drughouse and says: "I want this" and the drughouse replies: "This will cost you so much, but because it falls below our minimum order, we are going to have to charge you 50 cents or $1 for delivery." The cost of that product is increased by that 50 cents or $1. Is this not right? But if he

calls the wholesaler and says: "I want this", the wholesaler will say: "Fine, this is the cost". He does not impose a 50 cent or a $1 charge for this, because this is part of his service. He delivers it. This, to us, is a fine example.

Mr. BRAND: But you still have not answered the question. I just do not think they are cheaper. You are selling almost, according to page 37, $41,700,000 through the wholesaler, $52,969,000 direct.

Mr. WESTON: What we have said there is that the 10 largest manufacturers reported sales of $41 million. This is not the wholesalers. We said that the 10 largest manufacturers who distribute through drug wholesalers reported sales of $41 million. The 10 largest who sold direct had sales of $52 million. Our total gross sales were roughly $137 million; therefore, this $41 million is only part of that $137 million.

Mr. BRAND: But you also say those who sold through drug wholesalers and the 10 largest who sold direct, then you go on to say somewhere else in your brief that no one sells totally direct.

Mr. WESTON: No, but you will find a house which will sell 90 or 95 per cent. This figure will vary from as low as 5 per cent to as high as 25 per cent; it will depend upon the product line, and it will depend upon whether there is national distribution. There are a number of factors included in this.

Mr. BRAND: At the moment, we do not know if this would help or not; you just hope that it would?

Mr. WESTON: We believe it will, but until we know—

Mr. BRAND: One factor we know for sure, it would help the wholesalers.

Mr. WESTON: We know it will help the wholesalers, but we need the help and we need the money. We do not know what the manufacturers' distribution costs are.

Mr. BRAND: One other question. When you are talking about the number of salesmen employed, are you including detailmen?

Mr. WESTON: Yes.

Mr. BRAND: Are you suggesting then that we should cut our detailmen?

Mr. WESTON: No. What we are saying is that the wholesalers with the salesmen are augmenting the sales force of the manufacturer at no direct cost to the manufacturer. When we talk about salesmen, we are not only referring to the wholesalers' salesmen on the road, but also the telephone order clerks who do nothing but sit in the wholesale houses and take orders, or call the pharmacists and say: "This is so and so wholesale house, what can we do for you today?"

Mr. BRAND: Yet your statement here is made by Raymond Dupuis. It says:

> ...greater than the wholesale orientated houses it took another 266 salesmen to achieve this success.

You seem to be implying here that we should be able to cut down on a lot of these salesmen. Are you just referring to those who go direct to wholesale houses and pharmacies. Is this what you mean? This does not really make sense, when you look at it closely.

Mr. WESTON: If I am not mistaken, most detailmen make three calls, the hospital, the pharmacist, and the wholesale house, not necessarily in that order.

Mr. PEEL: And do not forget the doctor is the major call.

Mr. WESTON: Probably the order is the doctor, the pharmacist and the wholesaler.

Mr. BRAND: In other words, the statement on page 37 is really not valid, when you get right down to it?

Mr. PEEL: What we are suggesting is that the ethical manufacturer or the pharmaceutical manufacturer really creates demand for his product in the doctors' office, in hospital displays and so on, and possibly the wholesaler could call on the retail pharmacist and relieve the pharmaceutical manufacturer from that responsibility. We could handle the retail pharmacist and make sure that the products were in his store and he could create the demand in the doctors' office, and so on.

Mr. HOWE (*Wellington-Huron*): I have a supplementary, Mr. Chairman. On page 13 you lay out the percentage of sales to different people and I do not see the doctors included in that.

Mr. WESTON: Very small, six, I would say that most of the sales—

Mr. HOWE (*Wellington-Huron*): The witness said they were the most important people.

Mr. WESTON: No, these are wholesale sales.

Mr. PEEL: They create the demand of products.

Mr. HOWE (*Wellington-Huron*): You mean you do not sell wholesale to the doctors?

Mr. WESTON: Very little. I think the answer to that would be that if a doctor needs something in a hurry and he cannot get it from a pharmacist, he might call a wholesale house. I think that is probably the answer to your question.

Mr. BRAND: Do you think he would get it?

Mr. WESTON: I do not know.

Mr. BRAND: If they were all handled through the wholesaler in the manner you suggest, could you, by your efficient distribution, reduce costs sufficiently so that eventually it would mean cheaper drug costs to the consumer, yes or no?

Mr. WESTON: We would hope that any savings which we would pass on to the pharmacist, would be passed on by the pharmacist to the consuming public.

Mr. BRAND: You believe you could do this more cheaply?

Mr. WESTON: I think we can, but we cannot prove it, because we have no figures as I keep saying, from the manufacturers.

Mr. MACLEAN (*Queens*): Take a specific case. If two manufacturers were producing identical pharmaceuticals and one was distributing it himself and the other through the wholesaler, and if the retail price was the same, the manufacturer who as distributing through the wholesaler would be making more profit. It is a more efficient way of doing it, you believe?

Mr. WESTON: We will not say he would be making more profit. This is an area in which we do not wish to enter, but we do say that we can distribute this more efficiently, more economically, than can the direct house.

Mr. MACLEAN (*Queens*): Therefore, either the product that is distributed through the wholesaler is going to be cheaper to the final consumer, or someone along the way is going to make more profit?

Mr. WESTON: That is right.

Mr. BRAND: Since you can buy in quantity as a wholesaler, presumably then you can buy large quantities more cheaply than a drugstore who would buy directly. Is that correct?

Mr. WESTON: You must remember, sir, that the inventory of the wholesaler is going to be predicated on the demand by the pharmacists. In other words, you may have a very fine drug which is very seldom used, in which case there is no point to the wholesaler in stocking great quantities of this, but a fairly common drug, which is in constant demand, he will keep this in stock.

Mr. BRAND: The only reason I ask that question is that you made a statement in which you said that many of your mutual houses were set up for this purpose, so you could buy in quantity and therefore make it cheaper.

Mr. WESTON: This is true too, but this also applies to non-drug items, and even though there is the advantage of purchasing quantities of these products they are still limited by the demand of the pharmacists.

Mr. BRAND: Then, in effect, it has not cut down the actual cost to the consumer, has it?

Mr. WESTON: We still get back to our old argument, that we can do it faster, better and cheaper and we would hope that these savings would be passed on.

Mr. BRAND: Mr. Peel, I know has had some experience with Saskatchewan National Drugs, which is more or less a monopoly in that province.

Mr. PEEL: I would not like to say that, Dr. Brand.

Mr. BRAND: Let us put it this way: Are there any other wholesale drug or prescription drug houses in the province of Saskatchewan outside of National Drugs.

Mr. WESTON: No, not located in that province.

Mr. ISABELLE: Who owns it!

Mr. BRAND: Who owns it? Is it a mutual-type owned by pharmacist.

Mr. WESTON: You could be a little—You are talking of National Drug Limited when you are talking of Manitoba and Saskatchewan, and then you are talking of National Drug and Chemical Company of Canada. National Drug Limited in Manitoba and Saskatchewan is the subsidiary of National Drug and Chemical Company.

Mr. BRAND: Who owns the subsidiary?

Mr. WESTON: National Drugs Limited, the subsidiary, is owned partly by retail pharmacists and partly by National Drug and Chemical Company.

Mr. BRAND: And they provide this additional 10 per cent discount on things bought, as laid out in your brief, when they buy from the wholesale druggist; is that right.

Mr. WESTON: Yes.

Mr. BRAND: So it is financially to the druggist's advantage to buy from National Drug Limited in Saskatchewan?

Mr. WESTON: Where their prices are competitive, yes.

Mr. BRAND: That is the point. Either they buy from them or they buy it from the manufacturer directly. Is that right?

Mr. WESTON: Yes.

Mr. BRAND: Do you think there is any advantage in pre-packaging by the manufacturer in dispensable quantities, such as say 25 pills to a bottle. Do you think there would be any advantage to the consumer if you handle drugs this way, rather than in bulk?

Mr. PEEL: I think, in fact, there are many pharmaceutical manufacturers who package their material in dispensable quantities.

Mr. BRAND: I know this, but I mean across the board, let us say. This certainly is not true of pills though, is it, as much as it is of certain liquid refreshments, if you wish to call it that.

Mr. WESTON: I do not think all illnesses come in the same size, doctor. I may require only ten pills while other patients may require 50.

Mr. BRAND: Not only that, but I do not know if you are aware that we have had this proposal put before this Committee, pointing out that it would do away with a lot of bottles of 88 pills in druggist's stores because they would then be returnable, to the manufacturer for a complete refund, if they were not used, which would cut out this extra stock sitting on the shelves, of 88 pills that they do not sell, and therefore would cut down the inventory considerably and therefore the cost, and make his prices to the consumer much more reasonable.

Mr. WESTON: Dated products are returnable. As a matter of fact, we ourselves at this moment—

Mr. BRAND: Not if they are opened, are they?

Mr. WESTON: Not opened, no.

Mr. BRAND: That is correct, no.

Mr. WESTON: No, this is true we ourselves, at this moment, are working on a what we call a return goods policy manual, which will be available to our wholesale members, and to others, in which we spell out, as far as we can obtain it, the return goods policy of every manufacturer we have been able to contact. This will spell this out. A sealed bottle is returnable, but if they were in smaller quantities and they became dated, they would certainly be returnable regardless of quantity, as long as they are sealed. I think it is a saving on the part of the manufacturer.

Mr. BRAND: But I am talking about in dispensable quantities. You see the difference—

Mr. WESTON: What quantities?

Mr. BRAND: As I said, I already mentioned a figure, say 25 pills to a bottle, depending entirely on the product, certainly. Would this be advantageous? Now, it has been intimated to us that it would be advantageous.

Mr. WESTON: I think it would be advantageous if you could agree on what is a dispensable quantity.

Mr. BRAND: You think it would be advantageous, if such thing were agreed upon?

Mr. WESTON: If you could agree on what is a dispensable quantity.

Mr. PITCHER: It would be more costly, would it not?

Mr. BRAND: This is the question I am asking: Do you think it would be advantageous, price-wise?

Mr. WESTON: Oh, I do not know about price-wise. It may be, because, certainly if you walk into a pharmacy and you have a prescription for 12, the pharmacist fills this bottle from bulk. He has bought them in bulk and he is selling them in this fashion. If over a period of time he has half the bottle left he cannot return this, as far as the wholesaler is concerned.

Mr. BRAND: That is what I mean.

Mr. WESTON: We do not want it; you have a broken bottle. But if he has a dozen bottles which are sealed, in small quantities, and they have now become dated, he can return them to the wholesaler or the manufacturer. But what is a dispensable quantity? I do not know. This may even vary from doctor to doctor. One doctor may prescribe 25 pills; another may prescribe 15 pills. I do not know.

Mr. BRAND: Have you any questions you would like to ask on monopolies?

Mr. ISABELLE: Who controls National Drug? It has so many subsidiaries that to me National Drug is one coast to coast company. Am I right or not.

Mr. PEEL: That is correct.

Mr. ISABELLE: Now, you said that in Saskatchewan you have another company that is a subsidiary of the National Drug and Chemical Company. Am I correct.

Mr. PEEL: That is correct.

Mr. ISABELLE: Now who owns National Drug in Ottawa? Is that National Drug.

Mr. PEEL: The National Drug and Chemical Company of Canada, yes.

Mr. ISABELLE: But who owns National and Chemical Drug of Canada.

Mr. PEEL: It is a public company.

Mr. ISABELLE: It is a public company?

Mr. PEEL: Yes.

The CHAIRMAN: You can buy shares on the open market.

Mr. ISABELLE: Who controls the company. Would somebody who has the largest number of shares control the company?

Mr. PEEL: The largest shareholder apparently, yes.

Mr. ISABELLE: Who is that? Do you know that?

Mr. PEEL: Yes, M. Loeb Limited.

Mr. MACKASEY: Mr. Chairman, I will be very brief. I am sure most of the questions have been asked, but I do recall in the brief reference to the fact that most of the P.M.A.C. members are American controlled. Could you explain to me why so few of your firms are Canadian, as outlined on page 10, that only 12 companies out of 80 are considered Canadian owned or controlled.

Mr. WESTON: You mean the wholesalers?

Mr. MACKASEY: Yes.

Mr. WESTON: No; we have said that we feel it is of interest to point out that to the best of our knowledge, every wholesale drug member of C.W.D.A. is either Canadian owned or controlled.

The CHAIRMAN: I think maybe Mr. Mackasey's point is that your next paragraph is very ambiguous, because you list United States controlled or affiliates of 58 companies.

Mr. WESTON: These figures apply to our associate members, not our active members. Our associate members are our suppliers, manufacturers; the active members are the drug wholesalers.

Mr. MACKASEY: And the direct members are all Canadians.

Mr. WESTON: To the best of our knowledge, yes. Now, in the case of National Drug, there may be some shares held in England or in the United States; this we have no way of knowing, but to the best of our knowledge, the Canadian drug wholesale industry in Canada is all Canadian owned or controlled.

Mr. MACKASEY: I congratulate you on that fact. On page 37 there is a reference to the possibility of reducing the number of salesmen if direct wholesalers were used, I presume that is it; the three sections which Dr. Brand emphasized. Perhaps I am being facetious of course, but you emphasize the word salesmen; the manufacturers keep talking about detailmen, and imply that the detailmen do more than sell; that the detailmen instruct. Now is their definition wrong?

Mr. WESTON: This was a speech made by our immediate past president who unfortunately is not here today. I suspect that in using the word salesmen he was referring to detailmen, but we have used the word interchangeably.

Mr. MACKASEY: Yes, but it is interchangeable?

Mr. WESTON: We use it in that sense. We say salesmen of pharmaceutical houses; we are referring to detailmen.

Mr. MACKASEY: Yes, you use it in this sense, but I am asking you, is it interchangeable, because one of the arguments we have been getting for the 30 per cent of the expense which the manufacturers claim to have for promotion, includes what they call detailmen and they emphasize that this is necessarily high because the detailman is not a salesman, but rather he conveys information to the hard-pressed doctor, who would normally not be able to get this information unless he has a lot of time on his hands and unless he can read through briefs and journals, and so on. In other words, so far all witnesses have emphasized that detailmen are in most cases university graduates.

Mr. PITCHER: Who for the most part are professional men.

Mr. MACKASEY: Yes, whose sales activity is incidental to the role of carrying information. This rather destroys that theory.

Mr. PITCHER: Well, they do sell just the same, but for the most part the first duty of a pharmaceutical manufacturer's representative is to call on a doctor to show and sell his product to the doctor. That is where the selling starts. Then he goes to the druggist and he says, "I have been detailing all the doctors in Ottawa on this new product of ours, and we would like to have you carry it in your drugstore because you will get prescriptions for it". That is his second port of call. Then he goes on to the wholesaler and tells the wholesaler the same thing: "we would like to have you carry back-up stock for the retailer, because we have detailed this product."

Mr. MACKASEY: Then he goes on to the doctor.

Mr. PITCHER: No, no, he starts off with the doctor.

Mr. MACKASEY: Well, I mean he includes the doctor, but you people do not include the doctor.

Mr. PITCHER: That is right.

Mr. MACKASEY: Now, if we were to eliminate all those detailmen and function through wholesalers, what would he substitute?

Mr. PITCHER: He would have to have his detailmen. He could not get along without him, but instead of the detailmen dividing his time, as he does now, between the doctor, the retailer and the wholesaler, he could devote all of his time to the doctor.

Mr. MACKASEY: I leave the doctors to comment on whether they want to see the detailman. This is an ideal time. That is all, Mr. Chairman on that point.

Mr. LAIDLAW: Mr. Chairman, I have two short questions.

The first arises from a statement at the top of page 30 of the brief where it states that according to the operating survey the net profit after taxes of 10 wholesale drug firms, representing 28 members, was .59 per cent of net sales. Could you give us the percentage based on the investment of the houses concerned, which I think would be a more realistic picture.

Mr. WESTON: The return on net assets, net profit after taxes divided by net assets, the average was 5.19 per cent, the high was 23.44 per cent; the low was .02 per cent; the median taken was 3.45 per cent. Now, I must point out, of course, that in Canada the Canadian Wholesale Drug Association represents two groups of wholesalers: One would be the mutual companies, such as Pharmacy Moderne of Pharmacy Universelle at Montreal. There are the non-mutual companies which would be Pacific Coast Western Wholesale in Vancouver. Because of income tax and a number of other factors, these figures are not seriously affected, as we ourselves point out; although it is .59 per cent, this is for all companies. However, if we take the non-mutual companies, which again would be companies like Pacific Coast Western Wholesale, their net profit is 1.96 per cent after taxes; so these figures are weighted. There is no way in the world that we can do anything else about this, but they are weighted. We do think it is a pretty fair approximation.

Mr. MACKASEY: What did you say the average was again.

Mr. WESTON: For the 28 members—I might point out Mr. Mackasey that all drug houses with branches hold separate membership—it was .59 per cent of net sales.

Mr. MACKASEY: And what was the median.

Mr. WESTON: The median was .78 per cent.

Mr. MACKASEY: The medium was .78 per cent?

Mr. WESTON: Yes.

Mr. MACKASEY: How many firms then were up over the 20 per cent average; there could not have been too many.

Mr. WESTON: I beg your pardon.

Mr. MACKASEY: In how many firms was the relationship between the net profit and their investment over 20 per cent.

Mr. WESTON: I could not tell you, I do not know.

Mr. CHAIRMAN: But you are mixing two different sets of figures.

Mr. MACKASEY: I was referring to what was the average of profit to investment, the average figure.

Mr. WESTON: Return on net assets, net profit after taxes, 5.19 per cent.

Mr. MACKASEY: And the median?

Mr. WESTON: 3.45 per cent. This is on page six of the operational survey.

Mr. LAIDLAW: A second question Mr. Chairman, relates again to the 11 per cent sales tax. If the Government saw fit to recommend the immediate removal of the sales tax—I assume that your warehouses from coast to coast are stocked with pharmaceuticals on which the sales tax has been paid—presumably it would be too difficult to make the adjustment. In other words, with your stocks, until these were cleared and your warehouses emptied, the sales tax would be passed on, because it already had been paid. The manufacturers, on the other hand, have assured the Committee, in fact they have given an undertaking to the Committee, that if the sales tax were to be taken off immediately, the saving would be passed on.

What I am trying to point out to you is that with direct sales then to their own distributing houses, presumably the pharmacist would get the benefit immediately, where under the wholesale system this benefit could not take place, say for six months or a year. Am I correct?

Mr. PEEL: Yes, we would hope that if the sales tax were taken off, there would be a little lead time, we say three months, for the wholesaler. We say that we have $12 million in inventory in pharmaceuticals and wholesale druggists in Canada, and yesterday we were just projecting this and wondering what the inventory was in retail pharmacies in Canada on which the tax was paid, and we came up with—

Mr. WESTON: I think a figure of $25 million was given.

Mr. PEEL: Twenty five million dollars. This could be out—

Mr. MACKASEY: This represents how many months' sales in Canada?

Mr. PEEL: We had figured on an average inventory of $5,000 with roughly 5,500 pharmacies across the country. This will vary, of course. We have come up with a figure of $25 million. We think this is approximately right, so there you have $37 million in the business.

Mr. MACKASEY: Approximately $5,000 should not be more than a month's sale, according to that.

Mr. WESTON: I have forgotten Mr. Mackasey what the turnover in pharmacies is. I do not remember. I think it is around four or five times a year. Perhaps Mr. Peel knows.

Mr. PEEL: It is more like three. Three, three, two, I believe. This is total.

Mr. WESTON: So every three months or every four months they turn over their stock.

Mr. MACKASEY: Well, it sounds like a low volume, $5,000 over every four months. This does not make sense. This means that the average drugstore would have only $20,000 volume a year on pharmaceuticals.

Mr. WESTON: I think it is a little higher than that really but I do not know. I would have to consult the Canadian Pharmaceutical brief to find this out.

Mr. LAIDLAW: What you want to point out in your brief, Mr. Weston, is that there will be a delay; that the removal of the sales tax is not automatically or immediately going to reduce the price of drugs at all.

Mr. WESTON: It certainly would reduce it by the 11 per cent, which I think the lay public would expect. I think this has been agreed to by a number of people.

Mr. LAIDLAW: I mean it will not take effect for probably five or six months?

Mr. WESTON: Mr. Peel could probably answer that one.

Mr. PEEL: No, I cannot see how it could, with $12 million in inventory on which the tax was paid and at the low margins in which we are operating, it would mean that we would operate at a loss.

Mr. MACKASEY: How would we differentiate in that the period between the old drugs and the new drugs that come in from the wholesaler. What would prevent the public from the druggist from stating—and this is a perennial question in supermarkets—that this is an item that the tax has already been paid on. Let us say the law went in January 1 and you people certainly will be selling products to someone on January 1 or January 2—

Mr. PEEL: My reaction would be and this is personal, that the government announces that the sales tax on pharmaceutical drugs would be removed as of X date and leave a lead time of three to six months, or whatever the case may be, but this does not solve it does it?

Mr. MACKASEY: No. During that three to six months the pharmacist can be making an extra 11 per cent tax on the argument that this is one of my old products.

Mr. WESTON: I am afraid we would have to depend on the honesty of the pharmacist.

Mr. MACKASEY: I will make no comment on that, Mr. Weston.

Mr. WESTON: I think the pharmacist would be interested in passing this along as quickly as possible. It is certainly to his advantage even from a good public relations point of view. I suspect that some pharmacists, who are public-minded people, would probably realize the circumstances of some of their customers and pass the saving along on the stock they have on hand. I think this is quite true.

Mr. MACKASEY: Mr. Weston—if Mr. Laidlaw is finished—a few weeks ago I brought up a question here and I read it into the record—so if my figures do not jibe with the figures I introduced a few weeks ago, I hope I will be forgiven, it is the principle I am interested in. It was a case of someone buying tablets in the Montreal areas. Because it happened on a week end he could not buy them from the regular supplier on Bleury Street—I am not trying to indentify the druggist—where he was buying them at 11 cents. He ended up paying 22 cents on the Lakeshore, and found out the next day that he could have bought them for 18 cents. Why the wide variation from 11 cents to 22 cents. How did the druggist who can sell them at 11 cents get his hands on the same product?

Mr. WESTON: This is something you are going to have to ask the pharmacist, not us.

Mr. MACKASEY: In other words, do you sell to all your customers at the same price. Do you have a quantity price?

Mr. PITCHER: Yes; we sell to all of our customers at the same list price. We do have a sliding scale of discounts, which we give our customers, depending on their monthly purchases.

Mr. MACKASEY: Would a chain operation buy at considerably less expense from you people than a single pharmacist?

Mr. PITCHER: Yes.

Mr. MACKASEY: In the order of what per cent?

Mr. PITCHER: Depending on the volume they purchased.

Mr. MACKASEY: What is the maximum?

Mr. PITCHER: It ranges from 4 to 8 per cent. Our maximum discount to any customer is 8 per cent.

Mr. MACKASEY: Which would hardly account for my fluctuation of 11 cents to 22 cents.

The CHAIRMAN: We should record a "no" there, because the tape does not pick up head movements.

Mr. MACKASEY: Do any of the wholesale members have retail outlets?

Mr. WESTON: Yes.

Mr. MACKASEY: Is this generally known?

Mr. WESTON: LeDuc and LeDuc is well known in Montreal and a great deal of their sales is made to non-LeDuc and LeDuc drugstores—if I may use that term. Western Wholesale in Vancouver owns the Cunningham chain, but again a great amount of their business is done with non-Cunningham drugstores.

Mr. MACKASEY: Let us get back to LeDuc and LeDuc, and the LeDuc drugstores which I have in my riding. I have shopped at them and I am quite satisfied with their integrity. I have had many prescriptions filled at LeDuc, but I have never noticed any substantial saving in going to LeDuc over another druggist.

Mr. WESTON: I do not know if they have a special price for their own stores or not. I do not know them. This is something in which we do not enter. This deals with prices and we do not enter into this any more than we absolutely have to.

Mr. MACKASEY: This Committee is interested in prices and interested in passing savings on to the public and since some of the manufacturers have justified the bypassing of a wholesaler on the argument that you consider it is an expensive step on the part of the manufacturer—

Mr. WESTON: That is right.

Mr. MACKASEY: Is it not just as logical to assume that the wholesaler would set up outlets at which people could buy their drugs at wholesale?

Mr. WESTON: To the best of my knowledge, Mr. Mackasey, no wholesale druggist in recent years has set up any retail outlets. I may be wrong there, but I do not know of any.

Mr. PITCHER: There is one in Newfoundland.

Mr. WESTON: This is the only one—

Mr. MACKASEY: You just mentioned the LeDuc chain in Montreal which are not being set up, but are actually in existence.

Mr. WESTON: The LeDuc chain in Montreal has been in existence since 1872. I think originally they started off as a retail drug outlet.

Mr. MACKASEY: But are they not doing, Mr. Weston, precisely what you claim the manufacturer is doing and should not do and that is take a double profit. The manufacturer who sells direct and bypasses the wholesaler, we assume is keeping to himself the 5 or 10 per cent margin that normally would go to the wholesaler. Is not LeDuc doing the same thing with the public?

Mr. WESTON: I do not know what LeDuc's selling policies are.

Mr. MACKASEY: In other words, he may be passing it on?

Mr. WESTON: He may be passing it on, or he may not, I do not know. The only way you could find that out would be to do some comparison shopping.

Mr. MACKASEY: That is a good suggestion.

The CHAIRMAN: I would like to put one thing on record. I think one of the members has asked that we call one of the pharmaceutical chains from Halifax, and said that drugs are more expensive in Halifax. As far as you are concerned, your drug wholesalers have the same price in Halifax as they do in Montreal, Toronto or Vancouver?

Mr. WESTON: Right.

The CHAIRMAN: Are there any other questions? If not, the meeting for this afternoon has been cancelled. We were to deal with Prescription Services Incorporated and that meeting will now be held in January.

Our next meeting will be 9.30 a.m. on Thursday morning when we will have the Cystic Fibrosis Foundation here. We would like to thank the representatives of the Canadian Wholesale Drug Association for coming before us today. Thank you gentlemen, we appreciate it.

APPENDIX "A"

SUBMISSION

to the

HOUSE OF COMMONS SPECIAL COMMITTEE

ON DRUG COSTS AND PRICES

by the

CANADIAN WHOLESALE DRUG ASSOCIATION

FOREWORD

"The raison d'être of the pharmaceutical wholesaler is to complete the chain of distribution which commences with the manufacturer and passes through the retail chemist to the public. The activities of the wholesaler, therefore, are dependent upon the goods which the chemist supplies to the public either as a direct sale or in response to a prescription issued by a medical practitioner. The range of goods which the wholesaler stocks, therefore, is outside his control; he does not create a demand—he is there to see that it is met; and it is clearly in the public interest that is should be met promptly and efficiently."

A. G. Shaw, Assistant Secretary,
The Association of the British
Pharmaceutical Industry.

"The service they (the drug wholesalers) render is vital. Some manufacturers feel direct selling is more suitable to their distribution needs. But it's interesting to note that even those firms must depend on wholesalers to fill the needs of 10 to 25 per cent of their customers. We are convinced that if all of the approximately 1,300 firms that make up the drug industry were to move to supplying retailers on a direct basis, the result would be complete chaos. We of the drug industry have been criticized on a number of grounds, but, thanks in a large measure to the co-operation of wholesalers, we've never been accused of inefficiency in distributing our products."

Robert J. Lohrman,
Trade Relations Manager,
Menley & James Laboratories,
Philadelphia, Pa.

CHAPTER I

THE CANADIAN WHOLESALE DRUG ASSOCIATION

The Canadian Wholesale Drug Association* was organized in Montreal, Quebec, on October 27, 1964, and incorporated under the Dominion Companies Act on June 29, 1965.

Membership in the CWDA is divided into two principal classes: Active, or voting, members; and Associate, or non-voting, members.

Qualifications for membership in the Association are defined in the by-laws as follows:

Active Members:

"Any person, firm or corporation, who shall have been actively engaged in business as a full service wholesale druggist for at least five years prior to the date of election, and who meets the standards necessary to promote the objectives of the Association and whose application shall be endorsed by at least two active members in good standing who are in the same trade area, may be elected to active membership. Separate membership is required for each subsidiary, division or branch house, but the five year limitation shall not apply to the admission to membership of the subsidiary, division or branch house of a member or applicant for membership. Each active member shall have one vote."

"*Association Members*:

"Any person, firm or corporation engaged in business collateral or kindred to the business of service drug wholesaler, whose application for membership shall be endorsed by at least two active members in good standing, may be elected to associate membership. There shall be no requirements as to the time during which the applicant shall have been in business. Associate members shall enjoy all the privileges of membership except that of voting."

In addition, honorary or complimentary memberships may be granted by the Board of Directors at its discretion, but honorary or complimentary members shall have no vote.

Active Members

The active membership of the Association includes virtually every major full service drug wholesaler in Canada.

The term "full service" drug wholesaler is, generally speaking, taken to mean a company which carries a reasonably complete inventory of pharmaceuticals, drug products and associated lines, and offers a reasonably complete services to its customers, the retail pharmacists.

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*The initials CWDA or the word Association will be used in this submission from time to time in place of the Canadian Wholesale Drug Association.

For the benefit of, and to assist our members, both active and associate, we have adopted a "Wholesaler Policy", in which a drug wholesaler is defined as:

A firm or corporation:

(1) Which distributes pharmaceuticals, drug products and associated lines at wholesale to pharmacists for resale, to Federal, Provincial and Municipal Governments and to Hospitals. All controlled drugs are to be under the supervision of a pharmaceutical chemist as laid down by the Act or the Minister.

(2) Which has local warehouse facilities and carries an adequate inventory to fill all reasonable orders that might be offered.

(3) Which maintains a trained sales force to promote, inform about and sell the wholesaler's merchandise and to service the related needs of the customers, and represent the goodwill of the manufacturer or the supplier.

(4) Which provides rapid and dependable delivery to its customers.

(5) Which extends credit to the pharmacists or buyer in the territory within the terms of sales and does ot sell on cash terms only.

(6) Which co-operates with manufacturers and suppliers in the promotion and sales of their products by assistance and guidance with store layouts, displays, advertising literature, product knowledge and sales efforts, through retail pharmacy outlets.

This policy has been adopted because we believe it is essential that there should be a universally accepted definition of a "full service drug wholesaler." Two instances have occurred which bear out this contention.

In the first instance a supplier* queried the CWDA as to the bona fides of a company to which the supplier was considering selling on a direct basis at wholesale cost.

Our reply—and the Committee will appreciate that we cannot publicly identify either the supplier or the company—was:

> "Our position is that the company is a central buying chain and we do not regard them as wholesalers. Should they at any time open up their operation and sell to all pharmacists, then I do not doubt we would regard them as full service drug wholesalers and entitled to active membership."

In the second case, an executive of one of Canada's leading manufacturers of ethical pharmaceuticals stated that he was frequently asked by firms purporting to be drug wholesalers that they be given the privilege of handling the manufacturer's products. Although this particular manufacturer sells principally to retail pharmacists on a direct basis, a certain percentage of its sales are made through drug wholesalers. As the executive stated:

> "If the Canadian Wholesale Drug Association would establish a Drug Wholesalers Policy, this would make it that much easier for companies such as ours to determine their qualifications to handle our products."

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*The term supplier will be used in this submission from time to time to identify a manufacturer or primary distributor of pharmaceuticals, drug products and associated lines.

We wish to stress the point to the Committee that it is not the intention or the desire of the CWDA to suggest to any supplier that he make use only of a member of the Canadian Wholesale Drug Association as a distributor of his products. The CWDA does not hesitate to extend its recognition even to those companies which are not members of the Association. Any full service drug wholesaler may apply for membership, although for reasons of their own they may prefer not to do so. This, of course, is their prerogative, although we are pleased by the fact that virtually every major full service drug wholesaler in Canada has taken out membership in the Association.

The only other point we wish to add here is that, contrary to the belief of many people there is no such thing, to the best of our knowledge, as a "drug wholesaler's licence." It is only necessary to obtain a municipal business licence (and, perhaps, a provincial licence) to go into business as a wholesaler. The municipality is not concerned with the type or class of goods handled by the wholesaler, except where public safety is affected. Naturally, if the wholesaler is distributing controlled drugs or narcotics, he has to obtain authorization from the Food and Drug Directorate and must, according to Provincial Pharmacy regulations, employ a registered pharmacist who is directed to keep the necessary records.

Associate Members

As was noted on page 1, defining classes of membership, associate membership is open to any "person, firm or corporation in business collateral or kindred to the business of service drug wholesaler."

Admittedly, this is fairly broad. One of our active members, with branches across Canada has informed us that it purchases from more than 1,000 suppliers. Another, operating mainly in one province, states that it has about 600 suppliers.

Theoretically, each of these suppliers could apply for associate membership. In actual practice, such is not the case. Many of these suppliers are local concerns which do not distribute outside their immediate areas and are not interested in joining a national association, such as the CWDA, particularly on an associate basis. Again, there are many companies whose annual sales through retail pharmacy outlets are a relatively small percentage of their total yearly volume. Some suppliers are subsidiaries, affiliates or divisions of firms which are already members of the CWDA and have no wish or see any advantage to taking out separate membership, although they may do so if they wish.

Roughly, the associate membership of the CWDA can be broken down into five categories:

Manufacturers of ethical pharmaceuticals
Manufacturers of proprietary and patent medicines
Manufacturers of health and beauty aids
Manufacturers' agents
Miscellaneous

We cannot provide a percentage breakdown of the associate membership by categories because many of the members carry on multi-line operations. One

member, for example, is a manufacturer of pharmaceutical, chemical, agricultural and consumer products, the latter category including over-the-counter medicaments and beauty aids. Another manufactures health aids, surgical supplies and industrial products.

Objectives of the Association

As outlined in the by-laws, the objectives of the Association are:

(1) To promote amicable and social relations between drug wholesalers of Canada;

(2) To develop mutual acquaintance and respect among drug wholesalers of Canada;

(3) To foster sound business principles in all phases of drug distribution in the interest of the public as well as drug retailers and drug wholesalers;

(4) To organize and disseminate for the use of drug wholesalers such business information as may prove of value to them;

(5) To assist drug wholesalers to improve their efficiency through research and education;

(6) To promote the use of service drug wholesalers by drug retailers and manufacturers.

Projects Undertaken by the Association

Projects either undertaken by the CWDA, or under consideration for implementation, include:

(1) *Tele-Tips.* This promotional project is designed to keep pharmacists informed of the latest deals, promotions and new products available from manufacturers and suppliers through wholesale drug firms. The only cost to associate members participating in this project is to provide the necessary 5" x 8" information cards for the Tele-Tips Desk Easels.

(2) *Operating Survey.* The Operating Survey—which is compiled annually—shows a breakdown of the financial operations of the majority of drug wholesale members of the CWDA (which, in essence, is a majority of the drug wholesalers in Canada in terms of business volume). This Survey is the most comprehensive of its kind conducted in Canada by a non-government organization. W.E. Duffett, Chief of the Dominion Bureau of Statistics, has made the following comment:

"I have now had a chance to look this over and find it interesting. I am having it circulated among my officers, thinking some ideas can be obtained from it for use by the Bureau."

(3) *Membership Directory.* This Directory lists the executives and personnel of virtually every major full service drug wholesaler in Canada. It also includes information on the number of salesmen, order clerks and so on. To the best of our knowledge this is the only source where such information is so easily available. The Directory, which is issued annually, also includes similar information about associate members.

(4) *Monthly Luncheons.* Each month—except during the summer—the CWDA holds a monthly luncheon at which wholesalers and suppliers can meet to discuss problems of mutual interest.

(5) *Monthly Newsletter.* The purpose of the NEWSLETTER is to keep members informed of the activities of the CWDA and to pass along news and other items of interest to all members. The NEWSLETTER is also mailed to trade papers and related associations in Canada, the United States and Great Britain.

(6) *Service Survey.* The Service Survey was conducted to ascertain and appraise the services at present rendered to suppliers by drug wholesalers and stresses the importance of the drug wholesaler in the distribution of drugs.

(7) *Drug Store Survey.* The CWDA has undertaken a pilot study of a proposed system which will enable a manufacturer to obtain detailed information on the final distribution of each item of merchandise, to the retail, hospital and physician level, or specifically, a plan to tell a manufacturer which stores buy each item of his product line.

(8) *Code of Distribution Practices.* The CWDA has under study a "Code of Distribution Practices" which is designed to discourage and prevent acts or practices which injure, destroy or prevent competition.

(9) *Seminars.* The CWDA has under consideration seminars covering many aspects of drug distribution and merchandising.

(10) *Related Associations.* The CWDA has set up liaison committees with related pharmacy and health associations in Canada and also maintains close contact with wholesale drug associations in the United States and Great Britain. We are also in touch with similar organizations in a number of European countries.

(11) *Wholesale Policy.* The CWDA has prepared a definition of a wholesaler policy in order to provide guidance for manufacturers and suppliers.

The Canadian Wholesale Drug Association fills a vacuum that has long existed. The Canadian Pharmaceutical Association, representing professional pharmacy, and the Pharmaceutical Manufacturers Association of Canada, representing manufacturing pharmacy, and other related associations, long ago realized the necessity for an organization to represent their special interests. Unfortunately, except indirectly, there was no place in any of these groups for the third major arm of the drug industry—the distributive arm.

The Canadian Wholesale Drug Association now completes the picture and all three segments of the drug industry: professional pharmacy, manufacturing pharmacy and the wholesale distributors each has its own organization and complement one another.

Because manufacturing pharmacy—and the manufacturers and suppliers of related lines which reach the public through retail pharmacies—have an interest in the ultimate destination of their products, it was decided to admit them as associate members.

This makes possible a closer liaison, both at the association and the company levels. It ensures both wholesalers and suppliers getting together under the auspices of the CWDA to discuss mutual problems and, where necessary, taking joint action to protect their mutual interests.

Over the years many problems have arisen between wholesalers and suppliers. It has been possible to resolve some of them by individual action. Others have been tackled piecemeal with varying, and sometimes unsatisfactory, results.

We believe that through the Canadian Wholesale Drug Association a new era in wholesaler-supplier-retailer relations has now dawned—an era of greater understanding, friendlier relationship and mutual respect.

CHAPTER II

THE WHOLESALE DRUG INDUSTRY IN CANADA

Historically speaking, the Canadian wholesale drug industry predates Confederation, and is thus older than virtually all the suppliers it services or represents. As a matter of record, three CWDA wholesale drug members have been in existence for more than a century.

For the information of the Committee we have included with this submission a list of the active and associate members, as of July 1, 1966, the beginning of the Association's fiscal year. We have also listed the founding dates of our active members.

We feel it is of interest to point out that, to the best of our knowledge, every wholesale drug member of the CWDA is either Canadian owned or controlled. As the active membership constitutes almost all major drug wholesalers in Canada—and thus is representative of the industry—this is in sharp contrast to many other major industries in Canada where majority control rests outside the country.

(Although this submission does not concern itself in depth with the operations of the CWDA associate members except as they touch upon wholesaling and wholesalers, for the record we have compiled a breakdown of the control of these companies:

United States control or affiliation	58 companies
Canadian owned or controlled	12 companies
European (including British) control or affiliation	9 companies
Canadian-European controlled	1 company
Total	80 companies)

With perhaps one or two exceptions drug wholesalers in Canada originated as family-owned concerns or mutuals (sometimes referred to as co-operatives) established by groups of pharmacists seeking the advantages of quantity purchasing. Although originally the mutuals resold only to their own members or shareholders, as a rule today they sell to any retail pharmacist whose credit has been established.

In parenthesis we would add that the Canadian Wholesale Drug Association includes among its active members both mutual and non-mutual companies. An example of the former would be *Les Pharmacies Universelles Ltée.*, in Montreal, and of the latter, Western Wholesale Drug Ltd., in Vancouver.

In the United States each of these different types of wholesalers has its own organization. The National Wholesale Druggists' Association represents the non-mutual companies and the Federal Wholesale Druggists Association represents the mutual houses. Both these organizations accept Canadian drug wholesalers as members.

In Canada, because of the much smaller number of drug wholesalers it was decided that it was not economically feasible to have an association for each group, and that all wholesalers, both mutual and non-mutual, could belong to the same organization.

Although some Canadian wholesalers do belong to either the National Wholesale Druggists' Association or the Federal Wholesale Druggists Association, their membership, in either case, predates the formation of the Canadian Wholesale Drug association. As no drug wholesalers in Canada have made application to join either United States organization since the formation of the CWDA, we believe that this indicates that they recognize the value of the Canadian organization.

Sales

According to the 1965 CWDA Operating Survey, gross sales of 28 members—which includes branch houses which must take out separate membership—totalled $137,351,946. The 28 members constituted 76.5 per cent of the active membership. We have estimated that if all CWDA active members had participated in the 1965 Survey, gross sales would have been in excess of $160,000,000.

The Dominion Bureau of Statistics in its preliminary "Report on Wholesale Trade" showed 1965 wholesale sales of drugs and drug sundries at an estimated $316,000,000.

The DBS total is approximately $179,450,000 higher than that reported by the CWDA. Part of this can be accounted for by sales of non-member companies and part by members which did not participate in the CWDA's Survey. We have estimated that both these groups might account for $84,000,000 of this total, which still leaves a gap of over $95,000,000.

However, there is a basic difference between the CWDA and the DBS in compiling their respective statistics. In our questionnaire we asked our members to exclude surgical and hospital supplies, scientific instruments, tobacco, confectionery, etc. The Bureau, on the other hand, breaks down the industry into a composite of five kinds of businesses, some of which would not qualify as drug wholesalers under our definition. Under these circumstances one can see why the DBS figures would be much higher than those reported by the Canadian Wholesale Drug Association.

We believe that the figures arrived at in the CWDA's Operating Survey, and allowing for those companies which did not participate, show a fairly accurate picture of the sales volume and operations of the wholesale drug industry in Canada.

Customer Classifications

Drug wholesalers distribute, or sell, to four groups of customers; Retail Pharmacists; Hospitals; Government Institutions; and Non-Drug Outlets, the last-named including convalescent homes, doctors, beauty salons and, to a minor degree, general stores.

The CWDA conducted a two-part survey of its wholesale members to ascertain:

(a) The percentage of sales to each of these groups;

(b) The percentage of sales by classification of merchandise lines.

For the first part of the survey the following results were obtained:

Group	*Percentage of sales*
Retail Pharmacies	76.00%
Hospitals	4.07%
Government Institutions	2.00%
Non-Drug Outlets	17.93%

As can be seen by the foregoing table the greatest percentage of sales by wholesale druggists is made to retail pharmacies. Non-drug outlets come next, followed by hospitals and government institutions.

No explanation is necessary regarding the first group, retail pharmacies. The wholesale drug industry was established to make pharmaceuticals and other health aids available to retail pharmacies and this is where over three-fourths of their sales are concentrated.

Insofar as the non-drug outlets are concerned we cannot provide a breakdown between urban or rural areas, nor even the type of non-drug outlets. Some sales—and, we understand, a relatively small proportion in terms of dollars—are made to doctors and veterinarians. Sales are also made to beauty salons and convalescent homes. Sales are also made to general stores but we understand that in most instances these stores are likely to be located in smaller centres than in major metropolitan areas.

Hospitals and government institutions fall into special categories.

Much of the purchasing done by government institutions is on a tender basis. This places the wholesaler at a disavantage as in most instances he will be competing against his own suppliers. A drug manufacturer, in bidding on a hospital tender can quote a price under that which he sells to wholesalers, and even should he quote the wholesale price the wholesaler is still at a disadvantage as he must add his own costs and markup.

This factor also applies where hospitals purchase by tender. There are manufacturers who make use of drug wholesalers to service hospitals. This is particularly true where hospitals are located outside of Quebec and Ontario —where the majority of manufacturers are located—as the wholesalers can provide faster delivery and service.

The normal procedure in such cases is for the manufacturer to notify the wholesaler handling his products. The wholesaler ships to the hospital and at a

later date the manufacturer replaces the goods taken from the wholesaler's inventory.

It must also be remembered that hospitals and institutions do not pay the 11% Federal sales tax. A wholesaler selling to either of these must apply to the proper authorities for a rebate and unless the orders are large enough they do not justify the work involved.

Again, hospitals and institutions normally place large orders for many medicaments and drug wholesalers do not carry such large quantities.

The second part of the survey was concerned with the percentage breakdown of sales by classifications:

Classifications	*Percentage of sales*
Prescription Drugs	39.93%
Over-the-Counter Drugs	24.10%
Cosmetics and Toiletries	16.80%
Sundries	19.17%

It will be noted that sales of prescription drugs by wholesale drug houses were 39.93% of total sales. The study revealed that those companies which were located in major metropolitan areas had a much higher percentage than those firms which serviced smaller centres. For some companies sales of prescription drugs were reported well over 75% of total sales.

Over-the-counter products accounted for 24.10% of total sales. These included proprietary and patent medicines as well as certain other medicaments which may be sold with or without a prescription.

Cosmetics and toiletries, which are self-explanatory, accounted for 16.80% of total sales.

Sundries, which cover a wide range of merchandise, from cigarettes to photographic equipment, accounted for 19.17% of total sales.

It is not unreasonable to expect that the drug wholesaler will seek to sell as much merchandise as possible, particularly in the non-drug lines, to the retail pharmacist. The retail pharmacist must stock many non-drug lines simply because his customers expect him to. As we are all aware, the retail pharmacist today carries many lines of merchandise which were unavailable a generation ago, or for competitive reasons.

Under these circumstances it is only natural that the drug wholesalers will endeavor to provide their retail pharmacist customers with an increasing percentage of their non-drug requirements.

It must be stressed that not all drug wholesalers carry the same lines of non-drug merchandise. To take two of the most obvious lines, tobacco products and confectionery, there are some wholesalers who do not carry one or both of these lines. Again, there are wholesalers which carry photographic supplies, such as films and flashbulbs, but do not handle cameras.

As long as the Canadian public expects the pharmacist to stock many non-drug items, the drug wholesalers will endeavor to have the pharmacists purchase these items from them.

However, we wish to emphasize again that the primary function of the wholesale druggists is to distribute pharmaceuticals and other aids to health as rapidly and efficiently as possible in order that these are available to the Canadian public, through retail pharmacies, at any hour of the day or night.

CHAPTER III

FUNCTIONS OF THE DRUG WHOLESALER

The two principal functions of the drug wholesaler are distribution and service. He can perform these functions far better than the manufacturer whose principal activities lie in the production of goods and creating a demand and, in varying degrees, in research and development.

(Some drug wholesalers do have manufacturing subsidiaries or facilities but, generally, this is a relatively small part of their overall business operations. Although some prescription drugs are manufactured, the main lines are primarily proprietary medicines and household products.)

As was pointed out earlier, prescription drugs constituted 39.93 per cent of the total sales of drug wholesalers. An informed observer of the wholesale drug industry stated, in private correspondence:

> "At present, 60 per cent of the (drug) business is done on a direct basis, contrary to the U.S. and Great Britain, where 60 per cent is done through the wholesaler. All you have to do is look at the map (of Canada) to see how silly this situation is."

It would appear reasonable to ask why, in such a long-established industry, only 40 per cent of the drug distribution in Canada moves through wholesale druggists as compared with 60 per cent in the United States and Great Britain? Logically, with so many years of experience behind them, Canadian drug wholesalers should be handling a considerably larger percentage of the drug business than they do at present.

Certainly it is an industry for which the geopraphy of the country works in its favor.

There would appear to be four factors involved:

(1) Many suppliers in Canada are subsidiaries of United States firms which have a long established policy of direct selling. When these companies set up Canadian branches it seemed only natural, to most of them, to continue this direct selling policy.

(In retrospect, we can safely say they chose to ignore the map of Canada and failed to see "how silly this situation is.")

(2) Many suppliers follow a mixed policy. They sell through wholesalers and also direct.

(We would point out here that we are not concerned with those suppliers which sell direct to hospitals and institutions but use the facilities of drug wholesalers to supply retail pharmacists.)

The suppliers with a mixed policy fall into two major categories:

(a) There is the supplier which sells direct in some provinces and through wholesalers in others. The inequity of this can be seen in that it is not unlikely that a wholesaler handling such a supplier's products can make them available to pharmacists in a territory normally covered by a wholesaler who is unable to get these lines.

(b) Some suppliers will distribute certain lines—usually the slow-moving items—through wholesalers and retain the fast-moving items for themselves. Drug wholesalers, in such instances, are becoming increasingly reluctant to take steps to promote and merchandise these slow-moving items, particularly if they are competitive with products of a supplier who does all his distributing through wholesalers.

(3) Many suppliers are still not fully cognizant of the facilities and many services available through the full service drug wholesaler.

(4) Until recently, far too many drug wholesalers have been little more than storage depots and distributors. This is admitted by many responsible executives in the industry. But there has been an awakening by the wholesale drug industry generally and it has come to realize its responsibilities by taking long overdue steps in improving their merchandising methods and increasing their efficiency.

Direct Selling

There are many manufacturers and suppliers in both pharmaceutical and non-drug lines which sell direct to the retail pharmacist, by-passing the wholesale druggist.

These companies take orders direct from the pharmacist, either by mail or telephone or through their own salesmen; they do their own warehousing, packing, shipping, invoicing and handle their own returns.

Nevertheless, to the best of our knowledge, there is no company which sells 100 per cent direct. A certain percentage of these companies' sales are made through drug wholesalers.

There are a number of reasons for this.

A pharmacist may require an item quickly and the wholesaler is the closest and fastest source of supply. This is especially true where a supplier does not maintain warehouse facilities outside his home base of operations. As we noted earlier, the great majority of manufacturers are located in Quebec and Onatrio, with the heaviest concentration in the Montreal and Toronto areas.

Again, a pharmacist may require a minimum quantity which may be less than the minimum order accepted without charge by the supplier. (Some companies have a service charge for orders that fall below a certain dollar value.) In such instances the pharmacist places his order with his wholesale druggist, as generally, drug wholesalers do not require minimum orders.

Or the pharmacist may require an item after the supplier's regular deadline for delivery. If he called the supplier delivery would not be made until the following day (and if the manufacturer is in another province it may take two or more days) unless, of course, he picked up the required item himself.

We wish to point out, of course, that all pharmaceutical manufacturers will make delivery of emergency medication at any time.

Many wholesale druggists accept orders for same day delivery until late in the afternoon. One CWDA wholesale member has stated that he would take orders for same day delivery up to 5:30 p.m. We understand that many pharmaceutical manufacturers have a 12:30 p.m. deadline for same day delivery of orders.

It is difficult to determine what percentage of sales of direct sellers move through drug wholesalers. One manufacturer has reported that only 5 per cent of their sales go through wholesale druggists. Other sources have estimated that anywhere from 10 per cent to 25 per cent of the direct firms' sales are through wholesale druggists. The volume will vary according to the product line and the type of product or merchandise. A direct seller based in Montreal will probably find more sales are made through drug wholesalers located outside that city than by drug wholesalers in Montreal.

We believe that the dollar volume of such sales is not inconsiderable and most, if not all, direct sellers would find their total sales picture seriously affected if drug wholesalers refused to handle their products.

Distribution and Service

We stated at the beginning of this chapter that the two primary functions of the drug wholesaler are distribution and service. In order to ascertain the full extent of the services rendered by drug wholesalers to retail pharmacists on behalf of suppliers, the CWDA surveyed its active members.

We received a return of approximately 65 per cent of the active membership, which we believe is broad enough to adequately cover the industry. Replies were received from all sections of the country.

Rather than summarize the Survey here we have attached a copy to this submission for the members of the Committee. We believe that this Survey bears out our contention that the wholesale druggist, as a specialist in distribution, can far better serve the retail pharmacist in his special areas of distribution and service than can suppliers.

CHAPTER IV

GEOGRAPHICAL DISTRIBUTION OF CWDA ACTIVE MEMBERS

Wholesale drug members of the CWDA are located in every province except one—Prince Edward Island. Although this province is presumably well provided with pharmacists to serve the population, there is not a sufficient number to warrant establishing a wholesale drug company on the island. It is our understanding that the pharmacists on Prince Edward Island obtain their needs from drug wholesalers in New Brunswick and Nova Scotia.

Following is a breakdown of the distribution, by areas, of the wholesale drug houses which are members of the CWDA;*

Atlantic Provinces	9	wholesale drug houses and branches
Quebec	11	" " " " "
Ontario	7	" " " " "
Manitoba	2	" " " " "
Saskatchewan	2	" " " " "
Alberta	4	" " " " "
British Columbia	3	" " " " "
Total	38	

Checking our associate membership, we found that 36 suppliers fell into the category of manufacturers of ethical pharmaceuticals. Of this total only 11 maintain depots outside their headquarters' city.

The total of 38 as given in the preceding table is more than the total number of depots (33) maintained by ethical pharmaceutical manufacturers, which are members of the CWDA. On the following page we have listed the location of these depots.

It would appear to us that there is considerable duplication of effort and manpower. For example, there are three wholesale druggists in Vancouver but seven companies also maintain depots there. There are two wholesale drug members of the CWDA in Winnipeg, yet again seven manufacturers also maintain distribution facilities.

Location of manufacturers' depots:

Toronto	7	companies
Winnipeg	7	"
Vancouver	7	"
Moncton	2	"
Calgary	5	"
Montreal	2	"
Halifax, Quebec City, Edmonton	1	each

The drug wholesalers believe it would be more economical and efficient if greater use were made of their facilities and services by suppliers rather than going to the expense of constructing or leasing and staffing depots. Shipping costs are the same whether the goods are shipped to a drug wholesaler or the manufacturer's own facilities. But it certainly appears to us that there would be a saving in manpower and related costs if manufacturers would distribute through wholesale druggists. Certainly there would be no diminution of services.

We would also add that much of the foregoing also applies to manufacturers of non-drug items, the majority of which are not normally emergency items, although there may be an immediate need for such sickroom items as thermome-

*Figures on this and the next page dealing with both active and associate members do not correspond with those in the Service Survey as they were compiled for this submission at a later date.

ters, first aid products and similar lines. But if the pharmacist is out of stock he either loses a sale or recommends a competitive item. In the latter case the manufacturer of the item originally requested loses money.

By utilizing the services of the wholesale druggist, the supplier is reasonably assured that the sholesaler will make every effort to keep the retail pharmacists in his trading area stocked with all items. The wholesale druggist has an incentive to do this as lines which sit on his shelf do not make money for anyone; the wholesale druggist, the supplier or the retail pharmacist.

To sum up, Canadian wholesale druggists are trying to do an efficient job of moving their suppliers' lines and at less cost in all areas than can the suppliers. The wholesale druggists are continually seeking improved methods of promoting and merchandising their suppliers' goods and there is little doubt that in the years ahead there will be further gains in efficiency, to the benefit of not only themselves but also of the suppliers, the pharmacists and the Canadian public.

CHAPTER V

DISCOUNT AND DISCOUNT PRACTICES

Any submission made by the Canadian wholesale drug industry—either collectively through the Association or by individual companies, either member or non-member—must of necessity include some comments on its discount practices, as these are an integral part of the industry's normal business practices.

We would ask the Members of the House of Commons Special Committee on Drug Costs and Prices to bear in mind that it is not a function of the Canadian Wholesale Drug Association to specifically discuss discounts or discount practices with any of its members, either active or associate. Should a supplier change its policy regarding discounts the CWDA will, at the request of the active members, set up a pro tem committee to meet with the supplier to discuss the problem, but the CWDA itself will take no direct part in any such discussions.

We wish also to point out that it is not our intention in this submission to enter into a detailed discussion of drug prices. The Pharmaceutical Manufacturers Association of Canada and the Canadian Pharmaceutical Association have, on behalf of their respective members, made submissions to this Committee and have presented their views on drug costs and prices.

This is not to say that Canada's drug wholesalers do not have a vital and immediate concern and interest in drug costs and prices. But as the "men in the middle"—literally—the drug wholesalers have little voice in the establishment of drug prices at the manufacturers' or the retailers' levels.

We are acquainted, of course, in general terms, with the discount pricing structure of the industry, but we have no direct knowledge of any discount agreements between any one supplier and any one drug wholesaler.

However, it will be noted on Page 5 of the attached CWDA Service Survey, we did ask drug wholesalers what was the minimum discount required from suppliers.

The majority of members replying stated that they expected to get a minimum discount of 16⅔ per cent. However, it should be remembered that suppliers here included not only drug manufacturers but also manufacturers and distributors of many other lines carried by drug wholesalers, including sundries.

But we understand that most pharmaceutical manufacturers who make extensive use of drug wholesalers allow them a discount of 16⅔ per cent. Some of them make a further allowance of one per cent or two per cent for cash.

However, there are a number of pharmaceutical manufacturers who do their own distribution—the direct sellers—and these do not provide any discount for wholesalers. Their usual practice is to sell at 40 per cent off the suggested retail price. In other words, the price to the wholesaler and the retailer is the same. Other direct sellers do allow wholesalers a small discount, usually five per cent.

Needless to say, drug wholesalers are not happy with this particular situation. They are compelled to carry these companies' products as a service to their customers, and they carry them at a loss. These direct sellers are being subsidized at the expense of those companies which distribute through drug wholesalers.

Many wholesalers, we understand, carry only minimum quantities of the lines of these direct houses and, in the case of their non-prescription products, do not undertake any strong merchandising efforts.

The wholesale drug industry being non-productive—in the sense that it does little manufacturing on its own account—derives its revenues from services rendered to others: the manufacturers and suppliers of ethical pharmaceuticals, proprietary medicines, toiletries, cosmetics and sundry merchandise. The drug wholesalers must finance their operations out of the discounts—as the commissions are commonly called in the trade—allowed them by their suppliers for distributing their merchandise and performing certain services.

It might appear that the wholesaler would gain more financially from handling the lines of a wholesaler-orientated supplier than he would from a direct selling company. In some cases this is not always true.

For example, one of Canada's leading pharmaceutical manufacturers, a direct selling house, allows wholesale druggists five per cent for handling its lines. As this is a major manufacturer whose ethical lines and non-prescription products are sold in every retail pharmacy across the country, the amount of business accruing to wholesale druggists is not inconsiderable.

On the other hand, a drug house with very limited lines but which distributes exclusively through drug wholesalers will not, in terms of dollar volume, do as much business through the wholesalers.

As we noted, the normally accepted discount received by wholesalers is 16⅔ per cent with sometimes an additional two per cent for cash. To translate this into dollars and cents, let us assume that the suggested retail price of a product is $1.00. The pharmacist pays 60 c. , thus providing him, the pharmacist, with 40 c. or a 40 per cent markup. The wholesaler retains 10 c., which is 16⅔ per cent of the 60 c. paid by the pharmacist. The manufacturer gets 50 c. from the wholesaler, this being the wholesaler's cost. Where there is a cash discount the wholesaler receives an extra 1 c. if he pays within 10 days.

This, generally speaking, is the formula for ethical pharmaceutical lines. For proprietaries and non-drug items the discount may be higher or lower, depending on the product and if the merchandise is being promoted as "special deals."

Some suppliers have instituted what is known as "net pricing" for some lines. If the suggested retail price is $1.00, the cost to the pharmacist is 54 c., of which the wholesaler gets 4 c. and the manufacturer receives 50 c. The reasons for this are quite complex and require detailed explanation.

As we explained earlier, many wholesale drug firms in Canada are mutual houses, established by pharmacists to obtain the advantages of quantity purchasing and passing along the savings to themselves in the form of rebates.

The operation in itself is relatively simple. A pharmacist makes application to a mutual house to purchase shares. (There is nothing to prevent any pharmacist from purchasing shares in more than one mutual wholesale house.)

As a shareholder, the pharmacist is entitled to a return on his capital investment—or dividends on the number of shares he holds. This will vary from company to company. We are informed by one company that dividends are set at 10 per cent per annum, of which the shareholder receives 8 per cent, with the remaining 2 per cent being retained by the company for future business operations.

In addition, the mutual houses give their shareholder-pharmacists a rebate on purchases which may amount to 10 per cent. This is not a cash rebate but a reduction on purchases. In other words, if the rebate is credited to the following week's purchases.

Drug wholesaling is a very competitive business. Drug wholesalers are not only competing with each other but frequently with other types of wholesalers, such as tobacco and confectionery wholesalers and wholesalers of sundries. The non-mutual wholesalers, in order to get and retain pharmacies as customers, found that they also had to offer inducements. They, too, began offering rebates to their customers.

Many suppliers—particularly drug manufacturers—believe that this is not a sound situation and do not see any logical reason for the wholesaler to give up part of his discount. Therefore, they evolved the system of net pricing in the belief that the wholesaler, with only 4¢ out of each dollar, could not afford to give any rebate to the pharmacist.

On the other hand, some wholesalers have expressed the belief that this system is only another way of increasing prices.

Another form of discounting, practised in the United States but not yet in Canada to the best of our knowledge, is the "earned services allowance." Under this system the supplier pays the wholesaler only for services actually performed. A wholesaler who maintains inventory control, actively promotes and merchandises a supplier's products and performs other stated services, will earn more than the wholesaler who fails to perform all the services required by the supplier.

Profit Margins

Although we have attached to this submission a copy of the CWDA's 1965 Operating Survey, we would like to discuss briefly the profit margins of the Association's membership.

As we pointed out, the wholesaler receives a commission of 16⅔ per cent. If he turns back 10 per cent to the pharmacist this leaves him with only 6⅔ per cent. It is not surprising that the industry's profit margins are so low.

According to the 1965 CWDA Operating Survey, net profit after taxes of 10 wholesale drug firms, representing 28 members, was .59 per cent of net sales. For 1964 net profit for 15 members was .60 per cent. For 1965 net profit taken as a percentage of net sales ranged from a high of 2.48 per cent to a low of .19 per cent with a median figure of .78 per cent.

If the non-mutual CWDA members, which made returns to the Survey, are calculated separately, their net profit amounted to 1.96 per cent, after taxes, of their reported net sales.

This, incidentally, compares favourably with figures reported by the National Wholesale Druggist's Association in the United States. Net after taxes for U. S. wholesalers for 1965 was reported at 1.66 per cent.

We would point out, however, that volume of sales by U.S. drug wholesalers is approximately 10 times that of their Canadian counterparts.

Although not part of the CWDA's Operating Survey, we are informed by 31 members that they had a capital investment of more than $20,415,000 and that approximately 2,200 persons were employed in various capacities. The 31 members reported that they filled over 11,500 orders daily.

It has been said that by eliminating the wholesale druggist, considerable savings would result, to the ultimate benefit to the consumer. But this is fallacious reasoning. Even if the wholesaler per se is eliminated his functions must be carried out by someone. Those suppliers which deal direct with retail pharmacies must perform the dual functions of manufacturer and wholesaler, and are incurring all the necessary costs of wholesaling.

As Dr. S. G. Peitchinis pointed out in "The Role of the Wholesaler" in the Spring 1966 issue of The Business Quarterly:

> "If every small variety retailer were to negotiate directly with every producer, and the latter were to communicate with every retailer of his products, the distribution system would become most inefficient and costs would undoubtedly rise."

Royce N. Kephart, former President of the Michigan State Pharmacy Association, discussing the importance of the drug wholesaler, stated:

> "Much has been written about the drug wholesalers' absolute essentiality to the community pharmacists and the impossible predicament that would confront the community pharmacist if the drug wholesalers no longer existed. In this connection, the vital importance to the community pharmacist of his achieving fast inventory turnover has been stressed time and time again and it is particularly in this respect that the facilities of the wholesalers become so indispensable.
>
> "Without the wholesalers, the average community pharmacist couldn't hope to stay in business even if it was possible for him to buy direct from the manufacturer every item which he carried in his pharmacy, for the required capital investment alone would strangle him."

It is virtually impossible for any wholesale druggist to continue in business for any great length of time if he handled only ethical pharmaceuticals. Many of

these are slow-moving items and it may well be that the wholesaler will receive calls for these from pharmacists only once or twice a year, and then in small quantities. Thus, to assure that he can maintain adequate staff and facilities he also has to carry a wide variety of non-drug merchandise and over-the-counter products which are fast-turnover lines.

The wholesale druggist can in no way influence the sale of prescription pharmaceuticals. These sales to pharmacists are stimulated largely by the physician's prescription. This "script" is often influenced by the ethical drug manufacturers' detail men. Therefore, the prescription pharmaceutical becomes a product beyond the control of the wholesale druggist to sell. Only those products with wide consumer demand whose sale can be stimulated by the wholesale druggist's staff can be actively promoted by the wholesale druggist.

CHAPTER VI

WHOLESALE DRUG INDUSTRY'S PROBLEMS

Wholesaling is not a new industry although it was only with the advent of the Industrial Age with its mass production methods that wholesalers came into their own.

Prior to this there were individuals who acted as agents and filled many of the duties and services of the modern wholesaler. They accepted goods on consignment from manufacturers and reshipped them for resale. These agents, needless to say, accepted all sorts of merchandise, from food to hard goods.

But with the advancement of the Industrial Age and the vast variety of merchandise which became available, wholesaling gradually became specialized. The food industry, for example, developed into grocery wholesalers and fruit and vegetable wholesalers. Tobacco and confectionery wholesalers came into existence.

But it is doubtful if any other branch of wholesaling has the same problems which confront and are peculiar to drug wholesalers.

As the Canadian Pharmaceutical Association, which represents the majority of Canada's pharmacists, pointed out in its submission to the Royal Commission on Health Services, the full service wholesaler

> "is equipped with adequate plant and trained personnel fully acquainted with provincial Pharmacy Acts and the requirements of federal legislation. He may have one or more registered pharmacists on his staff—and if not, it is recommended that he have—to insure that all these regulations are adhered to, and to all render professional advice."

Certainly no other type of wholesaler is required to take as many precautions and such great care as does the wholesale druggist—to, in effect, keep a professional man on its staff in order to sell its goods.

The Canadian Pharmaceutical Association also noted that the drug wholesale industry in Canada functions under circumstances that are peculiar to the drug field, such as:

> "(1) To satisfy the needs of the health professions, upwards of 8,000 pharmaceutical products may be carried in stock and the inventory must

include sickroom supplies, first aid products, fine chemicals, essential oils, elastic support products, health appliances, prescription glassware, etc., along with patent and proprietary medicines, toilet articles and cosmetics and sundries, all of which may create an inventory of some 27,000 items. This inventory has probably been obtained from over 1,400 different suppliers and much of it requires the direct supervision of specially trained qualified personnel;

"(2) Signed legal orders from licensed pharmacists are required before orders involving one or more of some 1,387 items (452 narcotic preparations and 929 'controlled drug' preparations) can be processed for delivery. These entail the keeping of additional reports and records as stipulated by the Narcotic Control Act and the Food and Drugs Act, and the Excise Act requires particular records of alcohol preparations;

"(3) Acids require special handling for shipment to meet the regulations of the Board of Transport Commissioners;

"(4) Shipments are usually in less than case lot quantities, this requiring extensive additional handling and personal attention to sales. One estimate would indicate that only 9% of all orders are for original case quantities;

"(5) Highly trained warehouse personnel of above average knowledge and experience are required to handle the variety of pharmaceutical products with their great number of variations in dosage forms and strengths, difficult nomenclature, datings, special storage considerations, etc.;

"(6) Special delivery arrangements are required to speed up the flow of essential pharmaceuticals, the quick availability of which may often save a life."

Drug Trade News, a widely read trade paper, in its March 20, 1961 issue, summarized the position of the drug wholesaler:

"While the wholesale drug business may be only another business to the untrained and the uninformed, nevertheless it is truly an encyclopedic undertaking which demands an encyclopedic grasp of the complex economics of production and distribution as these bear upon the overall pharmacy field.

"The wholesale druggists must be in daily touch with the many segments of the pharmaceutical industry; the growing complexity of distribution; the underlying psychology of retail pharmacists and their mounting competitive problems; a close knowledge of drug industry products, their sources, varieties and their distributional requirements; a day-to-day knowledge of the competitive pressures bearing upon the manufacturer, wholesaler and retailer and a surefooted grasp of the basic economics of retail pharmacy operations."

Distribution Costs

The wholesale industry is firmly convinced that it can distribute more efficiently and at less cost than can the manufacturer.

According to the Association's 1965 Operating Survey, total delivery and shipping expenses for 28 members were .87% of net sales.

We have been unable to obtain comparative figures for pharmaceutical manufacturers so we have no way of knowing whether the figures for manufacturers are high or low in comparison to the CWDA findings. However, according to the submission to this Committee by the Pharmaceutical Manufacturers Association of Canada, 41 member companies of PMAC reported total sales (Federal Sales and Excise Taxes not included) aggregated $148,053,720. Distribution (including warehousing) expenses totalled $6,322,984. This works out to 4.33%.

If we include warehouse expenses in the CWDA figures, the total is, 4.17%.

However, the PMAC figures are not strictly comparable to those in the CWDA Operating Survey. In the first place, the PMAC figures are for gross sales, and the CWDA figures are a percentage of net sales. Second, the PMAC distribution costs include not only those to retail pharmacist and wholesalers but also shipments within the industry.

No doubt, being extremely cost conscious, many manufacturers have worked out figures which are comparable to those of the CWDA but these are not available to us.

Nevertheless, because the wholesaler is a specialist in distribution and despite the restrictions imposed upon him which are peculiar to the industry, we have every reason to believe that his distribution costs are lower than those of the pharmaceutical manufacturer.

The wholesale drug industry is continually exploring ways and means of increasing its efficiency in order to improve its services to both suppliers and retailers, to the ultimate benefit of the customer.

Many wholesalers have installed mechanical equipment to move goods through warehouses. In addition, studies are being conducted as to the feasibility of making use of electronic data processing equipment. A number of wholesalers have installed punched card tabulating equipment and several others are carrying out studies along these lines.

Studies are being carried out in the United States—which the CWDA is watching closely—whereby pharmacies can be hooked up to tabulating equipment and thus cut down on their billing costs and improve inventory control.

It has been suggested that wholesalers might increase their storage facilities and instead of placing orders for merchandise as required, the wholesaler would always have large stocks on hand. Such a system would cut the manufacturer's shipping and warehousing costs and also reduce the wholesaler's receiving costs as the manufacturer would ship less frequently, perhaps on some lines only two or three times a year.

The manufacturer would pay for services and an agreed-upon rental for storage space, which would certainly be less than his own warehousing costs.

The function of the wholesaler in buttressing the efforts of the suppliers' salesmen has not always been appreciated many wholesalers believe. Raymond Dupuis, General Manager of Pharmacies Modernes Inc., and Past-President of the Canadian Wholesale Drug Association, in an address to members attending a CWDA monthly luncheon, stated:

"In 1964, the 10 largest manufacturers of ethical pharmaceuticals who distributed through drug wholesalers employed 455 salesmen and reported sales of $41,700,000. This works out to $91,646 per salesman. The 10 largest manufacturers who sold direct had sales of $52,969,000 but employed 701 salesmen. This works out to $75,562 per salesman—or $16,085 per salesman less.

"In other words, although the direct houses reported total sales $11,269,000 greater than the wholesale-orientated houses it took another 266 salesmen to achieve this success.

"We think it is obvious that the wholesale-orientated houses are getting invaluable assistance from their wholesalers in moving their product lines—assistance, I wish to emphasize again, at no direct cost to these firms."

As business becomes more complex, as demands by all levels of government increase, the retail pharmacist finds he has less and less time to spend on the professional aspects of his job. The services rendered by the wholesale druggist free him from many onerous but necessary tasks by providing him with a complete one-step service to cut down on the time he has to spend on stock control, purchasing, receiving and billing.

The same, in varying degrees, holds true for the suppliers who make extensive use of the drug wholesaler's services and facilities. Fewer men are required for warehousing, packing and shipping; inventory costs can be reduced and invoicing cut to a minimum. The wholesaler's sales force augments the supplier's salesmen and the supplier's promotional efforts are increased at no direct cost to himself.

CHAPTER VII

THE WHOLESALE DRUGGIST AND MEDICARE

It is generally agreed by those most concerned with the establishment of a national health scheme that such a program, to be fully effective, must also include prescription drugs.

The Royal Commission on Health Services in its Report, Volume II, page 11, stated:

"Comprehensive includes all health services, preventative, diagnostic, curative and rehabilitative, that modern medical and other sciences can provide."

The Royal Commission also made certain recommendations dealing with the establishment of prescription drug services. Whether these drugs are free or whether there is a partial payment by the public is not germane to this submission, and the Canadian Wholesale Drug Association has no intentions of making any recommendations. As we pointed out earlier, Canadian drug wholesalers are not directly concerned with the establishing of drug prices. The drug manufacturer sets his prices and the retail pharmacist establishes the price (and sometimes including a prescription fee) at which he sells to the public.

The drug wholesaler's job is to see that the drugs are available at all times in any given quantity from the manufacturer to the retail pharmacist. The manufacturer allows the drug wholesaler a discount which must cover the wholesaler's cost and allow him a reasonable profit.

Cost of drugs is of great concern to everyone and the wholesale drug industry by mass distribution, evolved over the years, is in a position to aid in keeping the cost at the lowest possible level. Distribution by wholesale druggists does not add to the cost of drugs; by efficient and rapid distribution the wholesale druggist can keep costs down.

From the experience in other countries where national health programs have been established it would appear likely that there will be an increase in the number of prescriptions written. This means a greater demand on the services of the community pharmacists who will have to increase their inventory of prescription medication. Again, in turn, the pharmacists will have to depend even more than they do at present on the wholesale drug houses to keep them supplied with essential medicaments.

Brand Names vs. Generics

The CWDA and its drug wholesale members have no wish to enter into the controversy that has arisen regarding the merits of brand name drugs versus generic drugs. But we wish to point out that, generally speaking, Canada's wholesale druggists do not handle generic drugs to any major degree.

In the first place, we are informed that many of the manufacturers of generic drugs are direct sellers. This means that, for the most part, they by-pass the drug wholesalers.

Secondly, there is the problem of shelf or storage space. As an example, let us assume that a generic drug is produced by four or five generic prescription manufacturers. If a wholesaler carries all these generic house products in their various sizes and potencies, he will have to greatly increase his shelf space in order to stock them all. Multiply this by the number of individual generic products that are not only at present available but which might also become available with the abolition of the present patent system, and it will be seen that drug wholesalers will have to greatly expand their facilities but without any guarantee of a commensurate return on their capital investment in their warehouses and facilities.

Unlike many other items handled by the wholesale druggist, prescription drugs cannot be promoted or merchandised directly to the public, as we pointed out previously, (page 30). The wholesale druggist can do no more than keep his demands that may be made upon him by retail pharmacists. In many instances he may have a turnover in some prescription items of not more than three or four times a year—and frequently less often. He can only ship these items when he receives a call from pharmacists.

It is our understanding that the great majority of prescriptions call for brand name drugs, most, if not all, of which are stocked by wholesale druggists. With the demand for generics at what would appear to be a low level there is little incentive for any wholesale druggist to build up his inventory of generic drugs, particularly when he knows they are likely to sit on his shelves.

Insofar as the wholesale druggist is concerned, the substitution of generic drugs for brand name products is more likely to increase his overall costs instead

of reducing them. He will require more warehouse facilities; he will have to increase his inventory and probably require even more staff.

The wholesale druggist in considering his cost picture must always bear in mind his slow-moving items. If a large percentage of his inventory is tied up in slow-moving items he must absorb their cost in the faster moving lines. Yet even here he can reach a point where the one does not offset the other.

This is not to say that the wholesale druggists would not carry generic drugs. But we believe it is safe to assume that such stocks would be minimal and probably limited to those lines which experience would show are apt to be in demand. As for those generic products which would be called for infrequently, the wholesale druggist would only order them as required and this could conceivably mean a slowdown in distribution.

CHAPTER VIII

THE 11 PER CENT FEDERAL SALES TAX

One important aspect of drug costs which we have not yet touched upon is the 11 per cent sales tax which is imposed by the Federal Government on prescription drugs.

The Canadian Wholesale Drug Association, on February 10, 1966, wrote to Mr. Sharp suggesting that consideration be given in his forthcoming Budget to the elimination of the sales tax, as follows:

FEBRUARY 10, 1966

The Hon. Mitchell Sharp, P.C., M.P.,
Minister of Finance and Receiver-General,
Ottawa, Ontario.

Dear Mr. Sharp:

On behalf of the wholesale drug industry in Canada, the Canadian Wholesale Drug Association respectfully requests that consideration be given in the forthcoming budget to the elimination of the 11 per cent Federal sales tax on prescription drugs.

As you are no doubt aware, from 1936 to 1951 this tax was set at 8 per cent. In May, 1951, the tax was increased to 10 per cent and in April, 1959, was raised again to the present level of 11 per cent.

There is little doubt that this 11 per cent Federal sales tax on prescription drugs is an onerous burden upon the public—and particularly upon the chronically ill. We recognize the need of the Government to raise revenue by taxation but it is the opinion of the Canadian Wholesale Drug Association, which represents the majority of drug wholesalers in Canada, that the sick should not be so penalized.

It is also suggested that should action be taken to eliminate the 11 per cent Federal sales tax, that consideration should be given to the problems of manufacturers, wholesalers and retail pharmacists, who have inventories on hand and on which the 11 per cent sales tax has been paid.

This Association cannot, of course, speak for manufacturing pharmacy or retail pharmacists. These groups have their own recognized organizations and no doubt will be making representations regarding the elimination of this tax.

Our concern is with the wholesale druggists of Canada who hold stocks of prescription drugs on which the 11 per cent Federal sales tax has been paid. We have estimated that the value of these inventories is approximately $12,000,000.00. If the sales tax is eliminated, effective at the time of announcement, or very shortly thereafter, we do not believe it is economically feasible for the wholesalers to immediately decrease their prices to the level of the tax reduction.

At the present time the Canadian wholesale drug industry is operating on an extremely low profit margin. For your information I am attaching a copy of the 1964 CWDA Operating Survey, which shows a breakdown of the financial operations of the drug wholesale members of the Canadian Wholesale Drug Association—which, in essence, is a majority of the drug wholesalers in Canada. We are at present working on the 1965 Survey but it will not be available until May or June.

Gross sales of 27 member companies reporting—which constituted 79.4 per cent of the active membership—for 1964 totalled $115,799,705.00. After all deductions, including cost of goods sold and total operating expenses, net operating profit before taxes was .19 per cent.

Of the 27 members reporting, 12 finished the year with a net loss. For the 15 member companies reporting a net profit after Federal income taxes, net was .60 per cent of net sales of $106,454,256.00. Net profit figures ranged from a high of 1.65 per cent of net sales to a low of .30 per cent and the median figure was 1.05 per cent.

Obviously, operating on such low margins, the members of our Association do not believe they should be asked to absorb the entire cost should the 11 per cent Federal sales tax on prescription drugs be eliminated.

Needless to say, the elimination of the sales tax will result in a great deal of costly work for the wholesale druggist. It has been estimated that the average wholesale druggist has on his shelves some 8,000 different pharmaceutical products. The amount of work involved in making the necessary price adjustments is tremendous. If the sales tax is eliminated effective at the time of announcement, the cost of making the necessary price changes, resulting from hiring additional staff and overtime could not be absorbed by the wholesale druggist, particularly when consideration is given to their present profit margins. Under these circumstances the wholesale druggists would find it impossible to pass along the entire tax reduction.

One of our members, with branches across Canada, has estimated that their costs alone would be in the vicinity of $200,000.00.

It is suggested, therefore, that should this tax be eliminated and should be made effective immediately on announcement, then arrangements should be made for a refund to the manufacturers—as you know, the tax is paid at the manufacturer's level—and the manufacturers could

then make their own arrangements with wholesale druggists and retail pharmacists. This, of course, would apply to stocks in inventory.

As an alternate arrangement, it is suggested that the elimination of the sales tax could be deferred for a limited period. In the case of the wholesale druggists, the delay could be three months from the date of announcement, and three months beyond this date for retail pharmacists. By the end of the six month period it is likely that the bulk of prescription drugs in wholesale drug houses and retail pharmacies would have been disposed of and new stocks would be on hand.

Such procedure, we believe, would prevent financial loss to an important segment of the Canadian economy.

Your consideration of these suggestions would be greatly appreciated and should either you or the officers of your Department wish to discuss this matter further, both Mr. Raymond Dupuis, President of the Canadian Wholesale Drug Association, and I will be at your disposal.

Yours very truly,
Douglas R. Weston,
Secretary-Manager

Mr. Sharp in his reply to our letter, indicated that consideration would be given to our suggestions.

However, as the Committee is aware, the 11 per cent Federal sales tax is still being imposed on prescription drugs. It is still our contention that this tax should be eliminated, as early as possible in order to avoid penalizing the Canadian public when it finds it necessary to purchase drugs.

Membership of the Canadian Wholesale Drug Association

The following companies are members of the Canadian Wholesale Drug Association, as of July 1, 1966:

Active Members	*Founded*
Bate & Bate Wholesale Drugs Ltd.	1919
W. Brunet & Cie. Ltée	1855
Dale Laboratories Inc.	1951
Eastern Drug Services Ltd. (Company formed as a result of a merger between Estey & Curtis Co. Ltd., founded in 1901, and Eastern Division of National Drug & Chemical Co. of Canada Ltd.)	1966
Leduc & Leduc Ltée	1872
J. E. Livernois Ltée	1854
MacDonald Wholesale Drugs Ltd.	1945
M. F. McMahon Ltd.	1954
T. McMurdo & Co. Ltd.	1823
Pharmacies Modernes Inc.	1934
National Drug & Chemical Co. of Canada Ltd.	1906
Northwest Drug Co. Ltd.	1954
The Ottawa Drug Co. Ltd.	1899
Pacific Coast-Wholesale Drugs Ltd.	1946
Provincial Wholesale Drugs Ltd.	1947
Sorex Inc.	1936
Pharmacies Universelles Ltée	1931
Western Wholesale Drug Ltd.	1928

ASSOCIATE MEMBERS

Abbott Laboratories Ltd.
American Optical Co. Canada Ltd.
Ames Co. of Canada Ltd.
Anca Laboratories.
Ayerst Laboratories.
Beecham Products Ltd.
Bentley Lighter Corp. (Canada) Ltd.
Bristol Laboratories of Canada Ltd.
Bristol-Myers Co. of Canada Ltd.
Burroughs Wellcome & Co. (Canada) Ltd.
Canadian General Electric Co. Ltd.
Canadian Westinghouse Co. Ltd.
Chemway (Canada) Ltd.
Chesebrough-Pond's (Canada) Ltd.
CIBA Co. Ltd.
Clairol Inc. of Canada
Colgate-Palmolive Ltd.
Cress Laboratories Ltd.
Cyanamid of Canada Ltd.
The Denver Chemical Manufacturing Co.
DeVilbiss (Canada) Ltd.
K. J. Eccles Ltd.
Facelle Co. Ltd.
Charles E. Frosst & Co.
Fulford Dodds Ltd.
W. J. Gage Ltd.
ASSOCIATE MEMBERS
Gaylord Products of Canada Ltd.
Geigy (Canada) Ltd.
Gillette of Canada Ltd.
Herdt & Charton Inc.
John A. Huston Co. Ltd.
International Playing Card Co. Ltd.
Johnson & Johnson Ltd.
S. C. Johnson & Son Ltd.
The Kendall Co. (Canada) Ltd.
A. Alan Kennedy Ltd.
Kimberly-Clark of Canada Ltd.
Lakeside Laboratories (Canada) Ltd.
Laurentian Agencies Ltd.
Laurentian Laboratories Ltd.
Lewis-Howe Co.
Eli Lilly & Co. (Canada) Ltd.
Mallory Battery Co. of Canada Ltd.
Maltby Brothers Ltd.
McNeil Laboratories (Canada) Ltd.
Mead Johnson of Canada Ltd.
Menley & James Laboratories.

The Mennen Co. Ltd.
Merck Sharp & Dohme of Canada Ltd.
The Wm. S. Merrell Co.
Miles Laboratories Ltd.
ASSOCIATE MEMBERS
Minnesota Mining & Manufacturing of Canada Ltd.
The Noxzema Chemical Co. of Canada Ltd.
Ortho Pharmaceutical (Canada) Ltd.
Parfumeries de Paris (Ltée.)
Penick Canada Ltd.
Pfizer Co. Ltd.
Poulenc Ltd.
Princess Pat Products Ltd.
The Procter & Gamble Co. of Canada Ltd.
The Purdue Frederick Co. (Canada) Ltd.
Rayette (Canada) Ltd.
Riker Pharmaceutical Co. Ltd.
A. H. Robins Co. of Canada Ltd. Sandoz Pharmaceuticals.
Julius Schmid of Canada Ltd.
The Scholl Manufacturing Co. Ltd.
G. D. Searle & Co. of Canada Ltd.
Sherman Laboratories Ltd.
Smith Kline & French I.A.C.
Smith & Nephew Ltd.
Stella Pharmaceutical Co. Ltd.
Sterling Drug Ltd.
Sylvania Electric (Canada) Ltd.
Ulay (Canada) Ltd.
ASSOCIATE MEMBERS
Vick Chemical Co.
Warner-Lambert Canada Ltd.
Whitehall Laboratories Ltd.
Will Pharmaceuticals
John Wyeth & Brother (Canada) Ltd.

APPENDIX "B"

CWDA

1965

OPERATING

SURVEY

INTRODUCTION

The Second Annual Operating Survey of the Canadian Wholesale Drug Association, covering the year 1965, differs in a number of respects from the 1964 Operating Survey but the basic presentation of information has not changed.

The 1964 Operating Survey, being the first of its kind carried out by the CWDA (indeed, it was the first survey of this nature carried out by a non-government organization), had virtually no comparable figures for preceding years. In fact, most of the comparisons made were with figures available from the Dominion Bureau of Statistics (and this material was virtually outdated as it covered 1957), and with the National Wholesale Druggists' Association Operating Survey for 1964.

Because the NWDA does not include any mutual (co-ops) drug wholesalers in its membership, this year no comparisons have been made with the NWDA's results. Insofar as the Dominion Bureau of Statistics is concerned, the Bureau has made available to the CWDA figures taken from the 1961 census and we have included such figures as are comparable.

The CWDA includes both co-ops and non-co-ops in its membership; one member is a mixture of the two. This naturally has an effect on the total results.

As an example, one co-op reported gross sales of x-dollars (because all returns were on a confidential basis exact dollar figures of any member cannot be revealed), while a non-co-operative house reported gross sales of y-dollars, or approximately 50 per cent of the gross sales reported by the first company. After all deductions, including Federal income taxes, the co-op reported its net profit at .30 per cent of net sales as against 2.48 per cent for the non-co-op. This despite the fact that the non-co-op paid approximately 3½ times more in Federal income taxes in actual dollars than did the co-op.

On the other hand, discounts allowed by the co-op amounted to nearly 7 per cent of net sales as compared with less than 3 per cent of net sales allowed by the non-co-op.

The 1964 Operating Survey showed actual dollar figures—the combined results of all members participating—whereas the 1965 Survey deals largely in percentages. We feel this latter method is more informative. It does not appear very useful to us to know, for example, that management salaries for all reporting members amounted to $537,336. More to the point is the fact that management salaries were .42 per cent of net sales as compared with .52 per cent for the preceding year. Any drug wholesale member can then determine by comparing the CWDA Operating Survey with his own figures, where his company stands. He may find that in some areas his costs are out of line and in other areas that his expenses are below the average.

Because of the availability of comparable figures we have increased the number of tables for 1965. This year we have also spaced the tabular matter throughout the Survey rather than concentrating it in one section of the book. This, we feel, makes it easier on the reader.

Because of the comparatively few wholesale drug houses in Canada (the 1965 Operating Survey covers 10 companies which comprise 28 members) it is virtually impossible to show a breakdown by areas. If all members participated it might be possible to reveal certain data by areas without breaking the confidential guarantee we have given our members. This might be done by breaking the country into four areas: Atlantic Provinces; Quebec; Ontario; the Prairie Provinces and British Columbia.

Although the number of members participating increased—28 as against 27 for 1964—there was a percentage decline with 76.5 per cent of the members reporting for 1965 as against 77.1 per cent reporting for 1964. In addition, we also received a partial return from one member.

The return of 76.5 per cent is better than the average, particularly in view of the complexity of the Operating Survey, which requires considerable man-hours to complete. We hope that in succeeding years this ratio will be even better. We do not believe that the great majority of our members hold the view expressed by one member, who stated: "Some of the information requested by you, we would not even give to Dun & Bradstreet, because we see no point in doing so."

Indeed, the co-operation we receive from most of our members—not only for the Operating Survey but also for other surveys which the CWDA carries out—would indicate the reverse is true. The great majority of our drug wholesale members realize there is a paucity of information and statistical data about Canada's wholesale drug industry and they participate with us in providing such information and data.

Unfortunately we have not been able to provide as detailed an analysis of the Survey as one might wish. The principal reason for this is that the Survey has not been operating long enough. In other words, we believe that when we have at least five years of reports behind us, we will be able to provide a fairly complete analysis of the trends in the industry. Until then, the Survey will only grow little by little.

For 1964, we received 24 reports covering 27 members and thus were able to show a breakdown of gross sales. For 1965 we received 10 reports covering 28 members. In 1965, four companies reported gross sales of better than $10,000,000; one company reported sales between $5,000,000 to $10,000,000; five companies reported gross sales of between $2,000,000 and $5,000,000; and one company reported sales of under $2,000,000.

For the 1966 Survey it is planned to ask those companies with branch houses to provide a breakdown of their gross sales by branches.

Again, we hope that this 1965 Operating Survey will prove useful to not only drug wholesalers in making comparisons with their own operations, but also associate members, who will gain a better insight into the operations of the wholesale drug industry.

Douglas R. Weston,
Secretary-Manager.

NET SALES SHOW 12.6 PER CENT INCREASE FOR 1965

Net sales of 10 wholesale drug companies, representing 28 members of the Canadian Wholesale Drug Association, were 12.16 per cent higher for 1965, according to returns received for the CWDA's Second Annual Survey.

On a dollar basis, net sales aggregated $127,146,929, as compared with $113,355,530 for 1964, an increase of $13,791,399.

However, the 1964 Survey covered nine companies, representing 27 CWDA members.

Taking the same members for both years, the percentage increase in net sales amounted to 10.69 per cent.

The 28 members reporting represented a percentage decline (but an arithmetical gain) because of the increase in the number of wholesale drug members. The 28 members constituted 76.5 per cent of the active membership as contrasted with 77.1 per cent which submitted returns for the 1964 Survey. This includes branch houses, which must take out separate membership. For 1965 no separate returns were submitted by branch houses; whereas for the preceding year virtually all branch houses submitted separate returns.

In addition, a partial return was received from one member. If this is included, net sales for 29 members amounted to $129,051,981 and represents an increase of 13.49 per cent over net sales reported by 27 members for the previous year.

NET PROFIT REPORTED AT .59 PER CENT

Net profit for those members covered in the survey was .59 per cent of net sales, while for 1964 net profit for 15 members was .60 per cent.

Net operating profit was up sharply at .94 per cent of net sales as compared with .19 per cent for 1964.

As was noted in the 1964 Operating Survey, of the 27 members reporting, 12 finished the year with a net loss. For the 15 members reporting a net profit after Federal income taxes, net was .60 per cent on total net sales of $106,454,256 for the 27 members.

For 1965, net profit, again taken as a percentage of net sales, ranged from a high of 2.48 per cent to a low of .19 per cent with a median figure of .78 per cent.

Although generally this can be regarded as an improvement over 1964, it must be admitted that the net profit is extremely low. Part of the answer can, of course, be attributed to the fact that the CWDA includes in its membership both co-operative drug houses and non-co-operative firms. This mixture naturally has an effect on the total results, unlike the National Wholesale Druggists' Association, which does not admit non-mutual houses to membership.

If those non-mutual CWDA members, which made returns to the Survey are calculated separately, their net profit amounted to 1.96 per cent after taxes of their reported net sales.

The National Wholesale Druggists' Association reported net after taxes for 1965 of 1.66 per cent, which was slightly lower than those reported by CWDA non-mutual houses.

Following is a summary of 1965 Operations:

TABLE I

SUMMARY OF 1965 OPERATIONS

(Percent of Net Sales)

	Average	*High*	*Low*	*Median*
Gross Sales	108.03	112.00	102.00	106.53
Beginning Inventory	12.31	17.50	6.56	13.91
Purchases (Net of trade discounts and returns), including freight	89.99	92.67	87.10	90.90
Ending Inventory	13.23	19.37	7.33	14.02
Total admin. expenses	3.06	5.70	2.18	4.11
Total occupancy expenses	.60	1.00	.04	.52
Total selling expenses	2.13	4.70	.99	2.09
Total warehouse expenses	3.86	5.51	1.00	3.04
*Total delivery expenses	.87	.87	.10	.60
Gross profit	10.93	14.10	8.08	10.52
Net profit	.59	2.48	.19	.78

*26 members only.

CWDA-DBS COMPARISONS

The Dominion Bureau of Statistics has made available to the Association figures taken from the 1961 Census. In the 1964 CWDA Operating Survey we showed DBS figures as of 1957 and it is interesting to note that the change has not been as great as might have been expected.

For example, gross profit of 28 members for 1965 amounted to 10.93 per cent of net sales as compared with 10.63 per cent for 1964. The Bureau reported gross profit in 1961 of 12.82 per cent and in 1957 reported gross profit of 11.79 per cent.

For CWDA members total operating expenses and total administrative expenses for 1965 were below those of 1964, and warehouse and delivery expenses were higher. The Bureau reported a decline in both total warehouse and delivery expenses and operating expenses but total administrative expenses remain unchanged.

TABLE II

CWDA-DBS COMPARISONS

(Percent of Net Sales

	CWDA		DBS	
	1965	1964	1961	1957
Gross profit	10.93	10.63	12.82	11.79
Total operating expenses	10.52	11.00	10.53	10.34
Total warehouse and delivery expenses	4.73	3.69	4.69	3.31
Total admin. expenses	3.06	4.56	5.28	5.28

GROSS SALES $137,351,946 vs. $115,799,705

Gross sales for the 28 members covered in the 1965 Survey amounted to $137,351,946 as compared with $115,799,705 reported for 27 members covered in the 1964 Survey. If we include the gross sales for the member which only partially completed a Survey, the total reaches $140,600,587.

Taking this last figure, gross sales for the 29 members is less than half the estimated wholesale sales reported by the Dominion Bureau of Statistics for 1965. However, the basis of the CWDA Survey and that of the Dominion Bureau of Statistics is not strictly comparable, as the Bureau includes in its study many companies which would not fall into the category of drug wholesaler according to the CWDA's definition.

According to the Bureau, wholesale sales by drug wholesalers showed an increase of 10.6 per cent in 1965 over 1964 sales. However, taking the same 27 members in 1965 who also reported for 1964, sales were 17.17 per cent higher.

TABLE III

ESTIMATED WHOLESALE SALES 1960-65

Drugs and Drug Sundries

Year	*Amount*	*Year*	*Amount*
1960	$221,900,000	1963	$259,500,000
1961	$236,000,000	1964	$286,400,000
1962	$247,900,000	1965	$316,800,000

Source: Dominion Bureau of Statistics

It is probable that if all CWDA members had participated in the 1965 Survey that gross sales would have been in excess of $160,000,000.

AVERAGE NET SALES PER MEMBER HIGHER

It is encouraging to note that average net sales per member for 1965 was considerably higher when compared with results for 1964. Although no doubt part of this increase can be attributed to inflationary pressures, it is also true that the actual increase was real.

Average net sales per member for 1965 amounted to $4,644,713, as compared with $3,942,022 for 1964. Including the partial return of one member, average net sales per member totalled $4,484,516.

Average cost of goods sold amounted to $4,044,785 as contrasted with $3,523,726 for the previous year. Stock turnover was 7.6 times per year, up from 1964's 6.7 times per year. The high of inventory turnover rate was 14.0 and the low was 5.00 with the median at 6.32.

This year all members were also asked to report their pharmaceutical sales in terms of percentage of net sales. On a company basis, rather than on a member basis, this was shown for nine companies to be 49.19 per cent, and ranged from a high of 80 per cent to a low of 20 per cent with a median figure of 50 per cent.

TABLE IV

OPERATING RESULTS OF DRUG WHOLESALERS (Condensed)

	1965	1964
Average net sales per member	$ 4,644,713	$ 3,942,022
Average cost of goods sold	4,044,785	3,523,726
Stock turnover (times per year)	7.67	6.7
Average beginning inventory	$ 559,141	$ 506,349
Pct. of average net sales	11.41	12.84
Average ending inventory	$ 600,918	$ 537,472
Pct. of average net sales	15.24	13.63

TABLE V

INVENTORY TURNOVER RATE

	Average	*High*	*Low*	*Median*
Times per year	7.67	14.40	5.00	6.32

TABLE VI

PHARMACEUTICAL SALES*

	Average	*High*	*Low*	*Median*
Percentage of Net Sales	49.19	80.00	20.00	50.00

*Nine companies only.

TABLE VII

NET SALES—DRUGS AND DRUG SUNDRIES

*Calendar Year**	*Sales*
1963	$ 99,194,695
1964	113,355,530
1965	127,146,929

*1963 figures cover 27 members; 1964-65 figures from 28 members.

CURRENT ASSETS 1:47 TIMES CURRENT LIABILITIES

Ratio of current assets to current liabilities at 1:47 was below that reported for 1964 when the current ratio was 2:1.

Although total current assets at $31,906,304 showed an increase of $4,291,594 over the preceding year's figure, this was more than offset by an increase of $4,511,212 in current liabilities.

Cash on hand and in the bank was down at $167,788 as against $558,577. Trade notes receivable and trade accounts receivable were both higher, as were inventories and other current assets, but there was a decline in other current receivables.

On the liability side, all sections showed an increase, with accounts payable amounting to $12,163,080 compared with $9,958,064. Accrued liabilities were sharply higher, totalling $2,375,263 as against $770,666.

Turnover of net working capital (current assets minus current liabilities divided into net sales) averaged 8.77 with a high of 18.38, a low of 2.67 times and the median figure was 6.82.

Return on net working capital (current assets minus current liabilities divided into net profits) showed an astonishing difference between the high and low figures. The average for the nine companies was 5.17% but the high was 42.54% and the low was .05%, with the median figure 2.55%.

Return on net assets (net profit, after taxes, divided by net assets) showed an average of 5.19%, but here again there was a wide difference between the high figure of 23.44% and the low figure of .02%. The median figure was 3.45%.

TABLE VIII

FINANCIAL STRENGTH MEASUREMENT

	Average	*High*	*Low*	*Median*
Current ratio (Current assets divided by current liabilities)	1:47	2:1	1:1	2:00
Turnover of Net Working Capital (current assets minus current liabilities divided into net sales)	8.77	18.38	2.67	6.82
Return on Net Working Capital (current assets minus current liabilities divided into net profit)	5.17%	42.54%	.05%	2.55%
Return on Net Assets (Net profit, after taxes, divided by net assets)	5.19%	23.44%	.02%	3.45%

OPERATING EXPENSES SLIGHTLY LOWER

Although selling, warehouse and delivery expenses were all higher, this was more than offset by a decline in total administrative and occupancy expenses, with the result that operating expenses for 1965 showed an improvement over 1964 comparisons.

In administrative expenses, nine of the classifications showed a decline, expressed in terms of percentage of net sales and only one, punch card tabulation equipment expense, was unchanged. Non-executive payroll showed a wide drop, the total representing only .97% of net sales whereas for 1964 non-executive salaries represented 1.49% of net sales.

Total administrative expenses represented 3.06% of net sales and in 1964 they represented 4.56% of net sales.

Total occupancy expense was also slightly lower at .60% of net sales as against .73% for 1964.

Total selling expenses were slightly higher, and represented 2.13% of net sales. while for 1964 total selling expenses were 2.02% of net sales.

TABLE IX

OPERATING STATEMENT

	1965 %	1964 %
1) Gross sales	108.03	108.78
2) Returns	3.14	3.33
2A) Allowances and adjustments	.74	.75
3) Discounts allowed, including cash	4.15	4.70
4) Total deduct, from gross sales (2, 2A and 3)	8.03	8.78
5) Net sales (Line 1 minus Line 4)	100.00	100.00
6) Beginning inventory	12.31	12.84
7) Purchases (Net of trades discs. and returns), including freight	89.99	90.16
8) Total (Lines 6 and 7)	102.30	103.00
9) Ending inventory	13.23	13.63
10) Cost of goods sold (Line 8 minus Line 9)	89.07	89.37
11) Gross profit (Line 5 minus Line 10)	10.93	10.63
12) Cash discounts on purchases	53	.56
13) Gross profits after all discs. (Lines 11 and 12)	11.46	11.19
14) Total operating expenses (See Line 39)	10.52	11.00
15) Net operating profit (Line 13 minus Line 14)	.94	.19
16) Federal income taxes	.35	N/A
17) Net profit after Federal income taxes (Line 15 minus Line 16)	.59	.60x

x-For 15 members only.

TABLE X

DETAIL OF OPERATING EXPENSES

	Percent of Net Sales 1965 %	1964 %
Administrative Expenses		
18) Management salaries	.42	.52
19) Other executive salaries	.19	.29
20) Non-executive payroll	.97	1.49
21) Payroll taxes, group insurance, retirement	.11	.18
22) Punch card tabulation equipment expense	.18	.18
23) Telephone and telegraph (Admin.) See 33A	.07	.09
24) Stationery, print., office supply, postage	.28	.29
25) Taxes, excl. realty, payroll, Fed. inc. tax	.08	.10
26) Bad debts exp., net after recoveries	.11	.14

	Per cent of Net Sales	
	1965	1964
	%	%
27) Other admin. exp. (incl. interest paid)	.64	1.28
28) Total admin. exps. (Lines 18 to 27)	3.06	4.56
29) Total occupancy expense	.60	.73
Selling Expenses		
30) Salesmen's sals. and commissions (See Line 77A)	.69	.75
31) Salesmen's travelling expenses	.20	.27
32) Other selling payroll (See Line 78A)	.54	.49
33) Other selling expenses	.52	.37
33A) Telephone and telegraph (Sales)	.18	.14
34) Total selling expenses (Lines 30 to 33A)	2.13	2.02
Warehouse Expenses		
35) Warehouse payroll (See Line 85A)	2.55	2.79
36) Other warehouse expenses	1.31	.36
37) Total warehouse expenses (Lines 35 and 36)	3.86	3.15
38) Total delivery and shipping expenses	.87	.54
39) Total oper. exps. (Lines 28, 29, 34, 37 and 38) (See Line 14)	10.52	11.00

TABLE XI

FINANCIAL DATA

	December 31	
	a-1965	b-1964
40) Cash on hand, in banks	$ 167,788	$ 558,577
41) Mktble. securities, held temporarily	93,320	78,560
42) Contract notes receivable	27,500	Nil
43) Trade notes receivable	738,810	216,176
44) Trade accounts receivable	13,336,261	10,856,415
45) Other current receivables	77,451	191,377
46) Total receivables (Lines 42 to 45)	14,441,130	11,901,105
47) Less reserve for doubtful receivables	531,381	372,030
48) Net receivables (Line 46 minus Line 47)	13,909,749	11,529,075
49) Inventories	16,827,124	14,669,651
50) Other current assets	908,323	778,827
51) Total current assets (Lines 40, 41, 48, 49 and 50)	31,906,304	27,614,710
52) Fixed assets (Real estate—book value)	3,002,198	2,594,328
53) Fixed assets (All other—book value)	1,652,392	797,270
54) Deferred charges	184,027	52,263
55) Total assets used in business (Lines 51 to 54)	36,744,921	31,058,571
56) Accounts payable	$12,163,080	$ 9,958,064
57) Notes payable (Less than one year)	2,653,509	1,971,762
58) Accr. liabs. (Excl. Federal inc. taxes)	2,375,263	770,666

59) Federal income tax payable	232,474	212,622
60) Total current liabilities (Lines 56-59)	17,424,326	12,913,114
60A) All other liabilities (Inc. long-term debt) ..	$ 6,032,785	$ 5,260,956

a-28 members; b-27 members

Warehouse payroll showed a slight decline at 2.55 per cent of net sales against 2.79 per cent for the preceding year but this drop was more than offest by the increase in other warehouse expenses.

Total delivery and shipping expenses showed a modest increase and were .87 per cent of net sales, and in 1964 amounted to .54 per cent of net sales.

INVOICING PROCEDURES

Because of the change in reporting, that is, because no branch houses filed separate reports for 1965, comparisons of invoicing procedures are not valid. For example, in 1964 12 members reported that they made use of IBM tabulating equipment; in 1965 only three companies reported using IBM tabulating equipment.

We have included TABLE XII only as a matter of record.

TABLE XII

INVOICING PROCEDURES

61) Pricing method used: Tabulating: 3; Pick Price: 6; Terminal: 1

62) If tabulating, whose equipment: IBM: 3; Remington: 1; Other: 1

63) Card storage:	Bin	Tub
Shelf stock	2	1
Full stock		1

64) Audit cost for last fiscal year: $68,950.

On a per member basis, audit costs for the last fiscal year worked out to an average of $2,462, which was an improvement over the preceding fiscal year when audit costs worked out to an average of $2,639.

WAREHOUSE FACILITIES EXPANDED

To meet the increased demands by their customers, and, no doubt, also due to the increase in the availability of products, Canada's drug wholesalers were forced to increase their shelf space and warehouse facilities.

Taking the same members who participated in the 1964 Operating Survey, these 27 members in 1965 had 832,460 square feet of warehouse space as compared with 631,687 square feet for the preceding year.

In 1965 these 27 members had 991,751 square feet in their total premises as compared with 937,288 square feet in 1964.

TABLE XIII

WAREHOUSE AND OFFICE SPACE

	a-1965	b-1964
65) No. square feet in total premises	1,002,251	937,288
66) No. square feet occupied by warehouses	841,664	631,687

a-28 members; b-27 members.

Taking the figures for warehouse space in the preceding table, it can be seen that the average was 30,059 square feet per member for 1965, as compared with 23, 395 square feet per member for 1964.

LINE EXTENSION AND PRODUCTIVITY DATA

For the 1965 operating survey all members were requested to provide information regarding line extension and productivity data. Unfortunately, this information was not forthcoming except from two companies, one of which provided only partial data.

Because the figures provided would have little significance, it was decided, reluctantly, not to include this section of the Survey.

PERSONNEL TOTAL SHOWS DECLINE

The 28 members convered in the 1965 operating survey reported they employed 1,710 persons as compared with 1,744 reported by 27 members participating in the 1964 Operating Survey.

The decline requires some explanation. For 1964 separate returns were received from 16 branch houses; for 1965 there were no returns from any branch houses. In 1964 accounting departments were reported to have 242 employees; in 1965 there were only 60. The decline can be explained by the fact that in 1964 all accounting personnel in the reporting branch houses were included; in 1965 only head office personnel and divisional people were included.

Employees classified as management also showed a decline, being 46 as against 68 for the preceding year. This also resulted in a reduction in payroll expenses, management salaries constituting .42 per cent of costs as a percentage of net sales as compared with .52 per cent for the previous year.

TABLE XIV

NUMBER OF PERSONNEL BY FUNCTIONS

	1965	1964
71) Management	46	68
72) Accounting (Including Chief Accountant)	60	242
73) Buying (Including Buyers)	117	112
74) Pricing (If not included in Line 81)	21	32
75) Other office personnel	170	136
76) Total administrative	414	590
77) Salesmen, city and country	149	136
78) Other sales (Inc. sales management)	146	129

79) Total selling	295	265
80) Warehouse supervision	46	40
81) Picking, checking, shelving, full case and pricing	560	555
82) Packing	109	111
83) Receiving-shipping room	106	115
84) Other warehouse	71	68
85) Total warehouse	892	889
Total personnel (Lines 76, 79 and 85) ...	1,601	1,774

Total number of employees employed in selling showed a better than 10 per cent increase, with 28 companies reporting 295 sales personnel as compared with 265 for the preceding year. There were fewer employees engaged in packing, receiving and shipping but warehouse supervisory staff showed an increase, and there was slight gain in the number of employees engaged in picking, checking, shelving, full case and pricing.

This reduction in personnel was also reflected in a decline in payroll expenses as a percentage of net sales.

TABLE XV

PERSONNEL PAYROLL AS A PERCENTAGE OF NET SALES

	1965 %	1964 %
71a) Management (Same as Line 18)	.42	.52
72a) Accounting (Including Chief Accountant) ...	.19	.77
73a) Buying (Including Buyers)	.42	.44
74a) Pricing (If not included in Line 81a)	.06	.11
75a) Other office personnel	.46	.43
76a) Total administrative	1.58	2.31
77a) Salesmen, city and country (Same as Line 30)	.69	.75
78a) Other sales (Including sales management) ..	.54	.49
79a) Total selling	1.23	1.24
80a) Warehouse supervision	.18	.18
81a) Picking, checking, shelving, full case and pricing	1.49	1.64
82a) Packing	.31	.33
83a) Receiving-shipping room	.33	.41
84a) Other warehouse	.24	.23
85a) Total warehouse (Same as Line 35)	2.55	2.79
Total (Lines 76a, 79a and 85a)	5.36	6.34

Administrative salaries, in percentage terms, showed the widest drop, being 1.58 per cent of net sales as compared with 2.31 per cent for 1964.

Despite the better than 10 per cent increase in selling personnel, payroll costs, in percentage terms, were virtually unchanged at 1.23 per cent of net sales as compared with 1.24 per cent for the previous period.

In actual dollars paid out in salaries and wages, the difference was less than $375,000. Net sales for 1964 were $113,355,530, of which salaries and wages were 6.34 per cent or $7,186,740. For 1965 salaries and wages were 5.36 per cent of net sales of $127,146,929, or $6,815,075.

TABLE XVI

MISCELLANEOUS OTHER INCOME AND OTHER CHARGES

	1965	1964
84) Int. on receivables	$ 44,214	$ 125,207
85) Oth. misc. inc. (excl. recoveries on receivables written off)	284,730	289,440
86) Total other income	328,944	414,647
87) Interest paid	333,102	222,592
88) Other miscellaneous charges	47,769	51,452
89) Total other charges	380,871	274,044

STOCK TURNOVER FASTER

As was noted previously (on page 4, Table V), inventory turnover rate was 7.67 times per year, and ahead of 1964's 6.7 turnover rate.

To find the average number of days inventory is carried it is only necessary to divide the stock turnover rate into the number of days in the calendar—taking 365 days or, in the case of leap year, 366 days.

For 1965 this works out to an average of 47 days while for the preceding year this works out to an average of 54 days.

APPENDIX "C"

CANADIAN WHOLESALE DRUG ASSOCIATION
SERVICE SURVEY
CWDA

"At present, 60 per cent of the (drug) business is done on a direct basis, contrary to the U.S. and Great Britain, where 60 per cent is done through the wholesaler. All you have to do is look at the map (of Canada) to see how silly this situation is."

CANADIAN WHOLESALE DRUG ASSOCIATION
ASSOCIATION DES GROSSISTES EN MEDICAMENTS DU CANADA

FOREWORD

"The raison d'être of the pharmaceutical wholesaler is to complete the chain distribution which commences with the manufacturer and passes through the retail chemist to the public. The activities of the wholesaler, therefore, are dependent upon the goods which the chemist supplies to the public either as a direct sale or in response to a prescription issued by a medical practitioner. The range of goods which the wholesaler stocks, therefore, is outside his control; he does not create a demand—he is there to see that it is met, and it is clearly in the public interest that it should be met promptly and efficiently."

A. G. Shaw, Assistant Secretary,
The Association of the British Pharmaceutical Industry

"The service they (the drug wholesalers) render is vital. Some manufacturers feel direct selling is more suitable to their distribution needs. But it's interesting to note that even those firms must depend on wholesalers to fill the needs of 10 to 25 per cent of their customers. We are convinced that if all of the approximately 1,300 firms that make up the drug industry were to move to supplying retailers on a direct basis, the results would be complete chaos. We of the drug industry have been criticized on a number of grounds but, thanks in a large measure to the co-operation of wholesalers, we've never been accused of inefficiency in distributing our products."

Robert J. Lohrmann,
Trade Relations Manager,
Menley & James Laboratories.

Historically speaking, the Canadian wholesale drug industry predates Confederation and is thus older than the great majority of the suppliers which it services. As a matter of record, two wholesale drug members of the Canadian Wholesale Drug Association are more than a century old, with one tracing its origins back to 1823. Several other member firms were established in the last half of the last century or in the opening years of the Twentieth.

It would appear reasonable to ask, therefore, why, in such a long-established industry, only 40 per cent of the drug distribution in Canada moves through wholesale drug houses as compared with 60 per cent in the United States and Great Britain? Logically, with so many years of experience behind them, Canadian drug wholesalers should be handling a considerably larger percentage of the drug business than the 40 per cent they do at present.

IT IS ONE OF THE FEW INDUSTRIES IN CANADA FOR WHICH THE GEOGRAPHY OF THE COUNTRY WORKS IN ITS FAVOR.

There would appear to be four major factors involved.

(1) Many suppliers* in Canada are subsidiaries of United States firms which have a long-established policy of direct selling. When these companies set up Canadian branches it seemed only natural, to most of them, to continue this direct selling policy.

(In retrospect, one can safely say that they chose to ignore the map of Canada and failed to see "how silly this situation is.")

(2) Many suppliers follow a mixed policy. They sell through wholesalers and also direct.

(We would point out that we are not concerned here with those drug houses which sell direct to hospitals and institutions but use the facilities of the drug wholesaler to supply the retail pharmacist.)

The suppliers who have a mixed policy fall into two categories:

(a) There is the supplier who sells through drug wholesalers in one province and direct in another. The inequity of this can be seen in that it is not unlikely that a wholesaler handling such a supplier's products can make them available to pharmacists in a territory normally covered by a wholesaler who is unable to get these products.

(b) There are suppliers who will only distribute certain lines—usually the slow-moving items—through wholesalers, and retain the fast-turnover items for themselves. Drug wholesalers, in such instances, are becoming increasingly reluctant to take steps to promote these slow-moving lines, particularly if they are competitive with products of a supplier who does all his distributing through wholesalers.

(3) Many suppliers are still not fully cognizant of the facilities and services available through the full line full service drug wholesaler.

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*The term "suppliers" denotes manufacturers or primary distributors of drugs and drug sundries, or manufacturers' agents who sell to drug wholesalers.

(4) Until recent years far too many drug wholesalers have been little more than storage depots and distributors. This is admitted by many responsible drug wholesale executives. But there has now been an awakening by the wholesale drug industry generally and it has come to realize its responsibilities by taking long overdue steps to actively promote and merchandise their suppliers' lines.

Because the last two factors are so closely interdependent they will be discussed as one.

In order to ascertain what services the wholesale drug members of the Canadian Wholesale Drug Association now render to their suppliers, and what additional services they render to retail pharmacists that suppliers do not provide, we surveyed our members.

All drug wholesale members were asked to complete a questionnaire and we received approximately a 65 per cent return, which we feel was certainly broad enough to adequately cover the industry. Replies were received from all sections of the country.

The Survey can be divided into roughly three categories:

(a) What services do you now render your suppliers?

(b) What do you feel a supplier would gain by using drug wholesalers?

(c) What additional services do you as a wholesaler provide to retail pharmacists that generally are not provided by suppliers?

As was to be expected, there was considerable repetition in many of the replies received. Conditions and circumstances do not greatly differ in most parts of the country, and the demands for services are the same in Bristish Columbia as they are in Nova Scotia.

For this reason we have not shown a breakdown by provinces or areas but simply taken the country as a whole.

On the following pages are the questions asked in the Survey, with a breakdown of the replies, followed by a summarization.

1. How many deliveries do you make daily?

City:		Country:	
11	make 1 per day	15	make 1 per day
5	make 2 per day	2	make 2 per day
4	make 4 per day	2	makes as many as necessay
3	makes 3 per day	1	uses a commercial carrier
1	makes 5 per day		

2. If deliveries other than daily, please specify.

(a) Special deliveries by own truck to city accounts and by bus on special orders to country accounts.

(b) Specials and one to country weekly.

(c) A number of companies stated that in addition to regular deliveries they also made provision for specials or emergency orders.

3. How many salesmen do you employ?

City: 2 companies had 9
1 company had 7
1 company had 6
4 companies had 5
1 company had 4
1 company had 3
1 company had 2

Country: 1 company had 11
1 company had 10
2 companies had 5
5 companies had 4
4 companies had 3
5 companies had 2
3 companies had 1

4. How many telephone order clerks do you employ?

1 company had 25
1 company had 20
3 companies had 8
1 company had 7
5 companies had 6
3 companies had 5
4 companies had 4
4 companies had 3
2 companies had 2
1 company had 1

5. What is your deadline for deliveries made the same day?

1 company: 3:30 p.m. for country
2 companies: 4:00 p.m.
4 companies: 12:00 noon in city
4 companies: 4:30 p.m.
1 company: 3:30 p.m. for specials
1 company: Varies according to area
1 company: 10:00 a.m.-3:30 p.m.
2 companies: 11:00 a.m.
1 company: 2:00 p.m.
1 company: 12:30 p.m.
1 company: 12.00 noon-2:00-3:00 p.m.
1 company: 3:30 p.m.
1 company: City divided into three areas: 12:00 noon-3:30-4.30 p.m.
3 companies: 3:00 p.m.
1 company: 5:30 p.m.
1 company: 2 hours prior to delivery time
1 company: 1:00 p.m.

6. Do you have 24-hour service?

To this question, although 21 companies replied that they did not have 24-hour service, it was made absolutely clear that all firms had personnel who could be reached if necessary for emergency purposes.

7. If you do not have 24-hour service, how late do you operate?

9 companies: 5:00 p.m.
4 companies: 5:30 p.m.
2 companies: 4:30 p.m.
1 company: 10:30 p.m.
1 company: 6:00 p.m.
1 company: 7:00 p.m.

8. What promotional services do you use on behalf of suppliers?

(a) *Tele-Tips*

1 company had 25 Tele-Tips
1 company had 21 Tele-Tips
2 companies had 8 Tele-Tips
1 company had 7 Tele-Tips
4 companies had 4 Tele-Tips
10 companies had 3 Tele-Tips
1 company had 2 Tele-Tips

(We would point out that the total of 117 Tele-Tips Easels as reported above is misleading as approximately 135 Tele-Tips Easels have been ordered by drug wholesale members of the CWDA.)

(b) *Selling Sheets*

Replies to this question ranged all the way from a minimum of 6 to a maximum of 1,000. One drug wholesaler stated that selling sheets were sent to all pharmacists in his trading area.

Two firms stated that selling sheets were mailed out weekly.

Two companies stated selling sheets were mailed out twice monthly and one mailed out selling sheets as required.

(c) *Direct Mail*

Twenty-one drug wholesalers stated they made use of direct mail material on behalf of their suppliers.

(d) *Other Promotional Services*

Over 50% of the members replying stated they provided additional promotional services on behalf of their suppliers. These could be classified as follows:

Bulletins: weekly, semi-monthly, monthly and specials.
Sample rooms.
Special display allowances.
Merchandising groups, such as A.R.P.; P.S.M.; Atlas; U.P.P., etc.
Samples; personal letters; miscellaneous.

9. What is the minimum discount required from suppliers?

13 companies: 16⅔%
2 companies: 16⅔% plus 2% cash
2 companies: 15%
2 companies: 15% plus 2% cash
1 company: 10%
1 company: 8½% to 16⅔%
1 company: 12%
1 company: varies
1 company: 16⅔% to 20%

10. What is your average monthly inventory?

Companies replying to this question showed average monthly inventories ranging from a low of $90,000 to a high of $1,500,000 and the average figure was $527,140.

(It is interesting to compare this with the 1964 CWDA Operating Survey, which showed the average inventory figure to be $538,900. However, more members replied to the Operating Survey than to this Survey. It is also interesting to note that average stock turnover for CWDA drug wholesalers was reported at 6.7 times annually in the 1964 CWDA Operating Survey.)

11. What promotional aids do you expect suppliers to provide?

Although only two companies indicated they expected suppliers to provide promotional cards for Tele-Tips Easels, this doubtless was overlooked as the majority of wholesale drug members of CWDA have Tele-Tips Easels and they are certainly looking to associate members for strong support of this project.

Nineteen companies stated they expected salesmen support, retailing brochures and selling sheets.

Other promotional aids expected included: Advertising material; radio and television support; local and national newspaper advertising; samples (7 companies); direct calls by suppliers to retail pharmacists; prepack deals; posters and window banners; catalogues; advice on new products; card displays.

12. What is the average number of orders from suppliers per month?

Over 50% of those replying stated they placed orders with suppliers on the average of twice each month. Other firms stated it depended on terms and cash discount; some houses said it varied according to product.

There is little doubt that drug wholesalers generally tried to keep well stocked with suppliers' lines, be they drug or non-drug items.

13. What do you feel a supplier would gain by distributing through drug wholesalers?

As was to be expected, there were a great many replies to this question. In the interests of time and space, they are summarized as follows:

(a) Faster and more efficient distribution of products at lesser cost to suppliers.
(b) Additional sales promotion through the use of the wholesaler's sales force.
(c) Closer relationship with pharmacists in credit arrangements, adjustments and financial accommodation.
(d) Pharmacists can order all needs from one source, having precharge and one delivery.
(e) Local and quick source of product information.
(f) Reduced administrative costs.
(g) Economical storage of goods.
(h) Virtual elimination of credit risks.
(i) Reduced handling, shipping and accounting costs.
(j) More frequent contact by salesmen.
(k) Better relations with the trade.

Here again there were a great variety of answers, some of which overlapped into the foregoing question. The answers may be summarized as follows:

(a) Maintaining a complete range of pharmaceutical, proprietary, toiletry and sundry merchandise.
(b) Answer enquiries promptly on products, prices, promotions, etc.
(c) Assist pharmacist to maintain control of inventory.
(d) More effective handling on pharmaceutical products recalled from the market either by manufacturer or government action.
(e) Orders normally delivered day received.
(f) Assist customers in times of financial difficulty.
(g) Quick delivery of emergency orders.
(h) Assist in merchandising and store layout and renovation.
(i) More frequent contact with pharmacists.
(j) Faster coverage of new items.
(k) Retail clerk training.
(l) Prices of small quantities equal to massive deal prices.
(m) Co-operative advertising support.

(It is realized, of course, that not all drug wholesalers are doing all the things summarized in Question No. 14. Many are doing some of them and we believe it will be only a matter of time, plus the pressure of competition, which will compel all wholesalers to provide as wide a service as possible.)

A study of the Survey reveals certain conclusions in definite favor of the suppliers. These can be summarized as follows:

(a) Wholesale druggists adequately serve their customers with daily deliveries in both the city and the country. In addition, fast emergency service is always available.

(b) Wholesale drug houses are well staffed with salesmen and telephone order clerks, the total for both groups, according to the Survey, being just under 300.(The actual total is much larger as it will be remembered that only 65 per cent of the members replied to the Survey.) All these people are working on behalf of the suppliers at the expense of the wholesalers, there being no direct charge to the suppliers.

(c) Although deadlines for deliveries vary, all wholesalers, as previously noted, do have fast emergency services available. It should also be remembered that, if necessary, a pharmacist can pick up his own order at virtually any time. This, of course, is impossible in the case of a supplier who does not have a warehouse or depot outside his base of operations—in the majority of cases this is either Montreal or Toronto.

(It is interesting to note that of a total of 32 associate members of CWDA who fall into the category of ethical pharmaceutical manufacturers, only 13 maintain warehouses outside their headquarters' city. Obviously, if a pharmacist requires a product from any of the remaining 19 manufacturers who do not have depots or warehouses, he has to depend either on the wholesale druggist or wait at least a day for delivery.)

(d) Wholesale drug houses are continually seeking ways and means to actively promote and merchandise the lines of their suppliers—both drug and non-drug. The Tele-Tips project, initiated by the CWDA, is one example. Wholesalers are looking to active support of participating suppliers in this project.

Drug wholesalers are also making extensive use of selling sheets, direct mail, bulletins and other promotional services. In addition, many wholesale druggists have been forming merchandising groups which will help create demand for suppliers' products.

(e) We have no comment to make on discount practices as this enters the realm of prices and the CWDA does not at any time enter this area. This information is presented only as a matter of interest.

(f) Drug wholesalers do endeavor to maintain their inventories at an adequate level in order that retail pharmacists can replenish their stocks with a minimum of delay. As noted in Question No. 12, over 50 per cent of the wholesalers place orders at least twice monthly.

(g) Drug wholesalers are seeking promotional aids from their suppliers. This assistance, of course, is vitally necessary. Unless the drug wholesalers are provided with promotional aids they are severely restricted in the amount of help they can give suppliers in promoting the latters' lines.

(h) Drug wholesalers believe that they can distribute more efficiently and faster than suppliers. This is certainly true of products where the

supplier does not have any distributing facilities outside of his home base of operations. In general, wholesalers state that their costs are less in all areas—administrative, distribution, storage, selling and credit.

Wholesalers also stress that because they call upon the trade more frequently than do the salesmen or professional service representatives, they have a closer insight into the problems of the retail pharmacist and are better able to assess his needs. Through this frequent contact the wholesaler also has a better idea of the pharmacist's inventory, credit and business in general.

(i) Wholesalers also believe that they can render far more services to the retail pharmacist than is possible for most suppliers. As examples, they can answer questions quickly regarding prices, promotions and deals; they can make same day deliveries; assist in merchandising, store layout and renovating; aid in retail clerk training; provide co-operative advertising support; give advice on total inventory control, and so on.

This is not to say that many suppliers cannot do many of the things outlined in the questionnaire. However, wholesalers believe that, generally, it is more costly for the suppliers to undertake them. The suppliers' salesmen and professional service representatives are, for the most part, only concerned with their own employers' lines. The drug wholesaler is concerned with the entire picture and thus has a better idea of the many problems confronting the pharmacist.

The two principal functions of the drug wholesaler are distribution and service. He can perform these functions far better than the supplier whose principal activities lie in the production of goods and creating a demand and, in varying degrees, in research and development. By leaving distribution and service to the drug wholesaler the supplier, for example, can cut down on the cost of manpower employed for packing, warehousing, storage and invoicing, to name a few areas.

A direct house has to invoice several thousand accounts if his lines are distributed country-wide; a supplier distributing through wholesale druggists has only to invoice a hundred or so accounts, and that includes wholesalers with limited distribution as well as full line full service drug wholesalers. The saving in time and manpower in this area alone is tremendous.

Insofar as the ethical pharmaceutical manufacturers are concerned, their professional service representatives are expected to call on medical practitioners, pharmacists and wholesalers. The wholesalers' salesmen, on the other hand, are not concerned with calling on the medical profession; their only interest lies with the retail pharmacist although some wholesalers also service hospitals. It is obvious, then, that the wholesalers' representatives will be devoting virtually all their time to the pharmacist, and thus has a greater awareness of the needs of the pharmacist than does the professional service representative.

The retailer would much prefer to depend upon the wholesaler for help in maintaining inventory, in placing his orders through one central source, and paying his bill through the same central source.

By so doing he cuts down on his time and costs and can devote more time to rendering professional service to his customers and providing them with their requirements.

There is little doubt that there has been a revolution in the thinking of drug wholesalers in recent years. As we remarked earlier, there has been an "awakening by the wholesale drug industry generally and it has come to realize its responsibilities by taking long over-due steps to actively promote and merchandise their suppliers' lines."

C. M. Peel, General Manager of National Drugs Ltd., Winnipeg, told pharmacists attending the 1965 Annual Convention of the Canadian Pharmaceutical Association:

"Wholesalers—importantly—have become retail-minded and have greatly expanded their services and improved their efficiency. Many wholesalers are now merchandising experts, well equipped to assist and lead their customers to larger sales volume.

"The wholesaler acts in the capacity of the telephone switchboard. Through his warehouse flow the products of scores of manufacturers. His salesmen call intensively on the trade, making multiple sales offerings of hundreds of different items. The same group economy is reflected in his deliveries, made over short distances combining many small orders into a practical assortment of complete stock. His office procedures and invoicing are likewise simplified.

"By dealing with the full line full service drug wholesaler the retail pharmacist deals with

one salesman
One supplier
One delivery
One invoice
One account payable
One point of responsibility."

All this, of course, works in favor of the suppliers as well as the retail pharmacist.

Discussing this changing attitude of wholesaling, Eugene Luning, President of the Pharmaceutical Wholesalers Association in the United States, said there were four requisites for this new kind of distribution:

(1) Assure continuous availability of the entire body of modern pharmaceuticals at the retail level.

(2) Maintain a smooth flow of pharmaceuticals from manufacturers to pharmacy.

(3) The regulation of retail inventory for maximum utility with a minimum tie-up of operating funds.

(4) Provide the retailer support services, including around the clock delivery and product information back-up.

E. L. Kadlec, General Manager of Northwest Drug Co. Ltd., Calgary, also addressing the 1965 Annual Convention of the Canadian Pharmaceutical Association, said:

"The principal function of any wholesale drug salesman is to see that, in the minds of his retail customers, his wholesale drug house is foremost, and that his principal purchases are made from there. To this end he must remember the following:

"(1) When calling on retail pharmacists, it is up to the salesman, not only to see that they are supplied with every day needs, but that they are offered new products, special promotions and deals.

(2) He must not only take 'want book orders', but he should check the customer's stock.

(3) He should show samples and brief the manager and sales staff on the selling points of certain merchandise.

(4) He should keep his customer informed of special promotional material to sell new products and, if necessary, organize a special sales campaign to stimulate the sales of those products.

(5) He should keep his customers informed of any changes in Dominion, Provincial and local laws pertaining to Pharmacy.

(6) He should inform his customers about consumer advertising affecting his area."

We noted previously that of a total of 32 associate members of the Canadian Wholesale Drug Association who fall into the category of ethical pharmaceutical manufacturers, only 13 maintain warehouses or depots outside their headquarters city.

Wholesale drug houses are the closest sources of supply for most retail pharmacies, and, except for rarely-used medicaments, almost all wholesale drug houses can meet any demand placed upon them.

As a matter of record, the following is a breakdown of the distribution by areas of the wholesale drug houses which are members of the CWDA.

Atlantic Provinces	9	wholesale drug houses and depots
Quebec	10	" " " " "
Ontario	6	" " " " "
Manitoba	2	" " " " "
Saskatchewan	2	" " " " "
Alberta	4	" " " " "
British Columbia	3	" " " " "
Total	36	

The total of 36 is more than the number of depots and warehouses maintained by ethical pharmaceutical drug houses which are members of the Canadian Wholesale Drug Association and, of greater importance, they are more strategically located and thus can more efficiently attend to the needs of the retail pharmacist any hour of the day or night.

We would also stress that much of the foregoing also applies to manufacturers and distributors of non-drug items—the majority of which are normally not emergency items. But if the pharmacist is out of stock he either loses a sale or recommends a competitive item. In either case the supplier of the item originally requested loses money.

By making use of the wholesale druggist, the supplier is reasonably certain that the wholesale druggist will make every attempt to keep the retail pharmacists in his trading area stocked with all items. The wholesale druggist, obviously, has an interest in doing this as lines which sit on his shelf do not make money for anyone—the wholesale druggist, the manufacturer or the retail pharmacist.

To sum up, Canadian wholesale druggists are trying to do an efficient job of moving their suppliers' lines and at less cost in all areas than can the suppliers. The wholesale druggists are continuously seeking new ways and methods of promoting and merchandising their suppliers' goods and there is little doubt that in the years ahead the wholesale druggists will further increase their efficiency, to the benefit of not only themselves but also of the suppliers, the pharmacists and the Canadian public.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

SPECIAL COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 25

THURSDAY, DECEMBER 8, 1966

WITNESSES:

Representing the Canadian Cystic Fibrosis Foundation: Mr. Callum MacIver of Hamilton, Ont., first vice president; Dr. J. M. Park, M.B., Ch.B., of Ottawa, Member of the Medical Advisory Board; Mr. W. Mac McKenzie, of Rexdale, Ont., National Executive Director.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1967

25510—1

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

MINUTES OF PROCEEDINGS

THURSDAY, December 8, 1966.
(35)

The Special Committee on Drug Costs and Prices met this day at 9.45 a.m. Mr. Harry C. Harley, presided.

Members present: Mrs. Rideout, and Messrs. Brand, Harley, Howe (*Hamilton South*), Howe (*Wellington-Huron*), Hymmen, MacDonald (*Prince*), MacLean (*Queens*), Orlikow, Rynard, Tardif (11).

In attendance: *Representing the Canadian Cystic Fibrosis Foundation*: Mr. Callum MacIver of Hamiton, Ontario, first vice president; Dr. J. M. Park, M. B., Ch. B., of Ottawa, Member of the Medical Advisory Board; Mr. W. Mac McKenzie, of Rexdale, Ontario, National Executive Director.

Also in attendance: Mr. A. M. Laidlaw, Q.C. of Ottawa, Legal Counsel for the Committee.

The Chairman invited Mr. MacIver to introduce the members of the delegation.

Mr. MacIver made an opening statement to explain the aims and objectives of the foundation and read the recommendations contained in the brief.

Agreed,—That the submission presented by the Canadian Cystic Fibrosis Foundation be printed as part of today's proceedings (*See Appendix "A"*).

Messrs. MacIver, McKenzie and Park were questioned.

On behalf of the Committee, the Chairman thanked the representatives of the Foundation for their presentation and wished them every success.

At 10.50 a.m. the Committee adjourned to 9.30 a.m., Tuesday, December 13.

Gabrielle Savard,
Clerk of the Committee.

25510—1½

EVIDENCE

(Recorded by Electronic Apparatus)

THURSDAY, December 8, 1966.

The CHAIRMAN: Gentlemen, I think we might convene this morning's meeting. We have with us this morning the representatives of the Canadian Cystic Fibrosis Foundation. I ask the first Vice President Mr. MacIver to introduce his colleagues and to make an opening statement. Mr. MacIver.

Mr. MACIVER: Thank you Mr. Chairman, ladies and gentlemen. My name is Callum MacIver. I am from Hamilton; the gentleman on my right is Mr. McKenzie from Toronto, our Executive Director of the Foundation, and on his right is Dr. Park of Ottawa who is representing our Medical Advisory Board.

The Cystic Fibrosis Foundation appreciates this opportunity to present its story to this Committee, and briefly the history of the Foundation is that it was formed by a group of concerned parents in 1958 and incorporated in 1960. We have grown very rapidly since that time from a few people to over a thousand now. We now have chapters right from coast to coast, and since the brief was written, we have added two additional chapters, one in Quebec City and one in Moncton, New Brunswick.

The Foundation is composed almost entirely of voluntary aid; the only hired staff we have is Mr. McKenzie and a couple of assistant secretaries in Toronto. Briefly, the aims and objectives of the Foundation are to bring parents together in an organization to enable them to share their common experiences and their problems, to co-ordinate and support efforts in research and diagnosis; to disseminate information to an uninformed public of the disease and the problems surrounding it. And finally, to focus public attention and enlist community support for the children suffering from cystic fibrosis, and their families.

Now, I am not going into it technically; I will leave that for Dr. Park and any questions you may have about the disease. It is a chronic disease of childhood which has been recognized as one of the commonest causes of chronic lung disease. The statistics roughly state that about one out of a thousand children is born with this disease. It affects primarily two portions of the body, the pancreas which does not function properly without assistance, and the lungs. These children, when their lungs are infected, cough; they have a very harsh peculier kind of cough, and they cough and cough and cough until they can bring up the mucus that is clogging their lungs. It is a terrible thing for any child to have to go through.

The treatment of the disease is outlined in the brief, and again Dr. Park can answer any question about this far more adequately than I can. The recommendations that we have to place before this committee are these:

1. That cystic fibrosis receive the same recognition as diabetes and other chronic diseases as evidenced by exemption of insulin, liver extract, etc. from federal sales tax. All drugs prescribed for cystic fibrosis patients to be exempt from sales tax.

2. Remove federal sales tax from prescription drugs. Sales tax pyramids cost of drugs to consumer of every prescription.

3. All patients with chronic illnesses such as cystic fibrosis which of necessity sustain long term drug therapy, should receive consideration for additional governmental assistance.

4. The medical care insurance program should also include coverage for expense of all prescribed drugs including nutritional supplements.

5. The federal government should immediately institute some form of the above recommendations in order that all cystic fibrosis patients receive equitable treatment in all areas of Canada.

The federal government should provide funds for additional research in search of a cure for cystic fibrosis.

Gentlemen, this is our brief.

The CHAIRMAN: Fine, thank you very much, Mr. MacIver. Is it agreed by the Committee that we print today's brief as part of todays' proceedings? Agreed?

There is one point of clarification before we open the questioning. Is there a mistake in the brief on page 14, in the column where it says "Medical expenses in excess of 3 per cent of income" the figure of $1,020 is mentioned, but down below where it is quoting the same figure it reads "The C/F parent after taxes has $6,000 −$302 +$1,200". Should not that figure be the same in both places?

Mr. MACIVER: No, basically this is roughly $100 a month, and that is the cost of the treatment, averaging out.

The CHAIRMAN: I see, and the figure above, $1,020?

Mr. MACIVER: That is the expenses in excess of the 3 per cent of the income that is allowable.

The CHAIRMAN: Thank you. The meeting is open for questioning.

Mr. RYNARD: Well, I would just like to say as I understand it, looking over the brief, which I read on the way over here, there is no help given to the people now; they have to buy drugs for cystic fibrosis; is this correct?

Mr. MACIVER: No, not in every province.

Mr. RYNARD: Some provinces.

Mr. MACIVER: Some provinces are giving assistance.

Mr. RYNARD: Therefore, it is strictly a provincial thing.

Mr. MACIVER: At the moment, yes.

Mr. RYNARD: Yes. Insulin, for instance, is paid for where it is necessary, and you can get if free. I am wondering if this is a federal thing at all, from our standpoint, except to urge the provinces to help in this or to share costs in the program; it must be initiated at the provincial level. Why this could not be handled the same as we handle other diseases like diabetes and cancer, for instance, where they can get drugs, I do not know. I am wondering if your objective in writing this paper is to get this done.

Mr. MACIVER: Well, this is part of it, yes. Of course, we are interested in getting it exempt from tax because of the very high costs involved with this disease that parents have to meet. These figures are not exaggerated at all.

Mr. RYNARD: You mean to get the tax off drugs.

Mr. MACIVER: Yes, this is the first step; secondly, we would like to see all of these drugs exempt from tax.

Mr. RYNARD: I wonder Mr. Chairman, if you could tell us what provinces accept the payment now. What provinces do pay.

The CHAIRMAN: I am sorry.

Mr. RYNARD: You said there were some provinces.

The CHAIRMAN: I think there is some misunderstanding, Dr. Rynard. I think Mr. MacIver is saying that parents should be allowed to take the cost of their prescriptions off their federal income tax income the same as any other expense that they might have.

Mr. RYNARD: Providing that those people come within the range of what we are calling the means test that we have heard so much about. What happens to those people; how do they get their drugs. You are talking now about taxable income; I am talking about people who may not have a taxable income.

Mr. MACIVER: You are referring to somebody who does not have an adequate income to buy these drugs. Some of them are supported by welfare.

Mr. RYNARD: It has to go through a welfare channel?

Mr. MACIVER: Oh, yes.

Mr. RYNARD: In other words, it is not accepted in any province, as a payment of those drugs for people who can afford it.

Mr. MACIVER: Yes, it is, in some provinces.

Mr. RYNARD: The same as insulin, the same as cancer-controlling drugs.

Mr. MACIVER: Well, that I am not sure of, gentlemen.

Mr. RYNARD: This is one thing that I think should be.

Mr. MACIVER: We can easily find that out, but I can tell you that in our appendix B it shows you what assistance each province is giving, in prescription drugs, other care items, equipment and in-hospital requirements. It varies across the country. In Nova Scotia, for instance, there is no formal assistance, as such. But many of these parents or patients who have this problem, that cannot buy the drugs—and these children need the drugs to keep them alive—are given assistance. It would be the same as any other welfare case that needed assistance; the municipalities will step in if the province has not.

Mr. RYNARD: Mr. Chairman, I feel that in some way or another this should be treated in the same way as insulin is now treated, and cancer-controlling drugs, and cancer drugs which help arrest the disease. I would think that this should be an aim and an objective as in pure welfare departments. I am just suggesting this, maybe I am wrong. It is still not clear. I see in Alberta they purchase Ilosone, albamicin, orbenin, penbritin, but in Saskatchewan they are free. I do not know what the situation is even in my own province. It is done through welfare; is it not?

Mr. MACIVER: In Ontario? There is a grant from the federal government and the provincial government to the Crippled Children's Association, but everybody is not receiving assistance from the Crippled Children's Association in this province. It boils down to a means test.

Mrs. RIDEOUT: Mr. Chairman, I would just like to get one thing clear in my own mind. You present your brief because you are concerned about the high cost

of drugs; I am sympathetic to your problem, I have met with some of your representatives on behalf of the Minister of National Health and Welfare, and it is my understanding that this disease—cystic fibrosis—is comparatively new in diagnosis. Although children have been born with it for many years, it was never really known what was wrong. Consequently, you people have been pioneering in that your Foundation has tried to help people with early diagnosis of the disease and you have proven that children can have a longer life, and lead quite a normal life provided the disease is diagnosed early. If it is, it means the drugs have to be administered early, and this is a great hardship to parents, because I am sure in some cases there is more than one child in the family who has the disease, is this correct?

Mr. MACIVER: That is correct. There is a family here in Ottawa that has four out of their five children that are inflicted with this disease, and this is just an impossible burden for them, financially.

Mr. ORLIKOW: Where would that family get any assistance from?

Mr. MACIVER: They are receiving some assistance I believe, from the Crippled Children's Association.

Mr. ORLIKOW: From where?

Mr. MACIVER: From the Crippled Children's Association.

Mr. ORILIKOW: Well, where would they get their prescriptions filled?

Mr. MACIVER: Well, I think Dr. Park can answer that.

Dr. J. M. PARK *(Ottawa)*: This family has private insurance too, which helps, but they—like so many families in Ontario, particularly—obtain their drugs at cost through the hospitals here. We have a special arrangement with the local hospitals here to provide these drugs at cost, plus 10 per cent handling charge, and they are prescribed through the clinic.

Mr. ORLIKOW: I think all members of the Committee will be very sympathetic to the recommendations contained in the brief, although a large number of them really have nothing to do with the purposes for which this Committee was set up. It does seem to me, aside from the income tax exemptions, and aside from taking the sales tax off prescription drugs, and so on, that this organization could serve a very useful purpose if it could help make arrangements that all the people who have this problem could get their prescriptions filled at some hospital dispensary. Because it seems to me pretty obvious that this is not a short-range thing; this is virtually a permanent—

Mrs. RIDEOUT: I did not put my question, Mr. Orlikow. I was trying to lead up to that point. Excuse me for interrupting you, Mr. Orlikow. If I am correct, you have a project right now under which you are trying to get hospitals to provide a room where children can be examined and diagnosed. Is this correct?

Mr. MACIVER: Oh, yes; we have treatment centres across the country, and we are trying to establish more of them.

Mrs. RIDEOUT: So that with early diagnosis you feel that these children will have an opportunity to—

Mr. MACIVER: Yes; and until very recently there was no way of testing parents to determine if they were carriers of this disease. But there was an announcement recently in the paper that there has been a discovery made in the

United States; that there is now a test available that they can predetermine if parents are carriers. This will be a marvelous thing in itself.

Mrs. RIDEOUT: But is it not possible for these people to get their drugs at the hospital, where they certainly can get them much cheaper?

Mr. MACIVER: If they attend the clinics, and only if they attend the clinic.

Mrs. RIDEOUT: Is this another reason why it would be a great advantage if you were able to set up these clinics across the country?

Mr. MACIVER: Yes, a very great advantage. There is a great problem here, because of the geography of our country; people are not always living close to a large centre, where the treatment clinics are and where the majority of the hospitals are. So that there is travelling involved, and it is a problem. But there is an inequity in the treatment across the country as far as the cost of drugs is concerned.

Mrs. RIDEOUT: Would it cost a family about $30.00 a month for drugs, if they had one child who is affected.

Mr. MACIVER: Well, it depends on the drug they are on. The treatment varies from province to province, and also city to city and doctor to doctor, and child to child. It can go from as low as $10.00 a month, as some of the families have indicated, up to $300.00 a month.

Mrs. RIDEOUT: Even some families who are forced to use the welfare services might not be able to have the proper amount of drugs required to look after the child.

Mr. MACIVER: Well, I do not think any child will go without the proper amount of drugs. If it is necessary, drugs will be found for them in some way.

Mrs. RIDEOUT: Thank you, Mr. Chairman.

Mr. HOWE (*Hamilton South*): Does this Foundation in any way provide drugs? I mean do you have a set-up where you can provide drugs for people that are unable to purchase them?

Mr. MACIVER: No.

Mr. HOWE (*Hamilton South*): So you serve no function in this regard, I mean your actual function is to disseminate the information that you have on the disease.

Mr. MACIVER: We do provide equipment, the therapy equipment. When I say we provide it I mean we go out and find the money to buy it for the local chapters.

Mr. PARK: Some of the local chapters will buy drugs for needy cases.

Mr. MACIVER: That is right; they will step in, but we are not geared as a drug-providing organization; this is not our purpose at all.

Mr. HOWE (*Hamilton South*): You act as a central cupboard for these machines, and lend them out to cases who need them?

Mr. MACIVER: That is right.

Mr. HOWE (*Hamilton South*): And your main function in coming here is an attempt to get a federal grant, as far as drugs are concerned, to the provinces to lower the price to the patient rather than an interest in lowering drug prices *per se*.

Mr. MACIVER: That is correct. We felt that if it was handled from the federal government down through the provinces the cost of the treatment would equalize throughout the country rather than have the great inequity that occurs at the present time.

Mr. HOWE (*Hamilton South*): The lowering of the over-all cost of drugs would be helpful in either case, would it not?

Mr. MACIVER: Very definitely.

The CHAIRMAN: Mr. Orlikow.

Mr. ORLIKOW: Mr. Chairman, I just have one question. I wonder if the organization has considered or would consider the possibility and the advisability of the organization acting as a purchasing agent for people who are in these difficulties. First of all, you could buy the drug. I know that you mentioned in your brief that there is a variety of drugs, but there are still probably not more than a dozen. They could be bought in bulk, in quantity, which would reduce the price. Secondly, you could probably settle on generic brands which would reduce the price. Thirdly, if you did it co-operatively, I think there would be a very large saving on behalf of the people who are undoubtedly in the very difficult position which you outlined so eloquently in your brief.

Mr. PARK: In Ontario, this is in fact being done to all practical purposes under this scheme whereby the federal and provincial governments combined to provide a drug fund. This, as has been mentioned, has been administered through the Crippled Children's Society, and they pay for drugs which are dispensed through the various hospitals in all the big centres in Ontario. But, because they are the one central agency administering this, a great deal of work has been done in the past few months to standardize the cost of drugs and the drugs that are being prescribed. Consequently, although these drugs are prescribed through the various hospitals, they are all bought in bulk, and they are largely prescribed by generic name, purely to keep the cost down to a minimum, and because there is this one central agency that is virtually paying for them in Ontario. My personal feeling is that if this sort of scheme could be extended through the country as a whole, this would work very well. Each centre has its own particular problems, but we have found, in working with the Crippled Children's Society in administering this fund, it is quite easy to get in touch with the various drug companies that make the particular drugs that we use to a large extent, and we buy these drugs in bulk and we get special rates as a result. If this sort of scheme could be extended through the whole country I think it would make a big difference.

Mr. MACDONALD (*Prince*): Mr. Chairman, in reading through your report I note you mention that often a succession of drugs is used for a patient, and if he becomes immune to one he is put on to a succeeding drug. Are we any nearer now to the establishment of a standard drug, that, if it did become standard, perhaps this tremendous price differential might be overcome?

Mr. PARK: No; there are certain drugs which are standard and appear to have every prospect of remaining so. These are the drugs that supply the pancreatic deficiency; and it would appear from our experience over the last few years that these will remain this way almost indefinitely. But it is in the field of antibiotics,—and this is what I think you are referring to—that we have to change. As you well know, the various germs and infections tend to build up a

resistance to different antibiotics, and it is for this reason that we constantly have to change the antibiotics that are being used by these children.

I might say that most of these children are permanently on some type of antibiotic, and we have to constantly check them to see whether any resistance is being built up to the particular antibiotics that they are using, and this very often happens and consequently we have to change the antibiotic. As you know there are a large number of antibiotics available now; consequently we cannot say that a child with cystic fibrosis has to have penicillin and will stay on this drug, because this is not so. We have to change them every few months, very often, and this means that we have to draw on quite a wide range of drugs in this field to supply these children. Nevertheless, there are so many children being treated now that we still buy these antibiotics in bulk now and we find this is practical. However, I cannot say that they will remain this way; there are always new antibiotics coming out, and it seems unlikely at the moment that we will ever come across one particular antibiotic that will be the answer to this. We will continue with this, so there will be change in this field.

Mr. MacDonald (*Prince*): Am I also right in saying that there is no known cure or relief from this particular disease.

Mr. Park: No; this is one of the so called inborn errors of metabolism. These children are born with this disease; the exact cause is unknown, though we know it is a defect in glandular function in the body. It is rather in the same category as diabetes. The basic underlying cause of diabetes is still unknown, although we know it is a deficiency in insulin amongst other things. But what I am trying to get at is that this is something that an individual is born with, and until the cause is discovered they have it for life and they need treatment for life. The measures that we have been outlining in the form of drugs and equipment and so on, if you like, are purely palliative; mind you, they make the difference between life and death in a child. But they are purely palliative; you are treating the symptoms and keeping them going; you are not curing them. This is why they have to continue with this rather elaborate and expensive treatment into adulthood and for life, so far as we know.

Mr. MacDonald (*Prince*): You mentioned to us there has been an extension of the life expectancy.

Mr. Park: Yes; this disease was discovered just over 20 years ago, and it is in the past 10 to 15 years that this more elaborate and effective treatment has been developed and as a result this has entirely altered the picture. Before this present day treatment was in use for these children, more than 50 per cent of them died before the age of 5 years and the remaining 50 per cent usually never reached the teen years. In other words, when a child was diagnosed as having cystic fibrosis, before this treatment was instituted, you could tell the parent, this child will not grow up. Today, with this treatment, particularly if it is diagnosed early and started from the beginning, as has already been mentioned, these children lead a normal life; they go to normal schools; they participate in all the normal activities and we now have individuals in the mid twenties who are working, holding down ordinary jobs and even raising families, and leading to all intents and purposes, a normal life, apart from the fact that they have to continue taking their drugs.

Mr. MacDonald (*Prince*): With respect to raising families, would the person who has cystic fibrosis be more likely to have children with cystic fibrosis than a normal person?

Mr. PARK: They stand double the normal chance of having children with cystic fibrosis. Let me put it this way, if a normal individual,—yes this would be it—two carriers of the disease would stand a chance of one to four of their children developing cystic fibrosis. If a person with cystic fibrosis married a carrier, all their children would have cystic fibrosis, but they would stand a double chance if they married another individual who probably was not a carrier.

Mr. MACDONALD (*Prince*): A person could be a carrier and not have the symptoms, himself or herself?

Mr. PARK: That is so.

Mr. MACLEAN (*Queens*): In Appendix B I notice that in the case of Ontario and Saskatchewan the federal government pays a matching grant to a grant which is put up by the provincial government in each case, this would not seem to be so, from Appendix B—although I have only scanned it briefly—in the other provinces. Now, is this because of a special program initiated by the federal government on an experimental basis with Ontario and Saskatchewan, or is it a lack of initiative on the part of the other eight provinces.

Mr. MCKENZIE: I believe, sir, that this formula is available to all provinces, but it is only being utilized by these two you mentioned.

Mr. MACLEAN (*Queens*): This is what I am going to find. So that in the case of the other 8 provinces if they took certain steps, they too presumably would qualify for a grant from the federal government.

Mr. MCKENZIE: That is correct.

Mr. MACLEAN (*Queens*): The other question I was going to ask was the one that Mr. MacDonald asked, but perhaps I might pursue it a little further. As time goes on, and children now with cystic fibrosis live a more or less normal life span, the incidence of the condition will increase, statistically?

Mr. PARK: Yes, this is so, and of course it applies to a lot of these genetic disorders, including diabetes. If you are going to help these people survive, the indicence is bound to go up.

Mr. MACLEAN (*Queens*): This is, I take it, a recessive gene and it takes two carriers.

Mr. PARK: That is right.

Mr. LAIDLAW: I understood Dr. Park to say, Mr. Chairman, that large drug purchases which he is aware of, are made under the generic name. Am I correct in that assumption?

Mr. PARK: Well partly so. In some instances, particularly with the pancreatic extracts, we find that one particular drug company will manufacture a better product from our point of view than another, and so we prescribe that, but from the point of view from of antibiotics, by and large, we order by generic names.

Mr. LAIDLAW: Dr. Park, has your Foundation had any uneasy experiences because of the safety features, or the safety of using say, generic named drugs rather than brand named drugs? Have you had any bad experiences in this connection; are you aware of any?

Mr. PARK: I am not aware of any, no. I mentioned all these drugs are ordered through the hospitals, and I think they are very careful naturally with

their suppliers, but I cannot really answer this, I have no experience of this, and I have never heard of it.

Mr. BRAND: I just wanted to ask if you have had any offers of help from the Canadian Pharmaceutical Association in the purchase of drugs.

The CHAIRMAN: The Pharmaceutical Association or Pharmaceutical Manufacturers Association?

Mr. BRAND: The Pharmaceutical Association, that is the druggist, the retail druggist.

The CHAIRMAN: Thank you.

Mr. MACIVER: No, we have not been approached.

Mr. BRAND: How about the Pharmaceutical Manufacturers Association?

Mr. MACIVER: No, not that I know of.

Mr. BRAND: How about the manufacturers of the tents and the nebulizers, and all this jazz.

Mr. MACIVER: We get co-operation from these people. Of course, we have to pay for all this equipment, but they do give us a certain degree of co-operation.

Mr. BRAND: Approximately, how many cystic fibrosis patients would you have in the province of Ontario?

Mr. MACIVER: This is only an estimate, but at least 600.

Mr. BRAND: The reason I asked is that if you have an Ontario provincial grant of $125,000, matched by a similar federal grant of $250,000 for 600 patients, I wonder where the money goes.

Mr. MACIVER: That $250,000 is not enough this year. It will not be enough this year.

Mr. BRAND: Now, that is what I was wondering, where is the money going, this quarter of a million dollars? How much of it would go, for example, towards helping the patients?

Mr. MACIVER: All of it.

Mr. BRAND: It does not go to research?

Mr. MACIVER: Oh, no. This is all for drugs primarily, and handling equipment as well.

Mr. BRAND: I see, you would like to see, I presume, more federal assistance.

Mr. MACIVER: Yes.

Mr. BRAND: You made a few specific recommendations here.

> The medical care insurance program should also include coverage for expense of all prescribed drugs including nutritional supplements.

You are referring to the new medicare act that is coming in, I presume.

Mr. MACIVER: That is correct.

Mr. BRAND: July 1, 1968, is it?

Mrs. RIDEOUT: Now, Dr. Brand!

Mr. BRAND: I just asked a question; that is all.

The CHAIRMAN: That was a statement: that was no question.

Mrs. RIDEOUT: It was not a question.

Mr. BRAND: Rhetorical, perhaps.

The CHAIRMAN: Rhetorical, did you say?

Mr. BRAND: I wondered about this reference to all prescribed drugs. The experience of some countries in putting this across the board has been prohibitively expensive.

Mr. MACIVER: Would you care to comment on this, Dr. Park?

Mr. PARK: Which?

Mr. MACIVER: No. 4 on page 16.

Mr. PARK: Yes; actually, we find that there is less need for this except in some of the poorer families, the indigent families, actually. Nutritional supplements are tending to become less important, now that we are improving our treatment of the pancreatic deficiency. These children suffer from mal absorption control, they were not able to digest the food adequately, so we had to give them protein substitutes—supplements rather, and also extra vitamins. Now, this we find is important where the general diet of the family is poor; but in the average family of average income, it is not as important as it was. But I might mention here that these children, because of their poor absorption of food, require double the normal vitamin intake, so we have to give these children vitamin supplements, and these are not paid for by any grant. We have to buy these.

Mr. BRAND: Are you familiar with the proposal by the Canadian Pharmaceutical Association to take drugs at cost and add a dispensing fee. I wondered if your association had looked at this to see whether this will be of any benefit.

Mr. MACIVER: We have not as yet examined this.

Mr. BRAND: They suggest I know in their brief—that this would save a lot of money, particularly in the expensive drugs, but it is the amount you use which is expensive rather than the—

Mr. PARK: These antibiotics are expensive, particularly the new ones.

Mr. BRAND: But it would save some money along these lines, would it not but not over getting it through the hospitals.

Mr. MACIVER: No not really, the hospitals purchase in such large quantities that they get a far better price than anybody else can.

Mr. BRAND: Is this true right across the country, that you can buy them from the hospitals?

Mr. MACIVER: No, oh, no; just where there are treatment clinics; this is basically the only place where it happens.

The CHAIRMAN: I should point out that if you buy the drugs through the hospitals you are not paying the 11 per cent federal sales tax anyway, since the hospitals are exempt from that tax.

Mr. HOWE (*Hamilton South*): Would there be any hope of being able to buy all your drugs from the hospital pharmacies even for those patients who do not live near a hospital, and have a supply for them, I mean through your voluntary organization; would this be a feasible answer to some reduction in price?

Mr. MACIVER: Yes; this is possible.

Mr. HOWE (*Hamilton South*): I mean hospitals themselves would allow this if an organization were to purchase from them, possibly at their cost, because I am sure they are not interested in making money within the hospital structure.

Mr. MACIVER: I cannot answer for all hospitals. Dr. Park can answer for his, but I know that in a particular case in Hamilton the hospital insists that anybody who purchases drugs through the hospital must attend the clinic. In other words, there are some people who are living in one area, say, for example, Hamilton, but they are going to Toronto for the treatment of the child, so they cannot purchase the drugs in Hamilton. If they go to the Toronto hospital they get the drugs at hospital cost.

Mr. HOWE (*Hamilton South*): The hospital would not allow you, as an organization, to purchase sufficient quantities, let us say, to cover six months or a year, and allow these to be sold at your cost to the individual patients, wherever they may come from, provided they are in a cystic fibrotic condition that you look after.

Mr. MACIVER: We have not investigated that area. I think there are problems involved, with an organization like ours, purchasing drugs.

Mr. BRAND: Have you approached any of the manufacturing companies to see whether you could make a deal, as an organization?

Mr. MACIVER: We did many years ago when we were much smaller than we are now, and we did not have much sucess at that time, and we have not gone back at them.

Mr. MCKENZIE: There is a problem involved here, in that all of the C.F. children, of course, are under the care of different doctors who have different concepts of what that treatment should be, and this concept varies in every province and also in every particular area. Therefore, if the foundation were to maintain a drug bank of sorts, we would be faced with the problem of having so many different individual drugs, because it still depends on the physician who is in charge of the individual patient as to what shall be the treatment for that patient.

Mr. BRAND: Do you not think that if you circularized the doctors who are treating these and pointed out that certain drugs were available that you might obtain that certain degree of co-operation from these physicians? I mean it certainly happens in hospitals; I do not see why it should not happen any place else.

Mr. MACIVER: But you have to get the drugs in the first place.

Mr. BRAND: Well, yes, that is true. How much federal funds now go towards research for cystic fibrosis?

Mr. MACIVER: None.

Mr. BRAND: None. I am sure the Parliamentary Secretary to the Minister will take note of that.

Mrs. RIDEOUT: She has been making all kinds of representations, too.

Mr. BRAND: Good for her.

Mr. HOWE (*Hamilton South*): Would you draw the conclusion that the Pharmaceutical Manufacturers Association is not necessarily a philanthropic group, but were rather out to make money.

Mr. MACIVER: What is the question? That is a kind of loaded question.

Mr. HOWE (*Hamilton South*): It does not need to be answered.

Mr. BRAND: I could ask the same question about the druggists then, if you want to cover the whole field, since you have received co-operation from neither group obviously, which rather surprises me, quite frankly.

Mr. MACIVER: Well we have received co-operation in a small degree, let us put it that way.

Mr. MACLEAN (*Queens*): Have you any information on what the situation is in other countries, such as the United Kingdom or the United States with regard to cystic fibrosis. As a background question to this, is the incidence of this condition about the same all over the world, or are certain racial groups more inclined to be carriers of this condition than others?

Mr. PARK: The so called Caucasian group are the main carriers; in other words, the white races, also some of the orientals. It is very low in oriental groups, and very low in negroes. The white races, so far as we can tell, are the predominant group. Though, I might add here, that, of course, it is the white races that have had the most thorough investigation and treatment along these lines. I think in some of the so called underdeveloped countries, if you were to look for these diseases you might find them, but this I do not know. At the moment from the present statistics available, it is predominantly a disease of the Caucasian race.

Mr. MACIVER: If I may answer the first part of your question, the first organization that was formed was in the United States, and our organization was the second formed. We were the second country to form a Cystic Fibrosis Foundation, and it is only very recently—the last three years—that it has spread to Europe, England, some countries in Europe, and Australia. So that they are just in their very infancy in these countries. We are further ahead than they are. There is now an international organization and it has only been meeting 2 years.

Mr. MACLEAN (*Queens*): There are no specific programs in the United States, for example, that you have studied and recommend that Canada should copy? I am thinking of special methods of relieving the financial burden on families with this condition.

Mr. MACIVER: No, and again, I think it varies from state to state.

Mr. MACLEAN (*Queens*): One other final question: Is there any noticeable variation in the difficulty of treatment with regard to the areas in which people live? In other words, is the disease worse, the condition worse, in cities where there is air pollution, and so on.

Mr. MACIVER: I should think Dr. Park could answer that question.

Mr. PARK: My impression—and it is only an impression—is that there really is no difference. If a child is being adequately treated the degree of air pollution that we get in this country, I think, makes virtually no difference. I think, perhaps, in a child that was not adequately treated—and there are still, I am afraid, quite a number of these, particularly in the outlying areas—this might make a difference, but my impression is really no.

Mr. BRAND: Have any of the provinces got a program which would satisfy you as far as the provision of drugs is concerned?

Mr. MACIver: I am sorry, I did not quite catch what you said.

Mr. BRAND: In any of the provinces do you find a provision relating to drugs and therapy particularly as far as cost is concerned, that you would like to see

in every other province of Canada? In other words, is there an ideal province in this group?

Mr. MACIVER: Well, in Manitoba, of course, all care expenses are taken care of by the provincial government.

Mr. BRAND: Purely provincial grants; is that right?

Mr. MACIVER: Purely provincial, yes.

Mr. BRAND: What about Saskatchewan; it seems to pay quite a bit, too?

Mr. MACIVER: Saskatchewan has taken care of most of the costs involved. Saskatchewan and Manitoba are the provinces that are leading in this field.

Mr. BRAND: They are leading in many areas, too, you would agree, of course.

The CHAIRMAN: Dr. Brand, you simply had to throw that in.

Mr. BRAND: Tell us about New Brunswick, Mrs. Rideout. Tell us about New Brunswick. It says here "no formal assistance, no formal assistance, no formal assistance".

The CHAIRMAN: Any other questions?

Mr. BRAND: I was not posing a question there; I was pointing out the situation.

The CHAIRMAN: Are there any other questions of the witnesses?

Mr. BRAND: Well, I would just like an overall impression from the group here. It is a rather depressing impression I get from your attempts to obtain assistance. This seems to be the overall impression. Mrs. Rideout has given that impression as well; she has been making representations; is that not right? And this rather disturbs, I am sure, the whole Committee. I refer to the difficulty you are having.

Mr. MACIVER: Well, I think it is probably depressing in the area that you mentioned, primarily because it is such a relatively new disease, on to put it that way very few people know about it; we have difficulty getting through to people that this is a very serious problem.

Mr. BRAND: You have difficulty in getting through to the government.

Mr. MACIVER: Oh, yes we have that, but this is improving. This is improving as time goes on.

Mrs. RIDEOUT: Mr. Chairman, this is just for the record and for Dr. Brand's information. Am I correct, gentlemen, in saying that representatives of your Foundation did meet with the officials of the department very recently? I do not know the results of the meeting, but I would hope that it was a start, and I feel that this is encouraging.

Mr. MCKENZIE: Yes, meetings were held with the Department of National Health and Welfare, the Minister and Mrs. Rideout. We, as a Foundation made a presentation involving the establishment of care, treatment and research centres at all medical centres across Canada, and this is still in the discussion stage.

Mr. BRAND: This is more for research and the treatment centres, primarily. You have made no representation regarding additional funds for drugs—provision of drugs, and things of that nature.

Mr. MCKENZIE: Not specifically, no.

Mr. HOWE (*Hamilton South*): Mr. Chairman, may I make the suggestion that although this is not truly within our terms of reference that we print this brief if it has not already been arranged for.

The CHAIRMAN: We have already agreed to do so.

Mr. HOWE (*Hamilton South*): So that it can be considered along with our recommendations.

Mr. RYNARD: Well, I was just wanting to ask a question Mr. Chairman. Have you statistics on how many cases are treated and are then able to carry on for indefinite periods without treatment? You give the impression perhaps, that they all have to be treated continuously, and this I think is the wrong impression, if our records on that are accurate.

Mr. PARK: Mr. Chairman, this is a matter of degree. This is a peculiar disease in that it has a very wide spectrum, if you like, of involvement. Some children will have mild involvement of their pancreatic glands and no chest involvement, while others will have chest involvement and nothing else. And you can have all degrees between these two, including the most severe cases in which both are involved. Some have sinus involvement, and so on. Consequently, you can get a number of cases that are very mildly involved, and these need—if you like—minimum treatment. Nevertheless, it has been our experience that these children do need some form of treatment, even if it is minimum, and more important, of course, supervision on a permanent basis. But I do not know of any child with cystic fibrosis who needs, no treatment whatsoever. They may need just one drug, but they do need something.

Mr. RYNARD: Do you mean they would have to be given one drug pretty well continuously?

Mr. PARK: Yes.

Mr. RYNARD: We have one that has got along very well, and this is a very hopeful aspect. This kiddy was in the Sick Children's Hospital, and I think has gone along for something like two years now without treatment.

Mr. PARK: Well, this is a very fortunate and rather exceptional case. It does happen, I agree, but nevertheless these children do need treatment from time to time very likely, and they need very careful supervision, too, because they are on the knife's edge, as it were; they can very easily go over.

Mr. RYNARD: That one would have been a chest case by the way, too. It started out with mucus and pneumonia and was treated for about 10 days and was gradually getting worse when they felt that they had a problem, and the kiddy went to the Sick Children's Hospital.

Mr. PARK: I might say that I am a little surprised that they have no treatment at all. It has been our experience that even in these good cases, in order to maintain them in good health, we often have to keep them in mist tents at night as a prophylactic measure, if your like.

Mr. RYNARD: She runs around as a normal child. I do not know how long this is going to last, but she goes back every once in a while for a check-up.

The CHAIRMAN: Any other questions, gentlemen, madam?

Mr. BRAND: While I agree with all the recommendations here, and with the intent of them, I just wonder, from the immediate point of view, if there is an answer in here as to what you can do to provide additional assistance. I really do not see that there is an immediate answer to some of these problems in your recommendations, and I wonder if there is not some other way in which it could be set up. I do not know, perhaps you have a suggestion. This does not seem to be

an immediate method of making provision of drugs for these children across Canada on an equitable basis, as you say in your brief. I mean they are all very general things; there is nothing very specific here.

Mr. MACIVER: We are certainly open for any suggestions.

Mr. BRAND: I do not think I have any other then those you have.

Mr. RYNARD: Well Mr. Chaimran I will come back to my original statement, I do not see why this could not be provided as we are providing drugs now to our cancer cases, to our diabetics and others.

Mr. MACIVER: This we would appreciate.

The CHAIRMAN: Just for clarification, cancer patients and diabetics are dealt with really differently. Diabetics can get their insulin through municipal green sheets; but the pills, and so on, of cancer patients, come through the cancer institute, do they not? They really are not dealt with the same; they are dealt with quite differently.

An hon. MEMBER: This is so.

The CHAIRMAN: Are there any other questions or comments? If not we would like to thank the gentlemen who have come before us this morning from the Cystic Fibrosis Association, and we thank Dr. Park, Mr. McKenzie and Mr. MacIver very much for making the presentation today, and we wish you every success in your association.

Mr. MACIVER: Thank you.

APPENDIX "A"

CANADIAN CYSTIC FIBROSIS FOUNDATION

Submission to

THE SPECIAL COMMITTEE

on

DRUG COSTS AND PRICES

Thursday, December 8th, 1966

CANADIAN CYSTIC FIBROSIS FOUNDATION

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Jeffrey A. Skelton,	(as above)

The Canadian Cystic Fibrosis Foundation is appreciative of the opportunity to present its story to the Special Committee, and to outline how financially crippling a chronic illness such as cystic fibrosis can be.

CANADIAN CYSTIC FIBROSIS FOUNDATION

History

The Canadian Cystic Fibrosis Foundation was organized in 1958 and incorporated in 1960. The Foundation was organized by parents of children afflicted with cystic fibrosis, interested citizens and members of the medical profession who undertook the task of establishing the Foundation to bring to the attention of the public the seriousness and enormity of the problem.

Since the establishment of the first Chapter in 1959, the Foundation has grown in size very rapidly. The Foundation has become truly national in scope, with twenty-two established Chapters, representing areas in every province from Victoria, B.C. to Halifax, N.S.

In the early years of the Foundation, all work and activities of a varied nature were done by willing volunteer aid. As each succeeding year passed, the problems of organization became more complex and too vast for volunteer aid to handle. Eventually it became necessary to seek assistance of a professional nature. The foundation arranged an affiliation with the Canadian Rehabilitation Council for the Disabled, from whom professional guidance and administrative assistance was obtained.

This association lasted for a few years, until the growth and development of the Foundation had broadened to such an extent that permanent administrative personnel were required whose sole duties would be to assist the volunteer members in the aims and program of the Canadian Cystic Fibrosis Foundation. This administrative office is located at 1 City View Drive, Rexdale, Ontario.

Budget

The first budget in 1960 and the budget set in 1966 further illustrates the rapid growth of the Foundation.

In 1960 the Foundation budgeted for $25,000.00, the bulk of the money going towards assisting parent members in the purchase of therapeutic equipment.

In 1966 the Foundation has budgeted for $438,800.00, a copy of the budget is enclosed. An amount of $100,000.00 for research and support of care and treatment centres is included, of which $63,000.00 is already committed for this year. Please note also that we have budgeted to commit the Foundation for an additional $250,000.00 for Care, Research and Treatment Centres in 1967. Each year we have set higher goals for the Foundation to attain. We do not always reach the magic figure, but we come close.

The Medical Advisory Committee of the Canadian Cystic Fibrosis Foundation determines the size of each grant to be offered and the Hospital or University where the research is to be carried out.

It is the role of the Foundation to provide the essential medical and lay leadership for the overall direction and co-ordination of the research program. Such co-ordination avoids pointless duplication of effort.

AIMS AND OBJECTIVES OF THE CANADIAN CYSTIC FIBROSIS FOUNDATION

(a) To link parents together into an organization to enable them to share their common experiences and problems.

(b) To co-ordinate and support efforts in research and diagnosis.

(c) To disseminate information to an uninformed public of the disease and the problems surrounding it.

(d) To focus public attention and enlist community support for the children suffering from cystic fibrosis and their families.

CYSTIC FIBROSIS

The Nature of the Disease

Cystic fibrosis of the pancreas is a chronic disease of childhood which has only been identified since 1938. Since that time the disease has been recognized

as the commonest cause of chronic lung disease in childhood as well as one of the most crippling diseases affecting children today.

The exact nature of cystic fibrosis is still not understood. Basically it is considered to affect all the mucus-producing glands of the body and particularly those in the gastro-intestinal and pulmonary systems. The mucus secretions produced by glands in these two systems are thick and tenacious—with the result that they block the small ducts which normally carry the mucus away to a point where it can be properly excreted.

In the gastro-intestinal system the result is a failure to digest foods adequately, causing failure of normal growth.

In the pulmonary system the result is chronic lung disease. The sticky secretions not only interfere with the free passage of air but also trap bacteria which in turn produce chronic infection and repeated pneumonia and can lead to permanent lung damage.

Incidence of the Disease

Cystic fibrosis is an inherited disease in which both parents of an affected child, although themselves healthy, carry the defective gene. Statistically about 1 in every 1,000 babies is born with cystic fibrosis and 1 in every 15 or 20 people in the general population carry the gene. This means that more than 500 babies born in Canada each year have cystic fibrosis and more than 900,000 Canadians carry the cystic fibrosis gene.

One out of every fifty deaths in childhood is caused by cystic fibrosis.

If the parents both have the cystic fibrosis gene their risk of having an affected child will be one chance in four with each pregnancy.

Treatment of the Disease

While fundamental knowledge about the nature of cystic fibrosis is still missing, we know that with early diagnosis, vigorous antibiotic treatment, inhalation of materials to cleanse the lungs and the administration of missing digestive enzymes, the life expectancy of the victim can be increased and their general health improved.

Until present methods of treatment were developed, cystic fibrosis was considered universally fatal under the age of two. Now, however, it is possible to treat these children satisfactorily, maintain them in a good state of health and prolong their lives considerably. Today there are many young adolescent patients with cystic fibrosis who are attending school regularly and a few patients have survived to adulthood.

Early diagnosis is mandatory for the best treatment of this disease. Diagnostic procedures include the sweat test, which is a measure of the salt content in the sweat—sweat chloride is abnormal in 99 per cent of children with cystic fibrosis. Any chronic chest diseases that are not otherwise explained should have a sweat chloride test. New methods of analyzing the salt in sweat include a silver electrode by which a direct reading can be done. Recently, a new test has been devised for measuring the actual amount of enzymes, namely trypsin and chymotrypsin in the feces. This is an accurate way of assessing partial or normally functioning pancreas in various cases of cystic fibrosis.

25510—3½

X-rays of the sinuses and chest are extremely helpful in making the diagnosis.

Treatment of the gastro-intestinal manifestations of cystic fibrosis consists in supplying the missing enzyme by giving pancreatic extract at the time of each meal. With this treatment digestion is greatly improved and the poor nutritional state is consequently ameliorated.

Far more involved is the treatment of the pulmonary manifestations of cystic fibrosis. In order to facilitate the movement of mucus along the bronchi, the patient is required to breathe moisturized air which liquefies the mucus. To accomplish this the child must sleep in a mist tent at night. During the day, the mist tent pump is used to produce a mist through a mask which the child applies to his face for periods of 15 to 20 minutes three or four times a day. Further treatment consists of postural drainage exercises. In addition, antibiotics, nose drops, anti-histamines and other drugs must be used from time to time.

For the most part treatment of cystic fibrosis can be carried out satisfactorily at home. Whenever a child develops a more serious infection it may become necessary for him to be admitted to hospital for a varying length of time.

CARE, RESEARCH and TEACHING CENTRES

The Canadian Cystic Fibrosis Foundation has incorporated a program to provide the funds required to establish Care, Research and Teaching Centres. The location of each centre to be established and the timing of its establishment is determined by the Medical and Scientific Advisory Committee.

The composition of the Medical Advisory Committee is truly national in scope. The members of the Committee are some of the most highly respected men in their profession.

Medical and Scientific Advisory Committee

Dr. W. A. Cochrane, Chairman	Professor & Head, Department of Paediatrics, Dalhousie University.
Dr. S. Israels	Professor & Head, Department of Paediatrics, University of British Columbia.
Dr. H. Medovy, Past Chairman	Professor & Head, Department of Paediatrics, University of Manitoba.
Dr. D. N. Crozier	Hospital for Sick Children, Toronto, Ontario.
Dr. J. McKee	Department of Paediatrics, University of Ottawa.
Dr. M. Belmonte	Montreal Children's Hospital.

Under the quidance of the above Medical Advisory Committee, the Canadian Cystic Fibrosis Foundation has established Care and Research programs in the following areas with continuing financial support.

Doctor in Charge	*Location*	*Amount of 1967 Grant*
Dr. S. Israels	University of British Columbia	$12,000.00
Dr. B. Sproule	University of Alberta	2,300.00
Dr. L. Hardy	University of Saskatchewan	7,400.00
Dr. P. Adhikari	Winnipeg Children's Hospital	13,080.00
Dr. D. Crozier	Hospital for Sick Children, Toronto	27,764.00
Dr. R. Lasalle	Hôpital Ste-Justine, Montreal	10,000.00
Dr. M. B. Wise & Dr. R. Goldbloom	Montreal Children's Hospital	8,505.00
Dr. J. Duvenci	McGill University	7,037.00
Dr. W. A. Cochrane	Halifax Children's Hospital	10,000.00
	Total	$98,086.00

The above program, though modest, is a start on a research program. The program is organized by the Medical Advisory Committee and they strive to eliminate any duplication of effort. Prior to research programs instituted by the Foundation, little if any organized research into the cause and nature of cystic fibrosis was being carried out in Canada.

The programs of research that the Foundation is supporting are not confined to research into the cause of cystic fibrosis. The program embraces the broad spectrum of other respiratory problems.

The Medical doctors who are heads of the cystic fibrosis clinics throughout the country, have broadened the scope of the clinic to embrace patients with respiratory problems such as Karthagener's syndrome, asthma, bronchitis and bronchiectasis. Some of the patients with these other respiratory problems are using the mist therapy treatment developed for cystic fibrosis patients and have shown some improvement.

Drug Program

During the early years of the program, the types of antibiotics used by the medical profession varied from doctor to doctor. The cost of these drugs also varied a great deal.

One of the severe problems encountered in the use of some of the earlier drugs was the gradual building of resistance to the drug until finally the drug had to be changed in order to combat infection. Information gleaned from parents presented a picture of the medical doctors treating the children, experimenting in a sense, with different types of antibiotics. Criticism of the medical profession is not the intention here. The medical profession does not as yet know a great deal more of the cause of the problem, but in 5 short years they have learned a great deal more about the required treatment of the disease.

In the period from 1960 until the present time, new and much more effective drugs have been developed. One of the best features of the development is that

as soon as a child develops an immunity to a drug, a new drug has appeared on the market. The worst feature, from a parent's point of view, is the extremely high cost of these drugs.

Drug Costs

Another unfortunate feature is the inequity of cost of drugs from coast to coast in this great land of ours. The drugs even vary in cost from clinic to clinic in the same province, and from drug store to drug store in the same city. Some parents do benefit to a small degree in being able to purchase their drugs through hospital pharmacies but this again varies from hospital to hospital. If the family happens not to live near a large centre (where all the clinics are located) and their child gets ill, the cost of additional drugs purchased through a local pharmacy at retail prices is catastrophic to the average wage earner. Even at hospital pharmacy costs, the burden of these drug costs is beyond the average family.

The Foundation has conducted a survey of its parent members recently with respect to the high costs of treatment. The questionnaire forwarded to the parent members in all provinces, asked for information with respect to cost of treatment including drugs. The questionnaire also requested information regarding extent of assistance received by members from governments or other organizations. The information gleaned from the questionnaire has proven to be very interesting and illuminating to our own Foundation. It should be of interest to the Government Special Committee from a consumer's point of view.

The questionnaire also reveals a great inequity of treatment from province to province.

Some families are receiving complete drug subsidization by provincial governments, some are receiving partial subsidization by provincial governments, some are receiving no assistance at all. There are many families who strive to carry the tremendous financial burden themselves and who do not ask for assistance.

While this demonstrates an admirable spirit of independence, it does place a severe strain on family life, financially, emotionally and physically.

Psychiatric Ramifications

Until recent years, cystic fibrosis children have not lived into their late teens or adulthood. Today, due entirely to improved drugs and treatment, we have many children reaching this stage. A very disturbing problem is now developing in some of the teenagers—the need of psychiatric therapy.

Our medical advisors predicted this would happen. This development occurs with many handicapped children and is now coming to light with some of the cystic fibrosis children. The prognosis for these children is much brighter than a few years ago, but their future is not clear. Only research can improve the outlook. These children are intelligent, and their reaction to their prognosis is understandable, and yet very alarming and troubling to their parents.

APPENDIX A

Shows breakdown of drugs used and costs borne by cystic fibrosis families in each province. The case histories shown are typical with the exception of the family in Ontario with four cystic fibrosis children.

APPENDIX B

Illustrates assistance provided in each province whether it be governmental or private.

Note under Appendix B that there are many different types of vitamins required in the treatment of cystic fibrosis, the costs of which are not paid by any of the provincial bodies. The propylene glycol and distilled water used in the mist tent in which the children sleep, while not very expensive, are an additional burden.

Subsidiary costs

Food costs are higher because cystic fibrosis children cannot eat certain foods and are usually on a high protein diet. Many families live in areas that do not have a clinic and are further burdened by bus, train or plane fare to the clinic in the larger centre. These trips normally have to be made every two months. Additional costs on out of town trips to clinics are incurred by the eating of meals in restaurants and hotel accommodation if it becomes necessary to stay overnight, as often happens if clinicians decide further tests have to be taken. Very often, the father in the family must take time off from work to accompany the child or children to clinic as the mother must stay home to look after other children. This can also be a loss in income to the family, depending upon the nature of the parent's work.

A further additional hidden cost is the increase in hydro cost, estimated at approximately $10.00 per month. This cost occurs because of the necessity of running a compressor (or compressors) all night long to produce the mist in the therapy tent where the child sleeps.

Cystic fibrosis has a deteriorating effect on the teeth of many children. The teeth discolour and decay requiring approximate yearly costs of $60.00 for dental treatment.

By way of comparison the comparative net incomes are shown of a cystic fibrosis family and non-cystic fibrosis family in same income bracket—say $6,000.00, with two children. We will use costs for one cystic fibrosis child.

	Non-C/F	*C/F*
Gross Income	$6,000.00	$6,000.00
Allowable tax deductions	2,600.00	2,600.00
Net Income	3,400.00	3,400.00
Allowable tax deductions	100.00	
—or—		
Medical expenses in excess of 3% of income		1,020.00
Net taxable income	3,300.00	2,300.00
Tax on taxable income	453.00	302.00

Pharmaceutical Association statistics show that the average Canadian spends a maximum of $10.00 a year on prescription drugs.

The non-C/F family spends 4 × $10. = $40.00/year on drugs.
The non-C/F parent after taxes has $6,000. — ($453. + $40.) = $5,507.00 to feed, clothe, etc. his family.
The C/F parent after taxes has $6,000. — ($302. + $1,200.) = $4,498,00.

Note: Obviously, the C/F parent, because of the income tax inequity, cannot support his family to the same extent as the non C/F parent.

The unfortunate C/F family has $1,000.00 less income on which to live than his equivalent without a C/F child. The previously shown figures are calculated on Ontario residents. Provincial taxes in some other provinces are more severe and make the situation worse.

A Pharmaceutical Association-sponsored study showed that only 1.4% of all prescriptions dispensed in Canada were over $10.00. If this statement is correct then illnesses such as cystic fibrosis which require expenditures upwards of $1,000.00 must be an infinitesimally small proportion of the 1.4% referred to above.

Truly, cystic fiibrosis can be classed as a catastrophic illness, and as such deserves and should be given special and immediate attention by the Federal Government. All other illnesses that fall into the same catastrophic category, due to a heavy financial burden imposed on a family, deserve the same special consideration.

Conclusion

In conclusion, the Canadian Cystic Fibrosis Foundation wishes to state that:

(a) We are grateful that the drugs necessary to prolong the children's lives are available.
(b) We place no blame for high costs of cystic fibrosis drug treatment on other than sheer abnormal quantity of expensive drugs required.
(c) Frankly, we are appearing as a special interest group who want the cost of drugs and treatment for cystic fibrosis kept to an absolute minimum.
(d) We are representative of the less than 1.4% of population affected to any great extent by the high cost of drugs. The deductible amount considered reasonable by the Federal Government for medical expenses, is more than adequate for the average Canadian. However, we do believe that cystic fibrosis qualifies as a catastrophic illness that should be given special and immediate consideration.
(e) The ready availability of required drugs is just as important as the availability of the physicians who prescribe them.

RECOMMENDATIONS

That:

1. Cystic fibrosis receive the same recognition as diabetes and other chronic diseases as evidenced by exemption of insulin, liver extract, etc. from Federal Sales Tax.

*All drugs prescribed for cystic fibrosis patients to be exempt from Sales Tax.

2. Remove Federal Sales Tax from prescription drugs. Sales Tax pyramids cost of drugs to consumer of every prescription.

3. All patients with chronic illnesses such as cystic fibrosis which of necessity sustain long term drug therapy, should receive consideration for additional governmental assistance.

4. The medical care insurance program should also include coverage for expense of all prescribed drugs including nutritional supplements.

5. The Federal Government should immediately institute some form of the above recommendations in order that all cystic fibrosis patients receive equitable treatment in all areas of Canada.

6. The Federal Government should provide funds for additional research in search of a cure for cystic fibrosis.

APPENDIX "A"
to Submission

	Province	Drug	Monthly Cost	Pancreatic Extract	Monthly Cost	Other	Monthly Cost	Total Monthly Cost	Comments
Case A	Yukon Territories..	Teletrycin	$20.00	Cotazym	$18.00			$38.00	
Case B	British Columbia...	Orbenin Staphcillin	$55.74 $61.00	Cotazym	$19.27	Poly-Vi Tabs Propylene-glycol	$ 1.12 $ 1.60	$138.73	Only in the last month have free drugs been made available—cost borne by Provincial Government
Case C Two children)	British Columbia...	Isyprel Neosynephrine	$20.00 $10.00	Cotzaym	$80.00	Multi-vitamins Propylene-glycol	$ 6.00 $ 3.00	$119.00	Provincial Government bearing cost of drugs
Case D	British Columbia...	Neosynephrine	$60.00	Intrazyme	$10.00	Poly-vi-sol Propylene-glycol	$ 7.50 $12.00	$89.50	Provincial Government bearing cost of drugs. Additional costs: Plane fare—$138.00—Babysitter $2 to $5:00/day
Case E	British Columbia...	Penbritin Neomicin aerosol	$19.00 $ 5.00	Viokase	$22.00	Vitogens	$ 6.00	$52.00	Provincial Government bearing cost of drugs
Case A	Alberta.....	Ilosone, Albamicin, Orbenin, Penbritin, Lincomicin	Free	Intrazyme	Free	Vitamins Propylene-glycol	$ 4.00 $10.00	$14.00	Alberta Government now paying for drugs and pancreatic extract
Case B	Alberta.....	Oxicillin, Erythromycine, Tetracyclene, Ampicillin	Free	Intrazyme	Free	Vitamins Propylene-glycol	$ 5.00 $ 5.00	$10.00	Alberta Government paying for drugs and pancreatic extract. Prior to Government assistance—$70.00 monthly cost
Case C	Alberta.....	Isyprel, Ilosone	Free	Intrazyme	Free	Infantol Propylene-glycol	$ 1.00 $ 5.00	$ 6.00	Alberta Government paying for drugs and pancreatic extract.
Case D	Alberta.....	Promatussin	$10.00			Poly-vi-tabs	$ 1.12	$11.00	No assistance—Deceased C/F child died at age 13. This child cost family $50-$100/month.
Case A	Saskatchewan.....	Ilosone	Free	Pancreatin	Free	Propylene-glycol	$10.00	$10.00	Saskatchewan Government paying all drug and pancreatic costs since November, 1965.
Case B	Saskatchewan.....	Celbenin Cepracycline Ampicillin	Free	Pancreatin	Free	Vitamins Propylene-glycol	$ 6.00 $ 6.50	$12.50	Saskatchewan Government paying all drug and pancreatic extract costs. Prior to assistance $190.00 per month.
Case C	Saskatchewan.....	Neomycin Icyprel	Free	Viokase	Free	Tri-vi-sol Fer-in-sol Propylene-glycol	$ 3.50 $ 2.50 $ 6.50	$12.50	Saskatchewan Government paying all drug and pancreatic extract costs.

Manitoba—All drug and care expenses, plus many supplementary expenses are paid by Manitoba Government. Families have little financial burden.

Case A	Ontario.....	Mucomyst Lincocin		Cotazym		Poly-vi-sol Vitamin E Winstrol		$230.00	Ontario Society for Crippled Children administering provincial and federal Government grant (50-50) of $250,000
Case B	Ontario.....	Lincocin Mucomyst Orbenin Staphcillin		Intrazyme		Poly-vi-tabs Propylene-glycol Travelling	$ 2.00 $10.00 $ 6.00	$210.00	This family contributes $40.00 monthly towards drug costs. Ontario Society for Crippled Children pay for drugs and pancreatic extracts from Government grant.
Case C	Ontario.....	Orbenin	$63.00	Intrazyme	$26.00	Poly-vi-sol Vitamin E	$ 2.00 $ 2.20	$93.20	This family is not receiving any assistance.
Case D	Ontario.....	Lincocin Mucomyst Lincocin Capsules	$75.00 $52.42 $61.14	Intrazyme	$11.62	Poly-vi-tabs	$ 1.24	$201.42	Private medical insurance covers portion of expenses—family pays balance.
Case E	Ontario.....	Lincocin Mucomyst Lincocin Capsules		Intrazyme		Poly-vi-tabs		$240.00	This family receives no assistance.
Case F	Ontario.....	Lincocin Mucomyst Orbenin Staphcillin Neo-synephrine	$18.72 $29.97 $27.00 $50.00 $ 1.50	Cotazym	$63.00	Vitamin E Poly-vi-tabs Atarax Propylene-glycol	$19.20 2.00 2.00 6.00	$220.00	This family receives no assistance. They purchase drugs through a hospital pharmacy. If they had to purchase through local druggist—cost would be much higher.
Case G	Ontario.....			Cotazym	$40.00	Psychiatric Therapy	$100-$125	$165.00	No Assistance—Psychiatric therapy is a new and troubling area of treatment developing as children reach teenhood.
Case H	Ontario.....	Lincocin Aureomycin Prostaphlin Erythromycin Albamycin Sulfadiazine Organadin Neomycin		Viokase	$80.00	Poly-vi-tabs Riboflavin Propylene-glycol	$10.00 $ 3.50	$90-$100	Ontario Society for Crippled Children pays for drugs and pancreatic extracts. This case is most unusual—four afflicted children in one family. Before Crippled Children came into the picture, this family attempted to pay for all expenses. The burden was impossible—some assistance was given locally by the local Chapter of the Foundation.
Case A	Quebec.....	Prostaphylin		Cotazym		Poly-vi-sol Winstrol X-rays, etc.		$100.00	No assistance in this province
Case B	Quebec.....	Ilosyn Organadin	$10.00 1.00	Cotazym	$20.00	Poly-vi-tabs Winstrol Oval	$ 3.00 2.00 1.00	$ 37.00	No assistance
Case A	Nova Scotia.....	Ampicillin Organadin	12.50 2.50	Cotazym	5.00	Propylene-glycol	6.00	$ 26.00	This family receives no assistance
Case B	Nova Scotia.....	Lincocin Mucomyst Neomycin	30.00 40.00 18.00	Viokase	26.00	Vitamins Propylene-glycol	2.00 1.00	$117.00	This family receives no assistance
Case C (2 children)	Nova Scotia.....								All costs are borne by the Department of Public Health

	Province	Drug	Monthly Cost	Pancreatic Extract	Monthly Cost	Other	Monthly Cost	Total Monthly Cost	Comments
Case D (2 children)	Nova Scotia.....	Ampicillin Tetracycline Neosynephrine	35.00 40.00 39.00	Cotazym	36.00	Vitamins Propylene-glycol		$150.00	This family receives no assistance
Case A	P.E.I.....	Prostaphylin Neomycin Neosynephrine	33.00 14.00 1.50	Cotazym	10.50	Vitamins	$ 2.00	$ 61.00	This family receives some assistance from local Rotary Club. Some drugs free from hospital.
Case B	P.E.I.....	Lincocin Chloromycetin	28.80 21.60	Intrazyme	9.60	Multi-vitamins Vitamin B Propylene-glycol Medical exp.	$ 3.60 2.40 10.00 10.00	$ 86.00	Assistance from P.E.I. Rehabilitation Council, which pays up to $600. per annum.
Case A	Newfoundland.....	Ilosone	Free	Viokase	Free	Proplyene-glycol Medical exp.	Free $30.00	$ 30.00	This family receives drugs free from Department of Health

APPENDIX "B"
to Submission

THE CARE PROGRAM IN EFFECT IN THE VARIOUS PROVINCES ACROSS CANADA IS OUTLINED BELOW

	Prescription Drugs Antibiotics, etc.	Other Care Items Dietary supplements, vitamins, etc.	Equipment Mist tents, Nebulizers, etc.	In-Hospital Requirements X-rays, sputum cultures, etc.
NEWFOUNDLAND..	Dept. of Health will accept, on recommendation of their Welfare Officers, invoices for drugs prescribed for Newfoundland C/F children.	No formal assistance	Dept. of Health includes these as well, through the same channels.	There is a province hospital program covering in-service.
NOVA SCOTIA.....	No Formal Assistance	No Formal Assistance	No Formal Assistance	Province has an "In-Hospital" Insurance Plan.
PRINCE EDWARD ISLAND	Rehabilitation Council assists.	No Formal Assistance	Rehabilitation Council assists.	Unknown.
NEW BRUNSWICK..	No Formal Assistance	No Formal Assistance	No Formal Assistance	No Formal Assistance
QUEBEC.....	No Formal Assistance	No Formal Assistance	Supply and administration through Crippled Children's Society in Montreal area, assisted (+50%) by Provincial Government Grant.	No Formal Assistance
ONTARIO.....	Provincial Grant of $125,000, matched by a similar grant from the Federal Government, administered by Crippled Children's Society, for home therapy, drugs, and initial purchase of equipment.			No Formal Assistance
MANITOBA.....	All Cystic Fibrosis patient care expenses and many supplementary expenses are paid by the Provincial Government.			
SASKATCHEWAN....	Federal grant of $24,000 for the first year to support a program of the Medical Services Division of the Saskatchewan Department of Health, which pays for therapy equipment, drugs, and protein food supplements.			Comes under the Saskatchewan Hospital Service Plan
ALBERTA.....	Government will pay on receipt of invoices for drugs as approved.	C/F Association of Alberta receives $2,000 grant from Provincial Government. Province pays 80% of Physiotherapy Treatment.		Hospital costs $2.50 per day. Government pays rest of costs.
BRITISH COLUMBIA	Drugs now being paid for by Provincial Government as of November 1st, 1966. Further assistance indicated.			No Formal Assistance

APPENDIX 'C' to Submission

CANADIAN CYSTIC FIBROSIS FOUNDATION

Budget

Projected Statement of Income & Expenditure & Accumulated Income 1966

Income			
Chapters—existing methods less Christmas Cards (net)	$100,000.00		
Christmas Cards—Chapters & Central (net)	40,000.00		
Total—(net National contribution)		$140,000.00	
Other service clubs & organizations		10,000.00	
Donner Foundation		25,000.00	
Affiliated C.F. Organizations (net)		18,000.00	
Kinsmen (Dist. 8)		20,000.00	
Shinerama (gross)		35,000.00	
March of the Teenagers (gross)		100,000.00	
Medical Home Care Equipment		10,000.00	$358,000.00
Accumulated Income Dec. 31/65			80,800.00
			$438,800.00
Expenditures—National Office			
Administrative (incl. salaries)		28,500.00	
Public awareness (Literature & films)		5,800.00	
Exhibits (medical & lay)		2,000.00	
Expo '67 exhibit		5,000.00	
Chapter development		6,000.00	
Public Relations & promotional		3,500.00	
Kinsmen (speakers, lit. etc.)	2,000.00		
March of Teens & Shinerama	36,000.00	38,000.00	
(most areas—initial year)			
Lay meetings & conferences		10,000.00	
Medical Conferences		9,000.00	
Medical Home Care Equipment		10,000.00	117,800.00

Research Centre Grants (already committed)	63,000.00		
Centre Project (66 requirements)	40,000.00	103,000.00	
(67 commitments)	100,000.00		
Research Grants (67 commitments)	150,000.00	250,000.00	353,000.00
			$470,800.00
Projected *debit* position Dec. 31/66			32,000.00
cash vs. commitments			$438,800.00

NOTE: This budget does not include expenditures at the chapter level and, as a result, the income from chapters is shown as net to National also.

OFFICIAL REPORT OF MINUTES

OF

PROCEEDINGS AND EVIDENCE

This edition contains the English deliberations and/or a translation into English of the French.

Copies and complete sets are available to the public by subscription to the Queen's Printer. Cost varies according to Committees.

Translated by the General Bureau for Translation, Secretary of State.

LÉON-J. RAYMOND,
The Clerk of the House.

HOUSE OF COMMONS

First Session—Twenty-seventh Parliament

1966

STANDING COMMITTEE

ON

DRUG COSTS AND PRICES

Chairman: Mr. HARRY C. HARLEY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 26

TUESDAY, DECEMBER 13, 1966

WITNESSES:

Representing Jules R. Gilbert, Ltd: Mr. Jules R. Gilbert, Ph.G., B.S.Chm.E., of Toronto.

ROGER DUHAMEL, F.R.S.C.
QUEEN'S PRINTER AND CONTROLLER OF STATIONERY
OTTAWA, 1967

25512—1

SPECIAL COMMITTEE ON DRUG COSTS AND PRICES

Chairman: Mr. Harry C. Harley

Vice-Chairman: Mr. Patrick T. Asselin (*Richmond-Wolfe*)

and

Mr. Brand,
Mr. Clancy,
Mr. Côté (*Dorchester*),
Mr. Enns,
Mr. Forrestall,
Mr. Goyer,
Mr. Howe (*Hamilton-South*),
Mr. Howe (*Wellington-Huron*),
Mr. Hymmen,
Mr. Isabelle,
Mr. Johnston,
Mr. MacDonald (*Prince*),
Mr. Mackasey,
Mr. MacLean (*Queens*),
Mr. O'Keefe,
Mr. Orlikow,
Mrs. Rideout,
Mr. Roxburgh,
Mr. Rynard,
Mr. Tardif,
Mr. Whelan,
Mr. Yanakis—24.

(Quorum 10)

Gabrielle Savard,
Clerk of the Committee.

MINUTES OF PROCEEDINGS

TUESDAY, December 13, 1966.
(36)

The Special Committee on Drug Costs and Prices met this day at 9.45 a.m. The Chairman, Mr. Harry C. Harley, presided.

Members present: Mrs. Rideout and Messrs. Asselin (*Richmond-Wolfe*), Forrestall, Harley, Howe (*Hamilton South*), Howe (*Wellington-Huron*), Hymmen, Isabelle, MacDonald (*Price*), Mackasey, Rynard, Tardif, Yanakis—(13).

In attendance: Representing Jules R. Gilbert, Ltd.: Mr. Jules R. Gilbert, Ph.G., B.S. Chm. E., of Toronto.

Also in attendance: Mr. A. M. Laidlaw, Q.C., of Ottawa, Legal Counsel for the Committee.

The Chairman referred to correspondence dealing with matters brought up at previous meetings.

Agreed,—That the following letters be printed into the record:

1. Letter from the Treasurer and Controller of Cyanamid of Canada Limited, dated November 15, 1966, on the definition of Investment (*See Appendix "A"*).
2. Letter from the President of Charles E. Frosst & Co. dated November November 15, 1966, with reference to sale of Frosst Products in export markets, in answer to questions asked by Mr. Howe (*Hamilton South*) (*See Appendix "B"*).
3. Letter from the Executive Director of the Ontario Pharmacists' Association, dated November 16, 1966, expressing support to the submission of the Canadian Pharmaceutical Association and offering assistance to the Committee (*See Appendix "C"*).

The Chairman also submitted to the Committee the April 15, 1966 Report of the Special Committee appointed by the Minister of National Health and Welfare to study existing legislation on investigational drugs, and containing recommendations concerning preclinical trials of new drugs

Agreed,—That copies of a letter dated December 12, 1966 from the Vice-President and General Manager of Smith Kline & French Inter-American Corporation be distributed to the Members of the Committee.

The Committee proceeded to the consideration of the submission of Jules R. Gilbert, Ltd.

The Chairman introduced Mr. Gilbert who was questioned.

25512—1½

Agreed,—That the brief be taken as read and appended to this day's proceedings (*See Appendix "D"*).

Mr. Gilbert was further questioned by the Members and by Mr. Laidlaw.

The Chairman thanked Mr. Gilbert for coming before the Committee and presenting a brief.

At 12 o'clock noon, the Committee adjourned to January 12, 1967.

Gabrielle Savard,
Clerk of the Committee.

EVIDENCE

(Recorded by Electronic Apparatus)

TUESDAY, 13 December, 1966.

The CHAIRMAN: Ladies and gentlemen, will you please come to order. This is our last meeting before the Christmas Season.

There are several pieces of correspondence that I would like to have put on the record, which deal with the committee's request for further information to that which was given to us in presentations.

Some of this correspondence is rather lengthy and there are a great many figures. One is from Cyanamid concerning definitions of investment as a result of some cross-questioning that had taken place between our accountant and the company. I would like this letter from Cyanamid made part of today's record so that members will be able to read it. Is that agreed?

Some hon. MEMBERS: Agreed.

The CHAIRMAN: There is also a letter from Charles E. Frosst and Company in answer to questions asked by Mr. Howe regarding the sale of Frosst products and export markets. That also should become part of today's record.

Mr. HOWE (*Hamilton South*): I asked that question of two companies, Frosst was one and I think Parke, Davis & Company Ltd. was the other, although I am not sure. I asked for a comparison of prices between their export products f.o.b. the company to Canada and to other companies. Is that the answer from Frosst?

The CHAIRMAN: Yes, this concerns Falapen, and they also sent a representative list of other major products that are exported to Japan with prices in equivalent Canadian dollars, excepting Federal sales tax. I think we should make these part of today's record.

Some hon. MEMBERS: Agreed.

Mr. HOWE (*Hamilton South*): Could I see the letter in the meantime.

The CHAIRMAN: Yes. There is also a letter from the Ontario Pharmacists Association. They had wished to appear before us. They almost completely support the position taken by their own group, the Canadian Pharmacists Association. I think this letter should become part of today's record as well.

Some hon. MEMBERS: Agreed.

The CHAIRMAN: Going back to the work of the committee in the previous session, members who were on that committee at that time will recollect one of the recommendations that the committee made was that the new regulations of the Food and Drug Directorate concerning pre clinical trials of new drugs be reviewed in one year. This has been done and the Minister of Health and Welfare, Mr. MacEachen sent me three copies of that report. I will leave these

with the clerk so that committee members can see them. They should not become part of this record. I think it is evidence that sometimes the Minister does take our recommendations seriously.

There is one other letter that I have just received this morning from Smith Kline & French company which deals with Mr. Gilbert's appearance before the committee this morning. I really have not had time to study it.

Mr. MACKASEY: Perhaps it could be attached as an appendix to today's proceedings and then we would have both sides of it.

Mr. HOWE (*Hamilton South*): Who is it from, Mr. Chairman.

The CHAIRMAN: It is from Smith Kline & French, signed by Mr. Daly, the Vice-President and General Manager. Rather than perhaps print this letter as an appendix, I could see that members get copies of it.

Mr. HOWE (*Hamilton South*): I do not think it should be printed as an appendix.

The CHAIRMAN: All right. Is it the wish of the committee that copies of this letter be made available.

Some hon. MEMBERS: Agreed.

Mr. HOWE (*Hamilton South*): Could I have that letter now, please?

The CHAIRMAN: Yes. We have before us this morning the last witness before Christmas, Mr. Jules Gilbert from Toronto, who represents his own company Mr. Gilbert has an opening statement to make. You all have had his brief in your possession for more than one week.

Mr. JULES R. GILBERT, Ph.G., B.S., Ch.E. (*Jules R. Gilbert Ltd.*): Since our submission was prepared there have been several newsworthy occurrences which are related to our submission and which tend to support our stated position.

1. About two weeks ago the *Financial Post* reported that the P.M.A.C. had made representations to the Department of Industry for the purpose of strengthening the patent law in accordance with their wishes. In exchange they would agree to become good Canadian companies, a tacit admission that they had not been nor do they propose to be good Canadians unless they receive special protection and consideration.

2. The Canadian Cystic Fibrosis Foundation reported on the high cost of drugs to the Foundation and their membership. They also reported that they were refused help by the pharmaceutical organizations. We feel sure that any generic drug house would have helped them save a considerable part of their drug costs.

3. Last week it was reported that the United States Department of Commerce and Industry—I may not have the department correct—ruled that the Pfizer patent on tetracycline was obtained by misrepresentation of facts. Pfizer denies this, but at the same time began to liberally license tetracycline in the United States.

These three happenings serve to support the substance of our submission.

Our submission has been made without reservation and we hope that because of the too short time that will be allowed for examination the

committee will concern itself with the major issues and not with the economic details of a company that is doing less than one per cent of the total drug business in Canada.

We wish to summarize as follows:

Our submission was occasioned by the unsubstantiated accusations of Smith Kline & French regarding our product triperazine. We hope that the committee will set the record straight on this subject.

Our company produces and sells in excess of forty million doses of drugs per annum. This factor should allay any fear regarding the quality of our product and if these drugs were sold on the basis of the brand name equivalent, our business would be in the millions.

The subject of merchandising power, the good of it and the evil of it, should it be protected or penalized? Or, the economic balance of interest to Canada, should it protect the foreign interests or should it take steps by a moratorium on patents to help Canada become a drug producing and exporting nation?

The patent system should no longer be a one-way street in favour of the patentee. Should there be penalties for false patenting if the patents cannot be successfully sustained in the courts?

We have one additional recommendation to make to supplement our submission. We believe that the Food and Drug Directorate should be empowered and directed to permit governmental agencies to use alternative sources for new drugs on their own responsibility. We think this would be proper because these drugs could be used under the supervision of qualified professionals and would not be for general distribution. This could result in a considerable saving in mental and tubercular medication. Thank you.

The CHAIRMAN: Thank you very much Mr. Gilbert. The meeting is open for questioning.

I think we should again go back to our time system this morning to try to even the questioning off between various members.

Mr. FORRESTALL: Mr. Chairman, I cannot help but note from this brief and from the subsequent supplementary statement made by Mr. Gilbert the very distinct impression that we are becoming somewhat of a public relations forum for certain drug companies in Canada, and I want to register a mild protest about it.

Also, I hope that none of the committee members will involve themselves in what appears to be a litigation in respect of the letter that has just been handed to us and our guest panelist this morning. I questioned ten or eleven of them. I would like to ask the witness whether or not you consider yourselves simply a wholesale distribution house?

Mr. GILBERT: We are a manufacturer in every sense of the word, as much as any major drug house in this country, by the same connotation.

Mr. FORRESTALL: What then, for example, would be the extent of your medical staff, your scientific staff.

Mr. GILBERT: We have no medical staff.

Mr. FORRESTALL: You have no scientific staff?

Mr. GILBERT: With the exception of myself.

Mr. FORRESTALL: Do you then seek outside medical and scientific help?

Mr. GILBERT: On occasion. We work in conjunction with certain doctors on certain problems.

Mr. FORRESTALL: Under what conditions would you seek outside help?

Mr. GILBERT: Well if there is a new product. For instance, our company is very much interested in the promotion of the use of nicotinamide and nicotinic acid, which is probably a type of product which would have no interest to the major companies, because it is non-patentable.

Mr. FORRESTALL: Would you normally expect the medical profession to refer themselves back to you if they had some kind of difficulty with certain of your products?

Mr. GILBERT: We would be pleased to give them every co-operation.

Mr. FORRESTALL: Has this been the standard practice.

Mr. GILBERT: We have never refused it to anyone.

Mr. FORRESTALL: What I am asking is, have you ever been asked for it?

Mr. GILBERT: Yes.

Mr. FORRESTALL: Frequently?

Mr. GILBERT: Not frequently, but we have been asked.

Mr. FORRESTALL: You have a little history of rubbing some people the wrong way or being left with the impression that they rub you the wrong way. How do you go about getting yourself into all these difficulties, which you seem to have a record for?

Mr. GILBERT: Actually, I think we have minded our own business, it is just that certain people do not like what we are doing and that is what raises the controversy.

Mr. FORRESTALL: What do you mean when you say they do not like what you are doing?

Mr. GILBERT: Perhaps we are too good at copying.

Mr. FORRESTALL: Yes, I noticed some place, that you are pretty proud of the fact that you are a copier and a good copier.

Mr. GILBERT: That is right. I think it serves a definite economic purpose.

Mr. FORRESTALL: What economic purpose does it serve?

Mr. GILBERT: It gives the professionals a choice of products, otherwise there would be no choice.

Mr. FORRESTALL: What in your opinion do you think the role of this committee is?

Mr. GILBERT: To bring down the cost of drugs in Canada.

Mr. FORRESTALL: How do you think we could do that?

Mr. GILBERT: By rendering competition free. In other words, we do not ask for any protection. Contrary to the P.M.A.C.—and it has been brought out in an ad here, which is threatening the Canadian public that they will depart from Canada if they do not get this protection. We ask for nothing; just to be left alone and given a chance to produce our products.

Mr. FORRESTALL: And at the same time you ask that they not be protected either.

Mr. GILBERT: I think that would be contrary to our interests.

Mr. FORRESTALL: To get back to a trend of thought I had earlier. Could you perhaps outline for the Committee your basic standards for quality control processes?

Mr. GILBERT: We abide by the 47-GP-1 regulations with regard to quality controls. We have recently introduced a technical expert graduate from a pharmaceutical college to actually take physical control of every step in the processing. He has nothing to do with production, but he has to O'K everything that leaves the plant during the process right through to the final stages. Our products are analyzed by a commercial laboratory because we do not have our own laboratory, but this I think is an advantage to the public.

Mr. FORRESTALL: Do you still use South Peel labs?

Mr. GLBERT: It is not South Peel labs; it is Polytechnic Labs.

Mr. FORRESTALL: Does your firm now measure up to the 74-GP-lb standards?

Mr. GILBERT: That is a subject of controversy at the moment.

Mr. FORRESTALL: Controversy between whom?

Mr. GILBERT: Food and drugs and ourselves.

Mr. FORRESTALL: We will not get into that area, because that is another matter of discussion.

I notice from your catalogue, Mr. Gilbert, that in your attempt to bring drugs down to a lower price for people you use a lot of gimmicks. Is this a regular part of your selling pattern and program?

Mr. GILBERT: It is our form of merchandising, yes.

Mr. FORRESTALL: Is it successful?

Mr. GILBERT: We are selling drugs, and people are requesting the gimmicks: therefore, it must be successful.

Mr. FORRESTALL: Do you put them in because people expect the gimmicks?

Mr. Gilbert: No.

Mr. FORRESTALL: Do they ask you for them?

Mr. GILBERT: The opportunity is offered to them to ask for it, but they do not have to take it if they do not want to.

Mr. FORRESTALL: That would be worth pursuing for awhile too. None of these things that are an addition to drugs, dosages and what are sold by you; they are awards or inducements to purchase in larger quantity?

Mr. GILBERT: You will have to be more specific.

Mr. FORRESTALL: You say for example at page 62 of your catalogue: A $2,000 order which includes 100,000 tablets or capsules at the special prices along with other items in the catalogue, qualify for an M.D. frigidaire as a bonus.

Mr. GILBERT: That is right.

Mr. FORRESTALL: How many of these did you give away last year?

Mr. GILBERT: Three.

Mr. FORRESTALL: How many have you budgeted for next year?

Mr. GILBERT: I do not know.

Mr. FORRESTALL: If you were to remove these things, would it affect your business?

Mr. GILBERT: I do not think so.

Mr. FORRESTALL: Not if you have only given three away.

Mr. GILBERT: It would not affect us materially.

Mr. FORRESTALL: I have three other questions which will take a bit of time, so I will pass for now.

Mr. MACKASEY: Mr. Gilbert, I read your brief with a great deal of interest and I tried to break it down into three different areas, because I think there are three different areas in your brief. One is your running battle with Smith Kline & French—and I suppose you have the right to answer their brief; the second is the Food and Drug Directorate and third, the area of patents.

I would like to talk to you about the area of food and drugs, because frankly you are the first witness who has appeared before us, who has attacked the Food and Drug Directorate so directly. I think some of the charges which you made in your brief, if made outside, would leave you in an awful position. Would you agree with me?

Mr. GILBERT: Yes.

Mr. MACKASEY: Perhaps we should pursue them, seeing that you agree, and I will concentrate on what you say in your brief on the Food and Drug Directorate for a few moments. What has been your relationship with the Food and Drug Directorate?

Mr. GILBERT: I consider that it has been quite fair.

Mr. MACKASEY: In other words, there is no basic prejudice on your part toward them?

Mr. GILBERT: No. I think the Food and Drug Directorate is suffering from a lot of pressure.

Mr. MACKASEY: Have they had occasion to discipline you, fine you, or take you to court at any time?

Mr. GILBERT: There has recently been a case on a new drug product.

Mr. MACKASEY: Could you tell me briefly what it was all about?

Mr. GILBERT: It was the product diethyl propion and I must say that the case of the Food and Drug Directorate was very poorly prepared.

Mr. MACKASEY: By them or by you?

Mr. GILBERT: By them.

Mr. MACKASEY: But it was sufficiently prepared to get a conviction?

Mr. GILBERT: I think it is the type of thing where the conviction was due to the lack of knowledge of the Justice who handled the case, who came to a conclusion entirely different from the testimony.

Mr. MACKASEY: In other words, the Judge was unfair?

Mr. GILBERT: I did not say he was unfair; I think he was afraid.

Mr. MACKASEY: Was this in the area of new drugs?

Mr. GILBERT: That is right.

Mr. MACKASEY: Is this the only occasion you have been involved with the Food and Drug Directorate?

Mr. GILBERT: That is right.

Mr. MACKASEY: You have never had any problems with them before?

Mr. GILBERT: There have been internal questions about—

Mr. MACKASEY: You have never been before the courts before?

Mr. GILBERT: No; this was the first time.

Mr. MACKASEY: Have you ever had any of your products removed from the market by the Food and Drug Directorate for any reason?

Mr. GILBERT: Yes.

Mr. MACKASEY: Could you name a few of them?

Mr. GILBERT: Strangely enough they are Hoffmann-La Roche products.

Mr. MACKASEY: This is the point I want to get into.

Mr. GILBERT: We had an incident where the product, Sulfisoxazole, was picked up in Calgary, as being a new drug and this was reported by my distributor. I wrote a polite letter to the Food and Drug Directorate asking for advice and they called me back by telephone and said there had been a slight error.

Mr. MACKASEY: I have to form my own opinion on these things. You do have a bias, intentionally or otherwise, against the Food and Drug Directorate.

Mr. GILBERT: I have no bias against them.

Mr. MACKASEY: How many such occasions have the Food and Drug Directorate found it necessary to discipline you since 1960?

Mr. GILBERT: There has been only one case of disciplining.

Mr. MACKASEY: What category would you put the other cases in?

Mr. GILBERT: A question of interpretation.

Mr. MACKASEY: How many such questions of interpretation have there been?

Mr. GILBERT: I think there have been two or three.

Mr. MACKASEY: I know of six, and I do not ask questions unless I have the answers. I understand it goes back as far as 1960, when there was a question about multivitamins. Do you recall that?

Mr. GILBERT: There might be certain labelling infractions.

Mr. MACKASEY: This was not a labelling infraction; this was a question of your product being below potency.

Mr. GILBERT: I was not aware of this.

Mr. MACKASEY: Would you accept my figures, because I think it is important when we get into the area of Hoffmann-La Roche.

Mr. GILBERT: Yes, I will accept them.

Mr. MACKSEY: There were at least six and I believe you just mentioned the seventh, which I was not aware of.

Mr. GILBERT: I might add that we are the most investigated company.

Mr. MACKASEY: I want to get into the area that I looked into on the food and Drug Directorate. You make an awful accusation here, this really upset me, Mr. Gilbert; frankly I came here prepared to do a bit more hollering than I am doing,

but your manner is disarming—against the integrity of the average civil servant. On page 31 of your brief you have a section entitled "Civil Servants have definite earning limitations" and you say:

> It is understandable that at some future time they would like to get a higher paying position with greater possibilities in industry. We know of an instance where an individual has achieved this position. We find that the Directorate has been over zealous in the protection of a particular company's products. This would mean that drug control is not routinely regulatory, but instigated by outside pressures.

And further on you say:

> The directorate has paid particular attention to any copier of Hoffmann-La Roche products.

Now reading your brief, and getting the theme from it, in so far as the Food and Drug Directorate is concerned, this is an outright accusation that civil servants are accepting payola from the P.M.A.C. boys. What you are saying is that the civil servants in order to put themselves in a position where they can leave the directorate and go and work for a private industry are helping to circumvent the Food and Drug Directorate regulations, particularly in the case of Hoffmann-La Roche. That is exactly what you have accused them of doing.

Mr. GILBERT: Maybe that is the interpretation I would like you to make, but that is not what I said.

Mr. MACKASEY: What did you say and I will repeat it.

Mr. GILBERT: I was just explaining—excuse me sir.

Mr. MACKASEY: Would you explain this then, "Civil servants have definite earning limitations."

Mr. GILBERT: That is a fact.

Mr. MACKASEY: We all know this, just like the sky is blue. What is the inference?

Mr. GILBERT: The inference I am trying to place is this. Mind you, I do not accuse anyone of taking advantage of this. All I am trying to say is that there is a basic situation where an individual has unlimited power, as expressed in the Food and Drug Act, and he can bend this power to outside influences. This is all I am saying. This is what I say I think should be corrected.

Mr. MACKASEY: What has his salary earnings got to do with the integrity with which he applies the Food and Drug regulations? This is the point I am asking because you made that statement.

Mr. GILBERT: Well, if a man can ultimately receive a better job in the future by laying stress in a certain direction he might do that.

Mr. MACKASEY: What do you mean by laying stress in certain directions?

Mr. GILBERT: Protective of a particular company's products.

Mr. MACKASEY: Is that not what I just said five minutes ago? You are accusing the civil servants of protecting the product of a particular company.

Mr. GILBERT: I am not accusing them of doing that. I say it can happen.

Mr. MACKASEY: You do say it. You particularly go on and say that they pay particular attention to Hoffmann-La Roche products. Now, how many times has your firm been convicted for infringements against Hoffmann-La Roche?

Mr. GILBERT: None.

Mr. MACKASEY: None.

Mr. GILBERT: I mean there are no convictions.

Mr. MACKASEY: Then where is the basis of your statement? You mentioned earlier that you had six brushes with the Food and Drug directorate?

Mr. GILBERT: Ah! We had a new drug application in for the product, echlorodiazopoxide. All of a sudden out of a blue sky the Food and Drug Directorate drops in, commandeers our product, no more chlorodiazepoxide. How did this come about?

Mr. MACKASEY: Well, I am asking you.

Mr. GILBERT: I do not know. That you would have to find out from the Food and Drug Directorate.

Mr. MACKASEY: But you were inferring how it came about.

Mr. GILBERT: I am only relating the facts that I know of.

Mr. MACKASEY: But you are inferring that civil servants have definite earning limitations. It is not very hard for anybody at this Committee to presume what you are trying to say. You go on and say you know of an instance where an individual has achieved his position. Who is the individual?

Mr. GILBERT: Well, it is Morrell right now.

Mr. MACKASEY: Dr. Morrell is a gentleman who retired as of right, at the age of 65 from the Food and Drug Directorate and I resent the inference against the integrity of Dr. Morrell. Dr. Morrell is now a director, as I understand it, of a drug company, the name of which escapes me. I read it in the paper. Is it not a fact that Dr. Morrell retired as he had the right to do at the age of 65 from the Food and Drug Directorate.

Mr. GILBERT: All right.

Mr. MACKASEY: Did he not have a right to take up a position in the field which he knows best?

Mr. GILBERT: Absolutely.

Mr. MACKASEY: Are you therefore inferring that when Dr. Morrell was head of the Food and Drug Directorate that he did things that were dishonest in the carrying out of his duties?

Mr. GILBERT: I think he was always proper.

Mr. MACKASEY: But why besmirch his reputation by putting this in here?

The CHAIRMAN: Let the witness answer the question before you ask others.

Mr. GILBERT: Well, I would say that in various press releases that I have read about Dr. Morrell he was always in favour of the brand name drugs, outspokenly, essentially.

Mr. MACKASEY: I accept the chairman's admonition. You have said in here, and this is only one section, that civil servants have definite earning limitations and they have got to be good to the brand name companies in order that the happy day may come when they will be invited to go and work with these companies. You have come up with only one instance, a man who is retired

because he reached the age of retirement, and rather than go into retirement he accepted a position as a director of a pharmaceutical firm. Do you know of any other people?

Mr. GILBERT: I said I know of one incident.

Mr. MACKASEY: Yes, but you do not know of any others? Do you know of any incident where the reverse is true, where people have left the pharmaceutical industry to go and work for the Food and Drug Directorate?

Mr. GILBERT: Yes.

Mr. MACKASEY: Have any of your former employees left you and gone over to the Food and Drug Directorate?

Mr. GILBERT: No.

The CHAIRMAN: You have a minute left, Mr. Mackasey.

Mr. MACKASEY: There is another area I would like to go into, Mr. Chairman, but I will wait for my turn.

Mr. HOWE (*Hamilton South*): To get away from the inquisition and back to just ordinary questions—

Mr. MACKASEY: I take exception to the remark "inquisition". Dr. Howe may not share the same concern I do over the attack on the civil servants, but I happen to think that civil servants in general are decent people and they should not be attacked in a brief without at least the members of the Committee questioning the witness on his reasons and as to the basis of the facts. This is all I was doing. It was not an inquisition, regardless of how Dr. Howe wants to interpret it.

Mr. HOWE (*Hamilton South*): There are different ways of questioning witnesses, Mr. Chairman.

Mr. GILBERT: May I make a statement with respect to closing this off. Candidly, I knew what I was up against when I wrote that chapter, and I did an awful lot of soul-searching before I put it in. I put it in against all advice. All I want to point out is that there are certain iniquities in the Food and Drug Act, certain things which are not proper, and I thought it was necessary to bring it to the attention of the public—and I have taken a lot on myself to do this.

Mr. MACKASEY: On a point of order, Mr. Gilbert, I am perhaps agreeing with you that there is a lot wrong with the act, and I do not take exception to that so much. But you have not attacked the act; you have attacked a civil servant, who applied the act, by emphasizing that they are underpaid and therefore very nice to the P.M.A.C. boys in the hope that some day they may be attracted to the P.M.A.C. I am sorry, Dr. Howe.

Mr. HOWE (*Hamilton South*): I think this is getting a little touchy, Mr. Chairman, so I will drop this discussion.

Mr. Gilbert, may I ask where you get your raw drugs from? I presume and understand that you actually manufacture your own pharmaceutical products that you sell.

Mr. GILBERT: That is right.

Mr. HOWE (*Hamilton South*): Do you sell other than pharmaceuticals that you manufacture?

Mr. GILBERT: No, we do not manufacture any parenterals; these are products made by other people. We do not manufacture any kind of disintegration capsules. These are imported as such.

Mr. HOWE (*Hamilton South*): And you sell them as imported.

Mr. GILBERT: We sell them under our product because we have them tested and we feel that we are safe in putting our label on them.

Mr. HOWE (*Hamilton South*): You do not sell any P.M.A.C. actual brand name drugs?

Mr. GILBERT: Oh, yes, we do.

Mr. HOWE (*Hamilton South*): Oh, you do sell them.

Mr. GILBERT: As a wholesaler.

Mr. HOWE (*Hamilton South*): As a wholesale outlet.

Mr. GILBERT: We are impartial. We give a man anything he wants.

Mr. HOWE (*Hamilton South*): So you sell them at the normal—

Mr. GILBERT: At a professional discount.

Mr. HOWE (*Hamilton South*):—professional discount to the drug store and I presume that your market is both to drug stores as well as to doctors who dispense. Is that right?

Mr. GILBERT: Well, not P.M.A.C. products.

Mr. HOWE (*Hamilton South*): No; I mean your overall business and the drugs you manufacture.

Mr. GILBERT: We also sell to wholesalers.

Mr. HOWE (*Hamilton South*): And you sell to wholesalers as well.

Mr. GILBERT: That is right.

Mr. HOWE (*Hamilton South*): What per cent would you say ends up in the drug store and what per cent ends up as being dispensed by doctors. Have you any idea?

Mr. GILBERT: I would say about 20 per cent to drug stores, about 20 per cent to hospitals and about 60 per cent to doctors.

Mr. HOWE (*Hamilton South*): Where do you get your raw key chemicals?

Mr. GILBERT: There are several sources. We generally like to make the best buys that we can provided all standards are met and we go out competitively for these things. A good deal comes from Italy; some comes from Denmark, and we have imported from Switzerland.

Mr. HOWE (*Hamilton South*): Czechoslovakia.

Mr. GILBERT: And on one occasion we even imported from China—and I will say this, that the best Tetracyline we have ever seen has come out of China.

Mr. HOWE (*Hamilton South*): Would you say that some of your key chemicals have the same source as the brand name manufacturer in some instances?

Mr. GILBERT: We have even put out products with Pfizer label on the drum, with a Grand Poulenc label on the drum.

Mr. HOWE (*Hamilton South*): But these are your raw key active chemicals?

Mr. GILBERT: Active ingredients, yes.

Mr. HOWE (*Hamilton South*): Now you do not have a quality control of your own and you have this done by an independent laboratory?

Mr. GILBERT: Yes.

Mr. HOWE (*Hamilton South*): And does the quality control that you do have done go beyond the actual potency of the drug as to its availability and whatever medium it is going to be dissolved in, such as gastric juice or intestinal juice as the case may be? Does it go into more than simply potency?

Mr. GILBERT: Oh, yes, we watch this disintegration very carefully and we are very much concerned with the pharmaceutical elegance of the product.

Mr. HOWE (*Hamilton South*): Do you attempt then to aesthetically imitate the shape, colour, or particulars?

Mr. GILBERT: I have a sample here of stelazine and triperazine. I think I like ours better.

Mr. HOWE (*Hamilton South*): This is not prejudice?

Mr. GILBERT: No.

An hon. MEMBER: Do they taste better?

Mr. GILBERT: Much better.

The CHAIRMAN: The Committee members cannot see them, Mr. Gilbert; perhaps you could put them up here. One is in a brown bottle.

Mr. HOWE (*Hamilton South*): So other than the use of the active chemical, you actually attempt to imitate the appearance of it for psychological reasons. If a person is taking a particular drug and they were to be switched from the brand name to your product, there would not be any psychological difference in the appearance of the drug.

Mr. GILBERT: I think, it also eases his mind considerably.

Mr. HOWE (*Hamilton South*): Can you explain, in a few words, how you can sell your products at what one might say is a ridiculously low price? I am not looking in your most up to date catalogue because I am not acquainted with it, but I am acquainted with this one that you had last year, in which you gave away the refrigerators. Meprobamate will take 400 milligrams and—I am looking straight across this line—sell for $5.50 a thousand, whereas your better known brand name products sell for approximately $10 a hundred. This means that you are selling them for half a cent a tablet to their 10 cents a tablet, which is quite a price difference. In addition, if you bought enough of them you could get a refrigerator. Can you explain why you can sell at this price? I can understand maybe a 10 per cent, 20 per cent or, let us say, a 50 per cent reduction because you would not have some of the overhead costs, and you do not have the research and so on. How can you sell at one-twentieth—if my arithmetic is correct—of the amount?

Mr. GILBERT: Well, suppose I tell you what the product cost us, then you can see if we are losing money. I just made a rapid calculation and, given everything, it does not cost us more than $2.30 a thousand.

Mr. HOWE (*Hamilton South*): So at that you are more than doubling. Do you mean that you can manufacture them at $2.30 a thousand?

Mr. GILBERT: Yes, pretty near that.

Mr. HOWE (*Hamilton South*): This is the fully manufactured product in a bottle.

Mr. GILBERT: Assayed and everything.

Mr. HOWE (*Hamilton South*): By "assayed" you mean quality controlled, and put in the bottle and ready and available for sale.

Mr. GILBERT: And a very lovely product to boot.

Mr. HOWE (*Hamilton South*): You mean it also has this aesthetic quality.

Mr. GILBERT: Oh, yes.

Mr. HOWE (*Hamilton South*): I think one that maybe surprised me most of all was penicillin G. potassium 500,000 units at $17.50 a thousand. If my knowledge is correct, ordinarily on a prescription these would sell for $3 or $4 a dozen, under normal circumstances. I do not know which is normal really, and this is what I am trying to find out.

Mr. GILBERT: I am glad you brought that one up because we are competing with Pfizer, who is selling it at $18 to $20 a thousand.

Mr. HOWE (*Hamilton South*): Pfizer's are selling it at $18 to $20 a thousand.

Mr. GILBERT: Oh, yes, they can get right down there when they want to.

Mr. HOWE (*Hamilton South*): Well, do they sell at $18 to $20 a thousand as a general rule to the drug store?

Mr. GILBERT: No, competitively; not as a general rule to the drug store. But they have been selling on that basis.

Mr. HOWE (*Hamilton South*): In other words, they can sell at that price when they want to compete.

Mr. GILBERT: That is correct.

Mr. HOWE (*Hamilton South*): Well, we could go on with these but there is no point in going into each one of them individually. These were maybe the two that surprised me the most, although I did notice .25 milligrams digoxin at $6.75 a thousand, and I know that this runs, in one of the name brands, somewhere around $10 a hundred. Even some of the generic brands sell around $3 a hundred, and yours is $6.75 a thousand; again there is a tremendous differential in price. What I am trying to emphasize is that these price differentials are tremendous. They are a matter of you selling at approximately 5 per cent of what the name brand product sells for; not just simply a matter of 10 per cent or 15 per cent or 20 per cent off, but rather, 95 per cent off.

Mr. GILBERT: Well, I think this ties in with what I tried to say in my supplementary submission, that the effectivity of our sales goes very much beyond the value of the products which we receive, because if this competition had not occurred and these products were not available, the same quarter of a million units that I sell instead of costing the public, let us say, $350,000, would cost the public maybe $3 million. This is coming out of the hide of the major companies.

Mr. HOWE (*Hamilton South*): Have you any idea what these products sell for to the actual consumer? Do you have any way of tracing this to find what the retail consumer price is?

Mr. GILBERT: Well, a great deal of this goes to doctors who do dispense; what the druggist does with this, we cannot say because we have no figures to

cover it. Incidentally, this comes to the question of the value of a generic name, which I hope I will be questioned on later.

Mr. HOWE (*Hamilton South*): You made a remark about the doctors that I did not quite hear.

Mr. GILBERT: I said the doctors dispense this, and I hope they pass this item along to the patient.

Mr. HOWE (*Hamilton South*): But you do not know this.

Mr. GILBERT: No, I have no facts on that. We sell the product and our interest ends there except to substantiate the quality of the product that we sell.

Mr. HOWE (*Hamilton South*): I myself made the interesting observation that if a druggist were to buy at your cost and add on the profit that he would make from a brand name product, he would still be selling at about a quarter of the price that the brand name product would sell at, and this in actual dollars, not in per cent, would still yield him the same amount and still reduce the amount to the patient by half in most instances.

Mr. GILBERT: I honestly do not think the pharmacist has been hurt by the generic drug business.

Mr. HOWE (*Hamilton South*): Thank you, Mr. Gilbert.

The CHAIRMAN: Gentlemen, before I call on Dr. Isabelle, is it agreed that we print today's brief as an appendix to today's proceedings?

Some hon. MEMBERS: Agreed.

(*English*)

Mr. RYNARD: Mr. Chairman, I have no objection to Dr. Isabelle going on. I am very happy he is going on but he was not in here when you took my name. I just wanted to draw that to your attention so that if anybody else did notice it they would not think you were being unfair.

The CHAIRMAN: No, not at all. I will accept that because I did not take your name earlier.

Mr. RYNARD: Dr. Isabelle, you go first; that is perfectly all right. It is my privilege to let you go ahead.

(*Translation*)

Mr. ISABELLE: Can you hear me now, Mr. Gilbert? The Drug Companies came before us, and have been appearing before us for the past few months and it would appear that there is somebody that is not telling the truth. Whether it be the major Pharmaceutical Industry or the smaller companies, or the co-piers—we call them copiers here in this Committee—there is most certainly somebody who is hiding the truth from us. Therefore, it would be a good thing to have the witnesses sworn in before they come before us, because as things go on, we seem to be making up something to a Court, but we cannot really render a judgement. Now, there is a Company,—several people called it all kinds of names—and I, looking through your catalogue, note that you are a Company perhaps like other Companies who intends to make profits rather than cutting prices for poorer people.

Can you tell me, Mr. Gilbert, whether, when hospitals buy from you—Do hospitals buy from you Mr. Gilbert?

(*English*)

Mr. GILBERT: Yes, Mr. Isabelle.

Mr. ISABELLE: If they buy in certain quantities do you give them bonuses?

Mr. GILBERT: No.

Mr. ISABELLE: No, you do not give any bonuses.

Mr. GILBERT: That would be improper because there we are dealing with purchasing agents.

Mr. ISABELLE: Yes, but in your "Best Wishes for the New Year" last year you had some Xmas bonuses. If someone made, let us say, a purchase of $2,000, you gave away a refrigerator, he was entitled to a refrigerator. This has been mentioned before. You could also give away a projector with purchases of $1,500. You say you do not give away any bonuses; is it only at Christmas time that you do this or is it only year around?

Mr. GILBERT: Our new catalogue does have some offers based on quantity purchases, where they can get certain items as bonuses.

Mr. ISABELLE: But with the dollar purchases represented here I do not see how anybody could buy that much other than a retailer or a hospital.

Mr. GILBERT: There are doctors who use that much.

Mr. ISABELLE: And they received a projector?

Mr. GILBERT: Yes, if they ask for it.

Mr. ISABELLE: And if they do not ask for it you keep it for somebody else?

Mr. GILBERT: That is right.

Mr. ISABELLE: Have you ever given away any bonuses to hospitals.

Mr. GILBERT: It has only happened in respect of one hospital, where this was specifically requested.

Mr. ISABELLE: You said that you did not give away any bonuses with such purchase.

Mr. GILBERT: If the hospital want to buy at the prices in these catalogues we feel they are entitled to it if they officially ask for it.

Mr. ISABELLE: Who is paying for those fringe benefits?

Mr. GILBERT: I think this comes out of our profits.

Mr. ISABELLE: What is the percentage of your profit that goes into these bonuses?

Mr. GILBERT: It is figured out to be on the basis of the list price of the value of the item—about 10 per cent of the value of the merchandise being bought. This means about six per cent our cost, which I think is reasonable.

Mr. ISABELLE: Ten per cent of the total of your profit?

Mr. GILBERT: That is correct.

Mr. ISABELLE: The total sum of your profit.

Mr. GILBERT: No, not 10 per cent of the profit but 10 per cent of the value of the invoice is covered by a bonus. This normally costs us about six per cent.

Mr. ISABELLE: Do you sell cheap drugs?

Mr. GILBERT: I sell drugs cheaply.

Mr. ISABELLE: You sell drugs cheaply, not cheap drugs?

Mr. GILBERT: No.

Mr. ISABELLE: So you maintain that all your drugs are good drugs?

Mr. GILBERT: Absolutely. I take them myself.

Mr. ISABELLE: You said in your brief somewhere that the innovators of today were copiers of yesterday.

Mr. GILBERT: That is what I said, yes. It is a normal transition.

Mr. ISABELLE: But do you find that the price of drugs to the patient is too high today?

Mr. GILBERT: I think the prices of drugs are available to the patient in Canada at the lowest anywhere in the world if they can be made available to the public.

Mr. ISABELLE: Would you mind repeating that.

Mr. GILBERT: I think that the prices of drugs in Canada, especially using the PMAC reference, are the lowest anywhere in the world if they can be made available to the public. This means that they have to get through the doctor and the merchandising power of the PMAC. May I expand on this. You have a situation here where the entire industry is based on an economic fallacy; the man who pays the bills has no choice of the product or the price that he pays. This is the situation that the PMAC is taking advantage of and they are laying the stresses in the "education" of the doctor. It means that the doctor is persuaded to use these things because it comes down to the basic fact that because there is no valid medical reason, generally speaking, for the choice of a particular product when you have several competitions in the same product. Then there must be other factors which are material in value which should cause the use of that particular product. I do not know whether I have made myself clear.

Mr. ISABELLE: Yes, I understand you very well, and this is a point that should be investigated. You mean that the patient is blindfolded when he is paying for a product and he does not know whether it is too high or not. I agree with you 100 per cent. Something should be done—and it will be done. We have been talking only about industry, whether or not they are copiers or innovators. We all have been talking about the pharmaceutical industry, and we buy products from these big companies. However, do you feel the retailer is charging too much for drugs today?

Mr. GILBERT: No. I think the retailer is entitled to a professional fee for his services. He has responsibility and I think he is caught in three maelstroms: the PMAC, the doctor and the public.

Mr. ISABELLE: By the way, we are ready to pull out of there any time.

Mr. GILBERT: Well, this is the situation.

Mr. ISABELLE: Yes, but this is a comment that you are making on the question I asked you. I asked you if you felt that the retailer was selling his drugs to the patient too high, and you said no.

Mr. GILBERT: I do not think so. It costs a certain amount to do business and to maintain service. It does cost the pharmacist a lot of money. He has to keep

technical help, qualified help, to service the patient and maybe the qualified help is only utilized 20 per cent of the time in selling prescriptions.

Mr. ISABELLE: What do you think about the "green shield" plan in Ontario?

Mr. GILBERT: I think it would be a success if they went generically.

Mr. ISABELLE: They do not want it generically yet.

Mr. GILBERT: No; they are very much against it.

Mr. ISABELLE: You are very much against it?

Mr. GILBERT: No they are against it.

Mr. ISABELLE: Why?

Mr. GILBERT: I cannot explain that; I cannot even understand it. If they were interested in making a proper-working plan this is one of the first things they would do.

The CHAIRMAN: I should say, in defence of any client, of course, that this is dependent on the laws of the province of Ontario which refused to allow any drug store or anyone selling prescriptions to substitute generic for a prescription that might be written in a brand name.

Mr. RYNARD: Mr. Chairman, I would like to draw attention to the supplementary statement made by Mr. Gilbert, paragraph 2, in respect of the Canadian Cystic Fibrosis Foundation report on the high cost of drugs to the foundation and their membership. They also reported that they were refused help by the pharmaceutical organizations. Mr. Chairman, this was not my interpretation of what they said when they were here. It certainly was not my interpretation of what the pharmaceutical associations told me. I would like to question, through you, Mr. Gilbert on this point.

Mr. GILBERT: I only know what I read in the newspapers. This is the way it was reported.

Mr. RYNARD: I do not know whether I misheard what went on here.

Mr. HOWE (*Hamilton South*): Mr. Chairman, may I interrupt Dr. Rynard because I am the one who made this statement. I put the statement in the form of a question to the Canadian Cystic Fibrosis Association and suggested that possibly the pharmaceutical manufacturers were not of a philosophic nature. I did not say that the Cystic Fibrosis Association has asked anybody for any kind of drugs and that they were refused. And when I made my statement I was not referring to the retail pharmaceutical association; I was referring specifically to the PMAC, and I asked if they had offered services, not that they had asked for it and had been turned down. I want to make that publicly clear because I was accused of having said that both associations had turned down pleas for it, and this is not what was said nor what was meant in this committee last week.

The CHAIRMAN: As I remember, they also did say that they had asked them for help a long time ago, that they had received help of a minor nature and that they had not really asked them for a long period of time.

Mr. RYNARD: Mr. Chairman, that is the point I wanted to clear up. The next question I would like to ask Mr. Chairman is in respect of mailing information to doctors on triperazine. I was a little bit disturbed at the information that is

contained in the triperazine that is put out by Mr. Gilbert and the one that is put out by Smith Kline & French, which is Stelazine and of which you have a sample. In other words it seems to me that the indications, contraindications, dosage and everything are all too brief. If all of the information supplied by Smith Kline & French is necessary surely then the directions that are put out by Mr. Gilbert are in a very abbreviated form. I would like some comment on that, as well as on the fact that I do not see any listing at all for children on this.

Mr. GILBERT: I would like to make the position of my company clear. We feel that we serve an economic purpose in this industry in making available to the knoledgeable physician the product and an alternative choice to the product. We have no brief for any particular product. By the way sir, there are a half dozen tranquilizers we can sell doctors; we are not partial to any one of them. We assume that the doctor is already trained and knowledgeable about the product that he is using. All we are making available is a choice of product properly constituted, to be used in accordance with his knowledge of the subject. I will say this, however, we are in the process of preparing a complete bibliography on the product at any rate.

Mr. RYNARD: Mr. Chairman, I am very glad to hear that because when we had our training in pharmacology the one thing we were told was: When you take it down, look at it; and any drug that you are putting into a bottle, when you put it back on the shelf look at it again. I am simply saying to Mr. Gilbert, that while doctors may have all this knowledge it is good to duplicate that knowledge so that there will be no mistakes made because it is human to err.

Mr. GILBERT: I thoroughly agree.

Mr. RYNARD: Now another point I wanted to make is this. I see you have no suppositories or ampules in this particular drug?

Mr. GILBERT: No.

Mr. RYNARD: What is the reason for that? You market the drug orally but you do not market it in any other form?

Mr. GILBERT: We are not saying that it will not come, but we do not have it at present. This is new with us. We do, for instance, in a product called Promazine have it in ampule form; we have it as syrup; we have it in several forms. We could very well have them with trifluoperazine too.

Mr. RYNARD: Mr. Chairman, I would like to ask Mr. Gilbert to what extent he uses brand names. I was intrigued by Dexamo; that is getting awfully close to Dexamil.

Mr. GILBERT: We generally use brand names in conjunction with products which are multiple in character. We have a product called Spastolate which may be the same as Donnatal. Because this is something that is almost impossible to put in the name of a label and properly demonstrate the qualities in bold type you have to resort to brand names. However, I would say that our company feels at present that the use of the generic name is not quite serving the purpose that was intended. We are gradually veering away from that and it is why we called our trifluoperazine, Triperazine. Evidently it is the only way that you can assure getting the proper value to the patient. It is a very important point because if the generic name is written the patient is subject entirely to the whim of the pharmacist.

Mr. RYNARD: This brings up a very interesting point. On the one hand, as I see it, you can dispense any generic name that the pharmacist likes. Does this not indicate a weakness then, if you are going to accept generic names? How are you going to get over the weakness? There may be a half dozen generic names all of different types and probably all with different therapeutic values from the standpoint of efficiency.

Mr. GILBERT: This is a point where I think the pharmaceutical association falls down, if I may make this gratuitous comment. I believe that if the pharmaceutical association were truly and honestly serving its purpose, they would set up standards on which to judge and train their pharmacists in order to know what the best value would be for the patient. Instead of utilizing solely the merchandizing power of the big companies as a means for dispensing drugs and protecting that. They should become professional men interested in the intrinsic value of pharmaceuticals, and at that point I think we will have a good professional standing among pharmacists.

Mr. RYNARD: Mr. Chairman, I think Mr. Gilbert may have a very good point here. In other words, what, in effect, he is stating is that there has to be a quality control on all the drugs that are merchandized. One of the things we are very concerned with is the quality because he himself now will buy in Italy, Denmark or Switzerland and you really have not any check at all on the quality of how they are producing this drug that you are using.

Mr. GILBERT: That happens anywhere. You are assuming because they are a brand name that they are quality controlled. I see no proof of it.

Mr. RYNARD: Mr. Chairman, all I can say is that from all the evidence we have had here there is quality control. Maybe we have been misled on this but the evidence here, if you go over it, would indicate that there has been good quality control. I think this is the thing, Mr. Chairman, that we are concerned about. I think the witness, Mr. Chairman, put his finger right on it when he said there must be a quality control of all drugs. I would agree with him.

Mr. GILBERT: I might give a case in point. We have had one action, without naming the name of the company, in which they applied for an injunction in respect of the proceedings. Their brief mentioned the 36 quality control tests that they perform. After the testimony was completed it was found they performed less than we did, and that the quality was not quite as good.

Mr. RYNARD: Mr. Chairman, Mr. Gilbert makes me nervous. I thought when I was prescribing certain brand names I was absolutely safe. I think this is a question of great importance to this committee.

Mr. GILBERT: There are so many assumptions made.

Mr. RYNARD: Mr. Chairman, if a person is very, very ill, whether that drug has the potency it is supposed to have and is being used according to directions, may be the difference between his life and getting better.

There is one other question I would like to ask you, through the Chairman. I noticed in your catalogue that you had Parstelan listed for sale for some months after it was off the market.

Mr. GILBERT: Probably we could not change the publication after it was printed.

Mr. RYNARD: Was there any notification, Mr. Chairman, sent out to the doctors' offices?

Mr. GILBERT: Well if we were selling Parstelan it was because the doctor requested Parstelan. If he was advised that Parstelan was no longer on the market he would not write to us for it. In other words we never had any Parstelan in stock.

Mr. RYNARD: Do you always use the same supplier for your ingredients?

Mr. GILBERT: No.

Mr. RYNARD: Thank you.

Mr. GILBERT: We are thoroughly concerned with the product itself, the intrinsic product. It must meet specifications before we use it.

Mr. RYNARD: Then, Mr. Chairman, economics does enter very strongly into this picture because if you change your supplier it must be that you want to get it cheaper or you are a little bit doubtful that the quality was not there.

Mr. GILBERT: Is that a question?

Mr. RYNARD: It is a question I would like your comment on. Is it a fair comment?

Mr. GILBERT: Well anything can happen and I think you can project your thoughts any way and rationalize them. I mean you can say anything you like about a product and you are probably correct, in some instances.

Mr. RYNARD: In other words, Mr. Chairman we can take it that Mr. Gilbert does shop around, keeping economics in mind, and that there is not any quality control run on those ingredients.

Mr. GILBERT: I would only add this comment. We do not relax at any point our requirement for the product. That goes without saying.

Mrs. RIDEOUT: When I read your brief last week, I tried to imagine what sort of person you might be. It is one of the most unusual briefs I have ever read, and particularly your closing sentence in the Yuletide season "May the Good Lord protect us from our friends, for we can deal with our enemies". It is hardly the spirit of the season. You must realize that my association with the Department of Health and Welfare makes me aware of many of the activities within the department, and certainly I have the highest regard for the Food and Drug Directorate and all of those associated with it. We are, of course, in this committee studying the price of drugs, and safety is always an important aspect. I have had, since I have been associated with the Department, a feeling of security knowing of the protection of the Food and Drug Directorate, and so some of your remarks concern me, and if you do not mind I would just like to bring this to your attention for my own information. You say on page 30:

> —a lobby located in the same city and perhaps in the same building where the nerve centre for many Food and Drug decisions are made.

I find this an accusation that is very hard for me to understand. I am just wondering, if you would mind and for my information, explaining.

Mr. GILBERT: Well I believe that the P.M.A.C. has a very effective lobby and they are spending a lot of money to protect their position. It is as recent as this,

if you just pick up this "Drug Merchandising" the December issue—I only got this on my desk yesterday—

Mrs. RIDEOUT: But what I mean, Mr. Gilbert is which building and what lobby? Who are you suggesting and where is the building?

Mr. GILBERT: Well, actually, I think there is a slight error, they are not in the Brooke Claxton building, but they are in the building where certain other decisions are made, where the Department of Industry is concerned, which has a lot to do with drugs, etc. And I believe that there are good communications.

Mrs. RIDEOUT: Well, you imply more than good communications in your brief.

Mr. GILBERT: That is all it says.

Mr. MACKASEY: May I ask a simple question. Are you referring to the fact that Dr. Showalter's department is in the same building as the P.M.A.C.?

Mr. GILBERT: That is right.

Mr. MACKASEY: In other words, what you are saying is that because they are in the same building—and as you mentioned, there is a greater degree of communication between Dr. Showalter and the P.M.A.C.—that it is healthy for the industry.

Mr. GILBERT: I do not think that I said that, but I mean those are the facts.

Mrs. RIDEOUT: Well, I do not think that there is any connection between Dr. Showalter and the P.M.A.C. being in the same building. I do not share your feeling.

An hon. MEMBER: Let us put that on record.

Mrs. RIDEOUT: If I may just change the tune. You were speaking of your "Research and Research in Canada", which I find interesting. You make the statement:

> There is no question in our mind that we would give anything to become an innovator.

Yet, you have said that you are one of the best copiers, and you have said that you do not go along with research; you feel that the big companies take too much advantage, and you do not feel that these companies deserve any special consideration for the research they do.

Mr. GILBERT: Absolutely none.

Mrs. RIDEOUT: I am only asking this because I am new in this particular field, but I depend on these new companies. For instance, I know of people who have children who are ill, and they are borrowing time waiting maybe for a new discovery in drugs to save the lives of their children. In fact, I think the greatest headlines I could ever read would be a cure for cancer. Well, if everybody took your attitude where would we be, what would happen to us?

Mr. GILBERT: Well I think you will find a cure for cancer will come out of some government institution.

Mrs. RIDEOUT: You do not think that these companies that are spending—of course granted they are not spending as much money in research for cancer as I would like—

Mr. GILBERT: They might isolate a particular facet of the thing that they think may lead them somewhere, but it is an over-all problem which will be

done in many research institutes and will not come out of one place. And if it were left in the interests of industry to produce this, it could never be done, I think.

Mrs. RIDEOUT: Well, then, you, on one hand, say you wish more than anything else you could be an innovator, and at the same time you say that there is no need for them. I do not understand.

Mr. GILBERT: I did not say there was no need for them. I said unfortunately only about 20 per cent of the actual research done is truly productive. The rest of it is of commercial interest to them.

Mrs. RIDEOUT: But the productive end of it has been beneficial to you; apparently you have been successful in your business, because, as you say, you are a good copier.

Mr. GILBERT: Well—

Mrs. RIDEOUT: Now, I could be wrong.

Mr. GILBERT: No, I will try to qualify this. You must not isolate the subject of research from everything else; it is a composite of pictures. What is the purpose of a drug company? To serve humanity? I do not think the stockholders would buy this. They are interested in producing profits and creating a big sale for these products. I say this, that if a company has a good product going, and has a better product in their loaf, they will not put it out until the light of that first product is utilized, or unless there is competition.

Mrs. RIDEOUT: But the progress that has been made over the past few years does not really substantiate your argument.

Mr. GILBERT: I beg your pardon?

Mrs. RIDEOUT: The progress over the past few years in new drugs certainly does not substantiate what you have said.

Mr. GILBERT: Well, I will try and substantiate it.

Mrs. RIDEOUT: I am not meaning to argue with you, Mr. Gilbert, I want to find out.

Mr. GILBERT: No, no. I mean I think these are very sensitive questions, and I feel that drugs are foisted on the public, to a large extent. In other words, there is always the course of medication, but then somebody comes out with something, me too. I have got a case now with this nicotinic acid, for instance, which I think is an extremely valuable product, but no drug company will touch it because there is no exclusivity there.

Mrs. RIDEOUT: It seems rather strange.

Mr. GILBERT: Oh, it is not strange at all, it is true.

An hon. MEMBER: It is a strange truth.

Mr. GILBERT: In other words, they are paying for merchandising power and the doctor will use what he is made to use. In other words, if you have got four or five different products with the identical chemical construction, whatever doctor will make you use any one of them? You have not investigated; it is the detail man who has come in, the literature that you received, that has controlled your useage of that product. We are subject to pressures.

Mr. HOWE (*Wellington-Huron*): Mr. Chairman, I can agree with Mrs. Rideout that this is rather an unusual brief. There are some very definite statements made that are hard to understand and I can agree with Dr. Isabelle that

this is almost becoming a court between you and people who have made certain allegations. However, you did indicate, in reply to Mr. Forrestall, that you felt that drug prices could be reduced by changes in the patent laws. Is that correct?

Mr. GILBERT: I do not think you have to change anything; just give the public the opportunity to buy, and give them some control on what they buy. That is all you need.

Mr. HOWE (*Wellington-Huron*): You maintain there is a monopoly in the drug business?

Mr. GILBERT: I maintain there is a merchandising power in this industry, which no one can contravene, and they are looking for protections for this merchandising power.

Mr. HOWE (*Wellington-Huron*): Has this been brought to the attention of the Department of Justice under the combines legislation, or has there been any charges laid?

Mr. GILBERT: I have been there, and I am tired of going there.

Mr. HOWE (*Wellington-Huron*): And they just will not listen to you?

Mr. GILBERT: They have listened to me. I am fully documented.

Mr. HOWE (*Wellington-Huron*): They have not taken any action?

Mr. GILBERT: None at all.

Mr. HOWE (*Wellington-Huron*): Would the reason for this be indicated by your statement on page 7:

> This innovation has become a matter of great concern to the P.M.A.C., who have paid and suborned intellects to justify their monopolies.

Mr. GILBERT: I looked up the word "suborned" and I decided not to change it.

Mr. HOWE (*Wellington-Huron*): You feel that pressure is being put on the Department of Justice?

Mr. GILBERT: No; when I said suborned intellects, I meant that they pay experts to make certain types of statements which are half truths, and to me half truths are half lies.

Mr. HOWE (*Wellington-Huron*): You feel that they just cannot justify these monopolies?

Mr. GILBERT: No.

Mr. HOWE (*Wellington-Huron*): I was rather interested in your statement on page 4, where you say:

> Unlike the P.M.A.C., and its members, we are not here in the public interest, to protect the public's right to pay "fair prices" based on the man hour rate in Canada.

I was rather interested in that statement, because a short time ago the Department of Agriculture issued a statement indicating that an hour's wages today will buy more food than it would 10 years ago, the wages that a man gets in spite of all the investigations. Do you feel that is true of drugs?

Mr. GILBERT: I feel it can be true of drugs, but it is not true.

Mr. HOWE (*Wellington-Huron*): You feel that drug prices have gone up—

Mr. GILBERT: No. I made the statement that the prices of drugs available to Canadians are the lowest in the world, based on their standards, if it can get to the public. How do you get it to the public?

Mr. HOWE (*Wellington-Huron*): This is what we are here for.

Mr. GILBERT: Why not support me?

Mr. HOWE (*Wellington-Huron*): Further on your brief would indicate that you do not have too much—I would not say respect, but you feel that the medical profession is not as alive as it should be in connection with some of these things?

Mr. GILBERT: I think they are too busy.

Mr. HOWE (*Wellington-Huron*): You say that they have lulled the public and the medical profession into acceptance of these practices.

Mr. GILBERT: I feel very strongly about this.

Mr. HOWE (*Wellington-Huron*): You also make a statement here that I have agreed with for a long time, in regard to the Indian selling the pottery. They are both the same, but one was priced higher than the other, and they bought the better one because they thought it was better because it was higher priced. I feel this is true of people; it is human nature. Do you find that in the drug business?

Mr. GILBERT: Yes. Certain classes of people will not be satisfied unless they get the highest priced drug.

Mr. MACKASEY: These certain classes are doctors?

Mr. GILBERT: No. They are certain individuals.

Mr. HOWE (*Wellington-Huron*): No, they are people and in dealing with the public you will find that. I find that in my own small business, that there are certain items that are real cheap. I know certain department stores will do this. As I said in this Committee once before, they will move items from their bargain basement and put them in the French room, make them three times the price. They did not sell in the bargain basement but they will sell in the French room. They clear them out. This is the human element that enters into this whole question.

Mr. GILBERT: This is the preface of the expenditures of the members of the P.M.A.C. to inculcate that feeling that because the name is mentioned and seen in print, therefore it must be the only one to use and anything else is inferior, which is nothing further from the truth actually.

Mr. HOWE (*Wellington-Huron*): There is one other statement on page 19 which says:

> The intrinsic value of the product is secondary.

In other words, the merchandising is the important thing and the merchandising, in spite of and also because of the medical profession, will determine the course of treatment and medication that your family and our family will have to take.

Mr. GILBERT: That is right.

Mr. HOWE (*Wellington-Huron*): In other words, the high pressure advertising sells the product, not its actual value?

Mr. GILBERT: I honestly believe that, because you can get inferior products, and if a man were to spend $1 million, he is going to settle for a certain product because of this and whether it is good, bad or indifferent, makes no difference.

Mr. HOWE (*Wellington-Huron*): On CTV this morning, there was quite an advertisement on a news broadcast from 1866 and it mentioned a particular qualification of some blue pill. We think of the Lydia Pinkham's pink pills and all of this type down through the years. In other words, common usage made these things of value to the public.

Mr. GILBERT: I think the public is the undeveloped resource of the large pharmaceutical companies.

Mr. HOWE (*Wellington-Huron*): Thank you, Mr. Chairman.

The CHAIRMAN: Mr. Yanakis, you are next.

Mr. YANAKIS: Have you ever manufactured rimifon tablets?

Mr. GILBERT: That is isoniazid, yes.

Mr. YANAKIS: Do you still manufacture it?

Mr. GILBERT: On occasion, yes.

Mr. YANAKIS: Only on occasion?

Mr. GILBERT: It is not a standard product with us. We sometimes fill large government orders for this product, not rimifon but the isoniazid.

Mr. HOWE (*Wellington-Huron*): What was the name of the product, Mr. Chairman, I did not hear what he said.

The CHAIRMAN: It was rimifon.

Mr. LAIDLAW: Mr. Chairman, I would like to ask Mr. Gilbert a question or so relating to Section 41(3) of the Patent Act and I am sure Mr. Gilbert is familiar with that section.

Mr. GILBERT: Quite.

Mr. LAIDLAW: I have asked this question of several witnesses who have appeared before this Committee, Mr. Gilbert. Do you think it would be effective in bringing down the prices of drugs, if Section 41(3) was enlarged to give the Commissioner of Patents authority to issue compulsory licences of imports?

Mr. GILBERT: It would definitely affect the cost of products to the public; no question about that, and I have pointed this out in the instance where compluso-ry licences have been issued. To begin with, the licensee uses it almost solely for his own purpose. When he does make it available, he makes it available at a prohibited fee—I am thinking of the cloramphenicol licence, which is held by Penick, it used to be Fine Chemicals, and their price on cloramphenicol is about $228 a kilo, when it can be freely purchased on import for as low as $19 per kilo.

Mr. LAIDLAW: This, of course, would only be necessary in respect of patented products?

Mr. GILBERT: That is right.

Mr. LAIDLAW: I understand you have some compulsory licence you have already obtained under section 41(3), Mr. Gilbert?

Mr. GILBERT: No, we have no compulsory licences. We have a couple of voluntary licences—negotiated licences.

Mr. LAIDLAW: Were these licences negotiated after you made application for the compulsory licences?

Mr. GILBERT: Yes. In one case, yes. In one case I have an agreement. I could not obtain a licence but I have an agreement with Pfizer, for instance, not to be sued for past, present or future infringement on their tetracycline patent. Do you want to ponder that one?

Mr. LAIDLAW: Could you advise the Committee as to why a patentee will issue a voluntary licence.

Mr. GILBERT: I guess they love me.

Mr. LAIDLAW: So that the proportion of your business from licences is comparatively small compared to the business you develop from imports?

Mr. GILBERT: Well, to be candid, I consider a patent suit a form of licence.

Mr. LAIDLAW: Does this mean that you question seriously the validity of most pharmaceutical patents?

Mr. GILBERT: I have gone to great lengths in my brief to explain that.

Mr. LAIDLAW: I just mention this to bring it out because it has not come out in your brief so far.

Mr. GILBERT: I publicly made a statement in 1957. I may only be 99.94 per cent pure, but I made the statement that there is not a valid drug patent written and if you do not believe me sue me.

Mr. LAIDLAW: Let us take a different tack for a moment, Mr. Gilbert. We have had a great deal of evidence that has come before the Committee with respect to patents in Italy. As you are aware, there are no patents on drugs in Italy, but as you are also aware, the industry there is pressing the government to reintroduce a strong patent system. I believe this also applies in India at the moment. Why, in your opinion, would the pharmaceutical industry now seek patent protection when apparently it has managed to live very well during the past few years?

Mr. GILBERT: It is quite simple. The copiers have become innovators and they want to protect themselves from the copiers, the new generation.

Mr. LAIDLAW: In other words, the profit has been large but still not enough.

Mr. GILBERT: No; they want to protect what they have already developed, which they have done under a free enterprise system.

Mr. LAIDLAW: You, therefore, Mr. Gilbert, as an admitted so-called copier are probably looking forward to the day when you can be an innovator and strengthen the patent system? Am I correct?

Mr. GILBERT: I do not think you should personalize it, but I think this will be the pattern.

Mr. LAIDLAW: This could be the pattern here? If there was a moratorium on patents on drugs in Canada, as you have suggested in your brief—

Mr. GILBERT: I think that would be the greatest thing for Canada.

Mr. LAIDLAW: But then you feel possibly after 10 years or so the generic drug industry would revert back to the patent system?

Mr. GILBERT: I think there would be some shamefaced pressures put to bear to reinstitute it.

Mr. LAIDLAW: This whole industry is really based on a profit motive and there is never enough dividends to the shareholders. Am I not correct—

Mr. GILBERT: It helps a lot.

Mr. LAIDLAW: This is the philosophy that I am trying to elicit here.

Mr. GILBERT: In my submission I said that I was here to make a profit too in this business. It so happens that what I am doing it is on the side of the public. I do not say that it is my basic premise, but I am happy that it is so. I sleep well.

Mr. LAIDLAW: Then everything is really dependent—as long as the drugs are safe for the public, the injection of competition is a good and valid thing and will bring the prices down.

Mr. GILBERT: This is very necessary—very necessary.

Mr. LAIDLAW: Thank you, Mr. Chairman, that is all I have at the moment.

Mr. MACKASEY: Mr. Gilbert, just in case you have any doubt, I think that Canada needs copiers to provide the competition. I have said that many times. I want to be sure at the same time that the copiers live up to the requirements of the Food and Drug Directorate as well as the P.M.A.C. boys. Mrs. Rideout mentioned the fact that the P.M.A.C. office and the office of Dr. Showalter are in the same building. You said this; you have left the implication that this is unfair. Now, Dr. Showalter has nothing to do with the Food and Drug Directorate. Am I correct in this? I am not right?

Mr. GILBERT: No.

Mr. MACKASEY: Is he not chairman of an interdepartmental committee on the question of the purchase of drugs.

Mr. GILBERT: He is a member of the committee on which the Food and Drug Directorate is represented and on which he is represented. They decide who shall pass on the 47-GP-1 regulations.

Mr. MACKASEY: This is not my interpretation of it. My interpretation is that Dr. Showalter is head of an interdepartmental committee that uses the facilities of the Food and Drug Directorate when investigations are being made or when the application of the rules 47-GP-1a and now 1b—do you sell to the government at present time?

Mr. GILBERT: No, not at the present moment.

Mr. MACKASEY: Why do you not? It seems to be a big market.

Mr. GILBERT: We were on the 47-GP-1. It was rescinded. There might be a source of controversy on this thing. I do not want to go into the details.

Mr. MACKASEY: I would not mind the details at all.

Mr. GILBERT: I felt that our company was put upon a bit. I do know this that our company is the most regulated company in the industry and—

Mr. MACKASEY: Is there a reason why you were singled out—why you are persecuted like this?

Mr. GILBERT: I will ask you why Parke-Davis is only visited once in five years and why we are visited three times a year.

Mr. MACKASEY: The reason why I am asking these questions is that the Food and Drug Directorate will be before us the end of January and we intend to ask them. We had Dr. Showalter and other officials here a few weeks ago and we went into this 47-GP-1b—

The CHAIRMAN: I would like to mention this for clarification that it has been called 74-GP-1b and 47-GP-1b.

Mr. MACKASEY: What is it?

The CHAIRMAN: It is 74-GP-1b.

Mr. MACKASEY: Why can you not meet these standards? Why are you not selling to the government at the moment?

Mr. GILBERT: I did not say we did not meet the standards. They say that.

Mr. MACKASEY: Why has the government come to the conclusion that you do not meet the standards? I am going to ask them anyway at the end of January so I would rather—

Mr. GILBERT: May I suggest that you pull the dossier on Gilbert? Maybe you would find a lot. I do not know—I never see it.

Mr. MACKASEY: I have not asked for a dossier. But you are the one that has made the suggestion that there is an unholy alliance between Dr. Showalter and the P.M.A.C. This is in your brief. It is not something I have raised nor would I have ever raised it. You raised it. At the same time it is the same Dr. Showalter who applies 74-GP-1b. I am just wondering about the relationship between that fact that your company has been discriminated against, in your opinion—

Mr. GILBERT: I did not say we were discriminated against. I am sorry if I gave that impression. We have been ruled against.

Mr. MACKASEY: You have been ruled against by the same Dr. Showalter which you have now mentioned in your brief.

Mr. GILBERT: I did not mention Dr. Showalter.

Mr. MACKASEY: No, but is it Dr. Showalter you are referring to on page 30?

Mr. GILBERT: No, I am referring to a building and an office.

Mr. MACKASEY: All right, I am sorry. If you are trying to evade it I am going to ask you. On page 30 it says:

> —a loby located in the same city and perhaps in the same building where the nerve center for many Food and Drug decisions are made.

What is the name of the building?

Mr. GILBERT: If you look at the address of the P.M.A.C. I think it is the Gillin Building.

Mr. MACKASEY: The Gillin Building. Who else in that Gillin Building other than the P.M.A.C. is connected with Food and Drug.

Mr. GILBERT: I think the department of chemicals and industry.

Mr. MACKASEY: Who had that department?

Mr. GILBERT: Dr. Showalter, I believe.

Mr. MACKASEY: Who is the head of the administration of 74-GP-1b?

Mr. GILBERT: I imagine it would be Dr. Chapman.

The CHAIRMAN: Dr. Showalter.

Mr. GILBERT: I am sorry; it is Dr. Showalter.

The CHAIRMAN: He is chairman of the committee.

Mr. MACKASEY: I know that. It is just for the record I have asked each question.

Mr. Gilbert, I will get into another area. What is your opinion of the Hilliard report?

Mr. GILBERT: As Shakespeare might say: It stinks to the high heavens.

Mr. MACKASEY: I asked that objectively. What are your oppositions to the Hilliard Report which was brought about, as the Committee knows, through the questions of Dr. Jones.

Mr. GILBERT: I think it is a "paid for" recommendation and I think it has no basis in fact or reality and it is designed to protect this type of thing.

Mr. MACKASEY: In other words, you feel that the Hilliard report is unfair to the industry in general.

Mr. GILBERT: It is very fair to the industry—95 per cent of it.

Mr. MACKASEY: But I consider you part of the industry.

Mr. GILBERT: But I am only in the 5 per cent group. If you take it on averages it is very fair to the industry.

Mr. MACKASEY: Do you not think that the Hilliard Report was designed to protect the public against unsafe drugs.

Mr. GILBERT: Contrary. I think anything but. It is designed to protect the P.M.A.C., period!

Mr. MACKASEY: Would you elaborate and tell us how you came to that conclusion?

Mr. GILBERT: I look at it this way. You have a big bully in a ring and a fast little fighter in the ring with the bully. He cannot lay his hands on him. He is getting away with things, so he says to the referee: "Let us shorten the ring." This is the situation you have here.

Mr. MACKASEY: You feel the Hilliard report is working against the copiers?

Mr. GILBERT: Oh, definitely.

Mr. MACKASEY: What portions of the Hilliard Report bring about this unfair publicity to you?

Mr. GILBERT: This business of usurping the prerogatives of the Food and Drug Directorate. It is redundant.

Mr. MACKASEY: Some of the recommendations, as I recall the report, Dr. Gilbert, simply are concerned with the fact that when drugs are taken out of the new drug category, we presume that all side effects are made known and suddenly a side effect does spring up, a little like thalidomide, for instance, that the drug should be reclassified as a new drug, all over again.

Mr. GILBERT: The patent office is not going to do it for you. It is only the Food and Drug Directorate that is going to do it.

Mr. MACKASEY: Well, is this not what the Hilliard report is asking the Food and Drug Directorate to do?

Mr. GILBERT: No; the patent office, to usurp some of the functions of the Food and Drug Directorate.

Mr. MACKASEY: I agree with you. You are not against the basic principle, then, of the safety built in to the Hilliard Report.

Mr. GILBERT: I am all in favour of safety of drugs.

Mr. MACKASEY: But you are not against the report; you are only against the fact that you do not want the Department of Justice to implement the Hilliard report.

Mr. GILBERT: Yes, I consider it failed, yes.

Mr. MACKASEY: In other words, if the Hilliard Report was transferred into legislation under the jurisdiction of the Food and Drug Directorate, would you have any objection to the Hilliard Report?

Mr. GILBERT: They already have these directives and rights. What are you going to give them? Not only that, the Food and Drug Directorate not only concerns itself with patented products, but also non-patented products.

Mr. MACKASEY: You feel than that the Department of Justice should not take in consideration the Hilliard Report when it is ruling on compulsory licences.

Mr. GILBERT: That certainly has nothing to do with it.

Mr. MACKASEY: Right. Now, there is another comment on page 30, and I quote:

> Analysis of the definition of a new Drug will show—that any inspector, regardless of ability and training—can summarily stop a manufacturer from marketing a product. The regulation goes to such an extreme—that a mere change in the pressure used in making a tablet may be grounds for calling a product a new drug and a criminal charge can be laid against the "offender".

How would the inspector know whether pressure was changed.

Mr. GILBERT: What I said is this: if one wanted to—this has been stated; I would rather not mention the name because I am not sure of the name—but one of the members of the Food and Drug Directorate agreed that, according to these instructions they can even change the pressure—that is their own statement—and if we want to we can call it a new drug.

Mr. MACKASEY: Do you not think that the pressure used in the formation of a tablet is important?

Mr. GILBERT: Naturally, I can put a product in a capsule where there is no pressure involved at all.

Mr. MACKASEY: Even when the drug is in tablet form, there are cases where a doctor would prefer to prescribe a tablet.

Mr. GILBERT: Providing it disintegrates properly, I think the question of pressure is relatively unimportant.

Mr. MACKASEY: Does pressure have anything to do with disintegration?

Mr. GILBERT: Sometimes it may have.

Mr. MACKASEY: Then, there are some cases where pressure is important.

Mr. GILBERT: Yes, it could be.

Mr. MACKASEY: For instance, in the case of Tolbutamide, would you consider pressure important?.

Mr. GILBERT: Not really.

Mr. MACKASEY: Is the disintegration rate not important in a diabetic?

Mr. GILBERT: You get a certain disintegration rate; if it meets the specification, it does not matter what the pressure is.

Mr. MACKASEY: I ask you subjectively again, I keep repeating this: you did just tell me earlier that there is a relationship between pressure and the disintegration rate.

Mr. GILBERT: There might be, I should say.

Mr. MACKASEY: I would imagine in the treatment of a diabetic by oral form that the question of disintegration must be quite an important one. Do you agree to that?

Mr. GILBERT: I will explain it this way: the question of pressure is only brought up as an extreme, because it is something they had seen in print mentioned by the Department. I am not saying that the Food and Drug Directorate are really interested in the question of pressure, but I only bring this out to show the infinite totality of the definition of a new drug.

Mr. MACKASEY: I agree, I see your point now, but do you not agree that the Food and Drug Directorate, through its inspectors, should be the final say in all areas pertaining to safety?

Mr. GILBERT: Absolutely not.

Mr. MACKASEY: They should not?

Mr. GILBERT: No.

Mr. MACKASEY: And yet are they not the one protection for the public in the area of safety?

Mr. GILBERT: I confess they must have controls, too. I confess that the manufacturer who is dealing with the Food and Drug Directorate should know where his rights are and he should be permitted to substantiate himself and not be confronted with an authoritative decision, or an autocratic decision, I should say.

Mr. MACKASEY: But do you not think that an inspector should have the whole weight of the law behind him in all areas pertaining to safety. Do you not think that the inspector should—to take your example—demand the stoppage of the production of a new drug, even if he thinks, in the extreme example that you gave, that the question of pressure is important.

Mr. GILBERT: I think the inspector should always be right: unfortunately they are not.

Mr. MACKASEY: You are a good witness, Mr. Gilbert; you are evading the question, of course. Do you not think, for the safety of the public that the inspector should have this particular power to err. If they are going to make a mistake to make it on the side of safety.

Mr. GILBERT: But they should be open for questioning.

Mr. MACKASEY: Certainly. Now this leads me to another question, another point that surprised me. You mention that there is no appeal against the Food and Drug Directorate decisions. Did I see that in the brief somewhere?

Mr. GILBERT: Unless they bring charges against you there is not.

Mr. MACKASEY: Unless they bring charges against you.

Mr. GILBERT: Yes.

Mr. MACKASEY: You mean to say you have no appeal against the Food and Drug Directorate inspector.

Mr. GILBERT: Where would you go, unless you want to sue them?

Mr. MACKASEY: If the Food and Drug Directorate inspector should walk into your plant tomorrow and order you to cease production of a particular product for some reason best known to the inspector, have you no appeal?

Mr. GILBERT: No.

Mr. MACKASEY: You cannot—

Mr. GILBERT: I can go up and try to convince them, but the decision is there. There is no referee.

Mr. MACKASEY: I beg your pardon.

Mr. GILBERT: There is no referee.

Mr. MACKASEY: Now, this is important to me: when the Food and Drug Directorate inspector comes in and orders you to cease production of a particular product, are you telling me that you have no appeal under the law of Canada against this? You have nowhere to go?

Mr. GILBERT: Unless I want to sue the Food and Drug Directorate.

Mr. MACKASEY: Naturally.

Mr. GILBERT: In other words, anybody can sue anybody if they want to, as I have found out.

Mr. MACKASEY: Have you nowhere you can go to get an explanation.

Mr. GILBERT: That is something that would have to be investigated. If I had thought very seriously about it, I suppose I would find some means to effect this.

Mr. MACKASEY: You feel strong enough to put it in your brief. You state quite categorically in your brief—if I could find it, I can only go by memory—that you have no appeal.

Mr. GILBERT: That is right. They can summarily come out to my place and stop and say Mr. Gilbert, they are sealing this off and you cannot use it.

Mr. MACKASEY: And you cannot appeal it to anybody?

Mr. GILBERT: I can go to the Food and Drug Directorate and appeal to their sense of justice, but I do not know what else I can do.

The CHAIRMAN: There is no machinery of appeal.

Mr. GILBERT: No.

Mr. MACKASEY: Well, there is at least an appeal against the inspector's action to the directors of the Food and Drug Directorate.

Mr. GILBERT: That is right, and I have an idea that they would be very reasonable about it.

Mr. MACKASEY: Well, that is not the inference I got out of the brief.

Mr. GILBERT: As I say, it is slightly exaggerated in order to drive the point home; otherwise there would be no discussion on it.

Mr. MACKASEY: Mr. Gilbert, I appreciate your frankness; unfortunately Mr. Chairman I have to run to another committee.

The CHAIRMAN: Your time is up.

Mr. MACKASEY: I know, but there is a third and fourth time, is there not?

The CHAIRMAN: Perhaps.

Mr. HOWE (*Hamilton South*): No, I do not have any questions, Mr. Chairman. I would just like to say that this has been one of our more stimulating meetings.

Mr. ISABELLE: I have a few more questions. You are a manufacturer in Toronto.

Mr. GILBERT: That is right, only in Toronto.

Mr. ISABELLE: Do you have a plant in La Belle Province, in Montreal?

Mr. GILBERT: No.

Mr. ISABELLE: Just an office.

Mr. GILBERT: Yes. No, there is a distributor, who is entirely unrelated financially.

Mr. ISABELLE: A kind of warehouse.

Mr. GILBERT: No, there is a distributor who uses the name Gilbert but there is no financial relationship.

Mr. ISABELLE: Do you sell all across Canada?

Mr. GILBERT: Yes.

Mr. ISABELLE: In Vancouver?

Mr. GILBERT: Yes.

Mr. ISABELLE: To London Drug, to Mr. Batt?

Mr. GILBERT: Sometimes.

Mr. ISABELLE: How do you feel about Mr. Batt, the way he is running his business?

Mr. GILBERT: I think he is a forthright individual who is not afraid to say what he thinks and I think we need more people like that; that is the only way you are going to air problems.

Mr. ISABELLE: You are aware that the the thirty-five major drug companies in Canada in 1960, spent about $10 million in research, in hospital grants and things like that.

Mr. GILBERT: I am not aware of it, no.

Mr. ISABELLE: Since when are you in existence.

Mr. GILBERT: I have been in Canada since 1946. I might say, incidentally, it is the Canadian Patent Law that brought me here.

Mr. ISABELLE: But how long have you been in your business, Jules Gilbert Ltd.

Mr. GILBERT: About twenty years. I have been forty years in the drug business.

Mr. ISABELLE: How much have you spent in research?

Mr. GILBERT: To give a figure would make me blush, so I will not. We have not spent anything to be of any consequence.

Mr. ISABELLE: Thank you; very frankly.

The CHAIRMAN: Any questions.

Mr. LAIDLAW: I would like to ask another question following what Dr. Isabelle said in dealing with research. I believe a statement was made at the Sainsbury Committee hearing which is now going on in Great Britain, by one Dr.

Derek Dunlop and I just mention it to put it in the record. He states that 57 out of 66 most valuable drugs discovered in the last 25 years were developed by the drug industry. Now, in view of your comment earlier, Mr. Gilbert, that you felt that all the new drugs, at least from now on, would be discovered by government laboratories or university laboratories, could you elaborate further upon that?

Mr. GILBERT: I did not think they would be discovered in university laboratories. I just said that is where they should come from because I personally believe that the products of research should be impartial and I cannot say the results coming out of major industrial concerns are impartial. In other words, they have a product they think they can market and the public is going to use it because they are marketing it.

Mr. LAIDLAW: Do you think that much of the research going on now in Canadian industry, where it is going on, is not basic, that it is what, I think the words used here were molecular manipulation?

Mr. GILBERT: That is right.

Mr. LAIDLAW: In other words, not fundamental, not what Mrs. Rideout would like, not directed towards new drugs for cancer and that type of thing?

Mr. GILBERT: I think the industry uses a shop work technique. They set up a schedule of manipulating molecules and testing them for results, and taking their findings and if they find something interesting it becomes an invention. Furthermore, when they find something they want to market they set up a good all-inclusive patent which includes their failures and the good products, and some other things that might even be better. But they arrogate them for themselves the one compound they are selling, and I will say this conservatively, millions of compounds in the same area which will never be used and are ruled out from general investigative procedures because of this one patent. We pointed this out very strongly in our own patent litigation and for this reason many patents have been aside, some patents have been set aside.

Mr. LAIDLAW: Are you suggesting that much of the patenting by the drug industries is done as self-protection, to close in that particular market?

Mr. GILBERT: Absolutely. If you did not have this I think you would find that the potentiality of a firm, or of a company, or a research organization like Connaught, would be enhanced considerably because at every turn where they want to investigate a product they find they are constrained by a patent and they have to just drop it even though nobody will ever use these products.

Mr. LAIDLAW: This is from your own knowledge, Mr. Gilbert?

Mr. GILBERT: This I have had discussions with Connaught on.

Mr. MACKASEY: How long can you keep such a patent tied up?

Mr. GILBERT: Seventeen years.

Mr. MACKASEY: Even if they are not using it?

Mr. GILBERT: That is right, that is, a reputable firm will not question the legal propriety.

Mr. LAIDLAW: Mr. Gilbert, going a little further, in your brief I notice you suggested there should be a mortatorium on patents for a period of, say, ten

years to more or less see what would happen. But if the Committee does not choose to make this recommendation, what recommendations would you have with respect to the term of patents on drug processes?

Mr. GILBERT: I see nothing wrong with a 17 year patent. The harm I see is in the patent that are issued and the way they are granted. I think that is all wrong.

Mr. LAIDLAW: I see. Going one step further back to the compulsory licencing system, it has been stated before the Committee several times, for example a company which has introduced a valuable product, as soon as the patent is issued within a day or two a compulsory licence application can be made by a third party. It was suggested that the company should be allowed to certain length of time to recoup its research costs. The time suggested I believe was three years. Have you any suggestions?

Mr. GILBERT: My answer to that will be that they have already had their three years by the time the patent is issued.

Mr. LAIDLAW: In other words, they are selling prior to the patent being issued?

Mr. GILBERT: That is right.

Mr. LAIDLAW: In many instance?

Mr. GILBERT: That is right.

Mr. LAIDLAW: Do you think three years is a long enough time for a company to recoup its research costs?

Mr. GILBERT: I think they should be entitled to 17 years if they have a proper patent. I also feel strongly—this I want to intrude—that the system of patents is a oneway street in favour of the patentee. In other words, first he arrogates to himself certain rights granted by the commission; whether right or wrong does not matter. They have convinced the commission to grant the patent. They have got the patent. They use this as a club to stop competition in the industry. You have the threat of a $30,000 to $50,000 defence problem if you want to question the patent. The few patents that have really gone through the courts in the past few years have eventually all been declared invalid. However, we find that the patentee, in spite of the fact he has had an invalid patent, never has to pay back one penny of his gains, and the man who has set this thing right may get back one third of his costs. I feel that this thing should be put in the proper relationship, whereby the patentee, if he loses his patent, should suffer triple damages, based on actual costs of defence. I think this would put a new light on the matter.

Mr. MACKASEY: You said one third: is that an arbitrary figure or is it incident?

Mr. GILBERT: This is an incident.

Mr. MACKASEY: This is an incident. There is no law that says you are going to get only one third?

Mr. GILBERT: This is about the way it works out when your case is taxed.

Mr. MACKASEY: This is an incident. There is no law which says you are going to get only one third?

Mr. GILBERT: Less than one third of what it cost.

Mr. MACKASEY: —and the patentee never paid back any royalties.

Mr. GILBERT: As a matter of fact, they are still getting royalties on a patent which is invalid.

Mr. MACKASEY: But there is nothing in the law which says that you only get one third?

Mr. GILBERT: Oh, yes, the law controls it in the way and decides what expenses you are entitled to ask for.

Mr. MACKASEY: Yes; but that is a flexible figure.

Mr. GILBERT: No, rather inflexible.

Mr. MACKASEY: Now, Mr. Gilbert, it seems to me, you and I are on the opposite side of the fence a lot today. Is there anything in the law that says you are limited to one third of your expenses if you win your case?

Mr. GILBERT: There is nothing in the law. However, there is a system of taxing cost which allows you so much for each little particular action, regardless of what it cost.

Mr. MACKASEY: There is a schedule set up?

Mr. GILBERT: That is right.

Mr. MACKASEY: And in your case it added up to one third of the cost of your whole action?

Mr. GILBERT: That is right.

Mr. MACKASEY: But I had originally, from your remarks presumed there was something in the law which said you get only one third?

Mr. GILBERT: No, no. This is a fact. There is nothing in the law.

Mr. LAIDLAW: Do you think, speaking of it as a practical matter, Mr. Gilbert, that triple damages, as you suggest, for the reasons you suggest, is practical at all? It could not only, surely, be applied to the drugs or patent cases but all patent cases?

Mr. GILBERT: I think it would be a good suggestion for all patent cases, particularly with drugs.

Mr. LAIDLAW: I have no more questions, Mr. Chairman.

The CHAIRMAN: If the Committee will excuse me for a moment, we are having some trouble with the table. Mr. Mackasey, do you have any other questions?

Mr. MACKASEY: I suppose not, Mr. Chairman. There was one point I did want to raise. Perhaps I have lost the sense of it. Mr. Gilbert, we were talking about generics. Let me come back to Dr. Showalter. The evidence we received last week was that the Department of Industry's purchasing set-up is interdepartmental committee recommendations and that approximately, I would say, 90 per cent of the requests they are making are being made under the generic term. Would you agree with that?

Mr. GILBERT: Yes.

Mr. MACKASEY: This hardly, to me the layman, indicates any preference being shown the brand companies or the P.M.A.C, the establishment, as you call it.

Mr. GILBERT: I never suggested that.

Mr. MACKASEY: I see.

Mr. GILBERT: I know definitely that they specifically request their products by the product name rather than by the brand name.

Mr. MACKASEY: In other words, you have no complaint then with the directive that Dr. Showalter has sent out?

Mr. GILBERT: No.

Mr. MACKASEY: It just makes me wonder a little more about your reference to the fact that he is in the same building as the P.M.A.C., in view of your testimony now that he is acting at all times in a fair manner—

Mr. GILBERT: This was not an attack on the department. I am just referring to the P.M.A.C. lobby activities.

Mr. MACKASEY: You did get into an area—correct me if I am wrong—about generics. You did imply that you are not too happy about the generic industry in general. Am I wrong in saying this?

Mr. GILBERT: I spoke only for my own company, I never mentioned the industry.

Mr. MACKASEY: All right. Are you satisfied with the industry in general?

Mr. GILBERT: I think both sides need improvement.

Mr. MACKASEY: Including the generic side?

Mr. GILBERT: Oh, yes, definitely.

Mr. MACKASEY: In other words, if the druggist did have the right, as he has—do you sell in Alberta?

Mr. GILBERT: Yes.

Mr. MACKASEY: Where the druggist has the opportunity of substituting generic for brand?

Mr. GILBERT: Yes.

Mr. MACKASEY: Do you approve of this?

Mr. GILBERT: Well, this is the point I tried to make. I think the pharmaceutical profession should develop into true professionals in determining true value of products, regardless of source.

Mr. MACKASEY: Well, how would the pharmacist distinguish between the various generic companies?

Mr. GILBERT: How does the doctor distinguish? I do not know?

Mr. MACKASEY: Obviously he does not. You have said twice today that we have the cheapest drugs in the world in Canada?

Mr. GILBERT: That is right.

Mr. MACKASEY: When I interfered—which I should not have done, Mr. Chairman—with Dr. Howe who mentioned that people would prefer to buy on the third floor rather than the basement, the point that I was getting at was the people in this instance are the doctors. Am I right? Prescriptions are prescribed by a doctor?

Mr. GILBERT: Well, when I was referring to it in that connotation I believe that I referred to the fact that there are some individuals who are prepared to buy at the highest price, assuming that that is the best.

Mr. MACKASEY: Who is that individual in this particular instance? I never go and buy my own drugs; the doctor prescribes the drugs.

Mr. GILBERT: Well, I have personal friends who are in that category, who pride themselves in paying high prices.

Mr. MACKASEY: Yes, I agree with this philosophy, and I agree that this is a quirk of human nature. But let us get back to drugs. When I take sick and a doctor calls on me, he does the prescribing. It is up to the doctor to prescribe the bargain basement drug or the brand name; am I right in that?

Mr. GILBERT: If we put it this way: the low cost drug and the high cost drug, I will answer the question.

Mr. MACKASEY: All right, the drug is not necessarily the cheap drug, whether the drug sells cheaply or the drug sells dearly—

Mr. GILBERT: Now, this is a great mystery to me, as to what motivates the doctor's choice, when he knows what is available.

Mr. MACKASEY: Now we are getting down to my point. It is the doctor who has this quirk of human nature, not the patient?

Mr. GILBERT: No, the patient might very well like to have the lower cost drug.

Mr. MACKASEY: So, it is the doctor, despite his ethics, despite his degree of education, it is still the doctor who would rather prescribe an $8.95 prescription over a $2.95.

Mr. GILBERT: That is right.

Mr. MACKASEY: In other words, there is really nothing wrong with the cost of drugs in Canada.

Mr. GILBERT: No, if it is made available.

Mr. MACKASEY: And the only reason it is not made available is that doctors refuse to prescribe them?

Mr. GILBERT: That is right.

Mr. MACKASEY: Now, is there any difference between a Gilbert generic and somebody else's generic?

Mr. GILBERT: I have not investigated the others. All I know is that I have pride in my products, and I cannot speak for other companies.

Mr. MACKASEY: Would you have any objection if a doctor were to prescribe a Gilbert generic and a druggist were to change it to some other generic?

Mr. GILBERT: I think he would be doing his patient a big favour.

Mr. MACKASEY: I do not think you understood me.

Mr. GILBERT: Perhaps it is not understandable.

Mr. MACKASEY: No, but it would be very unfair to you. I may be hard, but I am not unfair. I simply said that presuming a doctor willing to take advantage of the low cost of generic products, and knowing your reputation for, we will say, safety—which in his case he presumes to be impeccable—he prescribes in such a manner that he insists on Gilbert generics.

Mr. GILBERT: Yes.

Mr. MACKASEY: This is the question I asked you.

Mr. GILBERT: This can happen.

Mr. MACKASEY: I am sure it must happen. In other words you brand your generical.

Mr. GILBERT: He has an awful lot of difficulty getting it, but it happens.

Mr. MACKASEY: You brand it in a sense. Now, what would your reaction be if the pharmacist were to prescribe somebody else's generic?

Mr. GILBERT: This is where merchandising power comes to play, and this is where you have to convince the druggist—in our own limited way—to support our stand. This is all salesmanship again, and we do not have the funds that the P.M.A.C. has.

Mr. MACKASEY: What you are saying is that not only must you have the double duty of convincing the doctor to prescribe generics, and the druggist to carry generics; you must also convince both of them that Gilbert generics are better than somebody else's generics.

Mr. GILBERT: Gilbert generics are proper. I would not draw any comparison. I would sell Gilbert products *per se*, not as a comparison; I might compare prices, but not quality.

Mr. MACKASEY: All right, why? Quality I am sure stands comparison.

Mr. GILBERT: Well, I would not talk about it. I mean, I would not knok a competitor's product; I like them to knock mine.

Mr. MACKASEY: You mention detailmen, and you mention merchandising, but looking at your catalogue, I think, Mr. Gilbert, you are a pretty shrewd merchandiser as well.

Mr. GILBERT: Thank you.

Mr. MACKASEY: You have substitute gifts for detailmen, have you not? In your catalogue, you mention—and this is another area I would have loved to go into, Mr. Chairman, the table in which Mr. Gilbert went to great extremes to compile all the balance sheets of the industry—that if the profits are high, the drug industry will then give out a few more gifts to a golf tournament.

Mr. GILBERT: Well, I sincerely believe that this is the least—I have never been behind locked doors—but I believe that the major companies budget to a profit.

Mr. MACKASEY: What is the basic difference between the big company giving a trophy, or a set of golf clubs, and you giving an electric typewriter?

Mr. GILBERT: The basic difference is that—and it is a big difference—when they do it they are using it as a form of blandishment to the doctor to utilize a product which is going to cost the patient more, and making the patient pay for what he is receiving. I think that is wicked.

Mr. MACKASEY: And your admonition is to prescribe a product that sells for less.

Mr. GILBERT: And this I will say no matter what gimmicks we give, or what bonuses we give; they are still getting basic value before that.

Mr. MACKASEY: In other words, your method of merchandising is justifiable because in the end result the patient will be saving money.

Mr. GILBERT: Exactly, and if I encourage the doctor to use our products because of a gimmick, or a premium, he is also extending the benefit to the

ultimate user and he can do it with a free conscience, which you could not do with a golf tournament.

Mr. MACKASEY: In other words, he can accept the typewriter, but he should not accept the golf clubs?

Mr. GILBERT: No; I think you have to go basically into the fact as to what he is doing. In other words, I say that he can utilize our products, regardless of gimmicks, with true conscience because he is giving value to his patient. On the other hand, if he accepts a gift from a company and then utilizes that gift, and supports that gift by prescribing a product which is out-priced, he is making his patient pay for that; that is wrong.

Mr. MACKASEY: All right, I just wanted to get you philosophy on this, Mr. Gilbert. On page 21 of your brief, you take the trouble of compiling all the briefs of the 41 companies that were available to you.

Mr. GILBERT: I took the actual figures in the first column.

Mr. MACKASEY: Yes; you have compiled their balance sheets.

Mr. GILBERT: I copied their balance sheets.

Mr. MACKASEY: Yes; I appreciate the work because what little education I have happens to be in accounting, so I understand what you have there.

Mr. GILBERT: I will tell you a secret, I have a machine that gives me the answer if I press a button. It is not as tough as it looks.

Mr. MACKASEY: I think your machine turns out a lot of answers, Mr. Gilbert. We will not get into that; not while we are both in good humour. But I would have to say that this is rather naive. All you have emphasized here and in your little lecture to us on the next page in your conclusions, is that once the company gets back its fixed expense area, its margin of profits go up very rapidly.

Mr. GILBERT: That is right.

Mr. MACKASEY: What is new about that theory? What are you trying to get at?

Mr. GILBERT: I am just pointing out the true profit that they are working on, what they get beyond a certain point. In other words, when you are talking about 8 per cent figures that is an over-all picture, it is true, but what I am trying to point out is that once they get beyond that point—in other words, when they get "off the nut", so to speak—what is their true profit? This is what I tried to point out.

Mr. MACKASEY: Is this not true of all industry? Is it true of your own business?

Mr. GILBERT: Yes, to a certain extent.

Mr. MACKASEY: It is true of your own business as well.

Mr. GILBERT: Yes, but until I sell a certain amount of goods I do not make money.

Mr. MACKASEY: What you have said here is that according to the balance sheets last year the net earnings of the pharmaceutical industry ran at about 8 per cent but, had they been able to increase their sales by 5 per cent, their profit would have gone up to almost 30 per cent.

Mr. GILBERT: No, the increase in profit would be on a 30 per cent basis after taxes.

Mr. MACKASEY: But only in that 5 per cent area, not on the whole picture.

Mr. GILBERT: That is right.

Mr. MACKASEY: You did not say that?

Mr. GILBERT: I thought it was obvious.

Mr. MACKASEY: Nothing is obvious in a brief. It is just as obvious, then, by your own arguments, that had their sales fallen 5 per cent.

Mr. GILBERT: I worked that out, too.

Mr. MACKASEY: Do you? I did not read it. I could not find it.

Mr. GILBERT: I have two tables, minus 5 per cent and plus 5 per cent.

Mr. MACKASEY: But your conclusions treat here only with the result if they increase their sales 5 per cent. You did not go to a—

Mr. GILBERT: I pointed out those, I believe.

Mr. MACKASEY: Would you like me to read it to you? It is on page 22.

Mr. GILBERT: If I did not, I meant to.

Mr. MACKASEY: I am sure that it was not left out on purpose. That is no inference on my part. I am just trying to make it complete.

Mr. GILBERT: The first statement is that on a sales reduction of 5 per cent of $5,389,225 the difference in profit before taxes was $3,621,448. That is the first statement.

Mr. MACKASEY: You did not mention the percentage.

Mr. GILBERT: Since the figure are almost alike I thought you could easily extrapolate the—

Mr. MACKASEY: Yes, we could have done it easily. Will you go on to the next one?

Mr. GILBERT: "On a sales increase of 5 per cent of $5,389,225, the increase in profit was $3,548,400, which shows a profit margin on the increased sales of 66 per cent, or almost 33 per cent after taxes, a far cry from the 8 per cent claimed".

Mr. MACKASEY: Let us stop there as two good accountants, Mr. Gilbert, and I understand you are one. You know this is apples and oranges. The 8 per cent claimed is on the total picture.

Mr. GILBERT: That is right.

Mr. MACKASEY: The 33 percent that you mention refers only to the increase in profit.

Mr. GILBERT: That is right.

Mr. MACKASEY: Therefore, this is inaccurate, is it not?

Mr. GILBERT: No, my statements are accurate.

Mr. MACKASEY: But there is no relationship between the 33 per cent—

Mr. GILBERT: But the P.M.A.C. have created the illusion that they work only on 8 per cent regardless of figures.

Mr. MACKASEY: I see, I thought—

Mr. GILBERT: This is the illusion I am trying to correct.

Mr. MACKASEY: The impression I got from the brief was that the balance sheet at the end of the year indicated that they made 8 per cent last year.

Mr. GILBERT: I point out further that if it were a product like stelazine it would probably have been an 80 to 90 per cent increase.

Mr. MACKASEY: The point I am trying to make Mr. Gilbert, is that I am under no illusions that if the P.M.A.C. could increase their profit from 8 per cent to 33 per cent they would not have increased it. You say that the name of the games is profit. I am just saying that by mixing up the 33 per cent after taxes, and then going on to say "a far cry from the 8 per cent claimed", you are talking about two different things. The 33 per cent refers to the degree of profit in that 5 per cent extra sales.

Mr. GILBERT: That is clearly stated.

Mr. MACKASEY: The 8 per cent refers to the total sales.

Mr. GILBERT: Yes, that is right.

Mr. MACKASEY: Coming back to the question, it intrigued me a little, and I would like to know how you can do it, because business-wise it would be a great secret. How can you distribute $6 millions more without increasing distribution costs?

Mr. GILBERT: I think any shipping clerk can ship 5 per cent more or less in one day, and the cost of the warehousing would be identical.

Mr. MACKASEY: You are presuming that this 5 per cent increase would be to the same customer. Let us suppose that this 5 per cent increase sales came about in a new market in a part of the country that is very difficult to get to.

Mr. GILBERT: You might take a gross package instead of a dozen package and the labour will be the same.

Mr. MACKASEY: You are telling me, then, that there is no basic difference between the distribution costs of selling $107 million and selling $115 million?

Mr. GILBERT: I do not think it would affect it materially. There would be a slight difference, but I could not put it in the 5 per cent category.

Mr. MACKASEY: Would you say there is no difference in marketing?

Mr. GILBERT: The assumption is on the basis that they have budgeted for a certain amount of sales. This has already been budgeted for, and my contention is that they cannot predict within plus or minus 5 per cent what they will get.

Mr. MACKASEY: What happens if they sell 5 per cent less than the 100 per cent?

Mr. GILBERT: They would be able to prepare a better brief.

Mr. MACKASEY: But they would have had 29.8 per cent less profit by your argument.

Mr. GILBERT: No, because it would reduce itself, perhaps, to 6 per cent.

Mr. MACKASEY: No; I am using the same argument you are using, the 33 per cent profit after taxes. I could change it to say that on a sales decrease of 5 per cent the decrease in the profit would be so much, which shows that the profit margin on the decreased sales was almost 30 per cent less.

Mr. GILBERT: All I am trying to prove there is that the percentage of profit on the basis of the combined statements of the P.M.A.C. after the basic cost of operation is met, is 66 per cent before taxes. Whether you reduce it or increase it does not make any difference.

Mr. MACKASEY: It is such an incidental point that I do not like to argue with you, but I do not like you to make a statement which is not accurate. You are leaving the implication that if the industry were to increase its sales by $5 million—or 5 per cent—it would increase its profit from 8 per cent to 33 per cent. That is not true.

Mr. GILBERT: I did not say that. I am glad you have helped to make this clear, because that is not what I meant. All I say is that they are working on a 66 per cent base after expenses are met.

Mr. MACKASEY: The inference I get from it—again as an accountant—is that once they get beyond a particular point in their operation, if they can increase sales 5 per cent and not increase the cost of distribution one cent and not increase marketing one cent, the percentage of gross profit in that 5 per cent area would be 66 per cent.

Mr. GILBERT: That is right.

Mr. MACKASEY: What effect would that have on the over-all picture?

Mr. GILBERT: It would have a total value of about five one-hundredths of the total. In other words, it would affect the over-all profit by 5 per cent.

Mr. MACKASEY: Now, we are getting down to the truth. In other words, if they could have increased their sales by 5 per cent and not increased the cost of distribution, the profit picture would no longer be 8 per cent but would be 13 per cent.

Mr. GILBERT: I would have to calculate that; I do not know, but it could be done.

Mr. MACKASEY: By the same argument, if the sales had fallen off 5 per cent, their over-all profit—

Mr. GILBERT: Would have fallen off, too.

Mr. MACKASEY: Yes, to between 5 and 6 per cent.

Mr. GILBERT: When you go down far enough you find out what the break-even point is.

Mr. MACKASEY: Thank you very much.

The CHAIRMAN: Are there any other questions? If not, I would like to thank Mr. Gilbert for coming before us today and presenting his brief. The Committee is adjourned until the 12th of January, when we will have Micro Chemicals and Paul Nancy before us.

APPENDIX "A"

CYANAMID OF CANADA LIMITED
635 Dorchester Boulevard West
Montreal 2, Que.

NOVEMBER 15, 1966.

SPECIAL DELIVERY

The Chairman,
House of Commons Special Committee on Drug Costs and Prices,
Parliament Buildings,
Ottawa, Ont.

Dear Sir:

On October 18, 1966 during Cyanamid's presentation to your Committee on Drug Costs and Prices, Mr. W. J. Blakely (Accountant for the Committee) asked two questions which our officials present were unable to answer.

Since these figures were prepared under my direction, you suggested it would be appropriate for me to reply by correspondence.

Cyanamid's presentation stated that its return-on-investment during 1965 was 10 per cent which was lower than the average of 19,666 manufacturing firms who responded to a survey conducted by Dun & Bradstreet. Regarding Cyanamid's statement, two questions are at issue:

1. The definition of investment stated by Cyanamid differs from the definition stated by Dun & Bradstreet. Hence the two results may be different:

In this instance, the basic of the computation used by Cyanamid is identical with that of Dun & Bradstreet. We could just as well have stated that our "Profits on Tangible Net Worth" for 1965 was 10 per cent. Mr. Blakely's point was well taken because theoretically there could have been a difference. However, in fact, there was no difference.

2. The Dun & Bradstreet figure of 12.47 per cent "Profits on Tangible Net Worth" for Canadian manufacturing corporations was not for the same year as Cyanamid's 1965 figure of 10 per cent:

In preparing our presentation, we thought Dun & Bradstreet's figure was for 1965. Upon rechecking, we find it was for the year 1962, which generally was not as profitable a year as 1965. Dun & Bradstreet's figures for 1963 are now available and are compared below with those of 1962:

Year	Profits on Tangible Net Worth	Number of Canadian Mfg. firms reporting
1963	12.88%	19,140
1962	12.47%	19,666

It also should be noted the Dun & Bradstreet percentages "are averages and include both profitable and unprofitable concerns."

Briefly summarized, Cyanamid's 1965 profit on investment was 10 per cent which was significantly *less* than that of the average Canadian manufacturing corporation.

Yours very truly,

T. F. Kyle,
Treasurer & Controller.

APPENDIX "B"

CHARLES E. FROSST & CO.
MANUFACTURERS OF QUALITY PRESCRIPTION MEDICINES
P.O. Box 247
MONTREAL 3, CANADA

NOVEMBER 15, 1966.

Dr. H. C. Harley,
Chairman,
Special Committee on Drug Costs and Prices,
House of Commons,
Ottawa, Ont.

Dear Dr. Harley:

Sale of Frosst Products in Export Markets

When we appeared before your Committee on November 1, I promised to give written replies to two questions concerning our export sales. From our records we find that the questions were substantially as follows:

1. How do the prices we sell at in the export market compare with the prices for the same products in Canada?

2. When products are sold abroad, how do we regain a reasonable proportion of the research costs which we incur in Canada?

Question 1

Falapen is the major product manufactured in Canada and shipped in consumer package sizes for sale in other parts of the world. The reason for this is that Falapen has to be produced by advanced manufacturing techniques which are only available at the Frosst plant in Montreal. Comparative prices to the retailer (i.e. the pharmacist) of Falapen are as follows:

	Price to Retailer ($ Cdn.)	
	Size	
	10's	*100's*
Canada (excluding F.S.T.)	$ 1.35	$ 12.09
Jamaica and Trinidad	1.65	13.80
Lebanon	1.63	

In Peru, Falapen is sold in different sizes. The price to the retailer there for packets of four is 98 cents, and for packets of eight, $1.88.

Falapen is also shipped in bulk to the Phillipines, England and Holland where other pharmaceutical companies package, promote and sell the final product. Our bulk selling price is comparable to the price that would be charged for similar quantities in Canada and allows us to meet all our manufacturing, research and administrative costs, and give us a fair return on the sale. The price of Falapen to the retailer in these countries is decided by the foreign company to ensure a return that covers all its costs including any sales and marketing it is required to do.

The Caribbean is the one area to which we export a wide range of products directly from Montreal. Jamaica is the largest single market in the area and is, therefore, used as the example.

The following is a representative list of the major products we export to Jamaica, with prices in equivalent Canadian dollars, excluding Federal Sales Tax. For practically all products the Canadian price is lower; for the few exceptions, the Canadian price is only marginally higher.

		Price to Retailer	
		Jamaica	*Canada*
Product	*Size*	*($ Cdn.)*	*(Excl. F.S.T.)*
"292"	100	$ 4.32	$ 2.94
"282 MEP	100	5.85	4.86
Aurimel	4 oz.	1.53	1.10
Dulsana No. 631	4 oz.	0.70	0.69
Entrophen	100	1.58	1.10
Flavedrin	1 oz.	0.83	0.69
Megacillin 500 Susp.	60 cc.	1.65	1.46
N.C.F. Rx 1	24 day	1.44	1.26
N.C.F. Geriatric	16 oz.	2.89	3.18
Orchisterone-P No. 518	10 oz.	3.60	2.01
Pamovin	6	1.51	0.82
Progesterone 25 mg.	10 c.c.	4.50	4.18
Prohema	100	2.88	2.18
Propl-Thyracil 25 mg.	100	2.45	1.54
Trulfacillin Ped. 3-200	60 cc.	1.01	1.04
Trulfacillin Susp. 7½-200	60 cc.	1.20	1.10
Tutamate	60	2.79	1.65

Question 2

Where we export the finished product, a percentage to pay for research costs is built into our price to the distributor. Where we have manufacturing agreements, such as in the Middle East and South America, we recover a fair proportion of our research costs through royalty and other payments.

Where we make bulk shipments (the only instances involve Falapen to the Phillipines, England and Holland, as mentioned on page 2), our bulk selling price includes all direct selling expenses and a built-in royalty, which again contributes towards our research and developments costs.

This year sales of our Canadian-made products in the export market will total $1,100,000 representing some 10 per cent of our total sales.

I trust this is the information that your Committee required. If any further explanation is needed, I will be pleased to supply it.

Yours sincerely,

James E. Frosst
President

APPENDIX "C"

ONTARIO PHARMACISTS' ASSOCIATION
175 College Street,
TORONTO 2B

NOVEMBER 16, 1966

Mr. H. C. Harley, Chairman
Special Committee on Drug Costs & Prices,
House of Commons,
Ottawa, Ontario.

Dear Sir:

Further to our communication regarding a submission to the Special Committee on Drug Costs and Prices from the Ontario Pharmacists' Association.

We beg to advise that it is our decision to support the submission of the Canadian Pharmaceutical Association presented by Mr. John C. Turnbull in Ottawa June 14, 1966. We ally ourselves completely with the facts set out in this presentation but would re-emphasize particularly the facts set out on page 107.8 (1 & 2) as they relate to the 11% Federal sales tax and the information on "multiple pricing policies". Aside from the remuneration needed for the operation of this dispensing service the pharmacist has little control over costs which, by and large, is totally influenced by prescribing habits and the replacement value of the medicinal agent. The remuneration or dispensing fee is under constant study by this Association, attempting always to be fair and equitable to the profession yet with equal consideration of the public interest.

The Ontario Pharmacists' Association record here their desire to be of any assistance possible to the Committee, and if it were your thought that we could add any supporting information from the retail point of view, we would be most willing to appear for questioning.

Please be assured of our continuing interest in the deliberations of this very important committee.

Yours truly,

S. G. TURNER, Phm.B.
Executive-Director

APPENDIX "D"

Submission to

THE SPECIAL COMMITTEE

on

DRUG COSTS AND PRICES
HOUSE OF COMMONS, OTTAWA

by

Jules R. Gilbert, Ph. G., B.S. Ch.E.

on behalf of

Jules R. Gilbert, Ltd.
Toronto 9, Canada

December 13, 1966.

1. *Introduction:*

This submission has been motivated by allegations made by Smith Kline & French (SKF) in their submission dated October 1966 before this Committee.

These allegations had widespread newspaper publicity and must have created erroneous impressions in the public mind. We trust that equal publicity will be given to our denials, and that a formal apology will be issued by SKF. Failing this, they should be made to support their allegations.

1.1 *Scope of submission:*

We propose:

To reply to, and factually discuss the allegations of SKF.

To discuss the P.M.A.C. brief and testimony from the vantage point of an outsider in the industry.

To discuss drug Research in General and drug Research in Canada.

To discuss the Food and Drug Act as an Act and its bearing on drug costs.

To discuss Patents and Patent Law.

1.2 *Aims:*

It is our hope that we may be instrumental in brushing away the cobwebs that have been so skillfully spun by the P.M.A.C. and their paid experts, and the members of the P.M.A.C. who have made their submissions before this Committee. Light thrown on the cobwebs will permit observation of what lies behind.

2. *Vital Statistics:*

We regret that we are not in a position to present a battery of vice-presidents, legal counselors, accountants, marketing and research directors to handle each phase of the problem. It is only by a miracle of fortitude and endwrance that we can stand here and say the things that we propose to day. This may be considered as a tribute to Parliament and Canadian justice.

Our background follows:

2.1 Ph. G. from Columbia College of Pharmacy 1926 (magna cum laude).

2.2 B.S. in Ch.E. from Cooper Union Institute of Technology 1931.

2.3 Employed between 1926 and 1931 as an apprentice pharmacist, and analytical control and research chemist for G. W. Carnrick Co., Newark, N.J.

2.4 Spent a short time on a privately endowed Cancer Research problem.

2.5 1932-1936, Assistant Supervisor of the Pharmaceutical Department of National Aniline & Chemical Co. Engaged in actual synthesis of about 150 medicinals and biological stains.

2.6 Initiated the firm of National Synthetics now known as Bell-Craig Inc. This firm specialized in the manufacture of contrast media for use in X-Ray diagnosis. (1936).

2.7 Engaged in a patent suit with the Schering Corporation between 1941 and 1945.

2.8 Started a drug company in Canada in 1946.

2.9 Branched out into hospital and medical supplies under the current name and style of Jules R. Gilbert Ltd.

2.10 In 1957 our company initiated its Generic Drug program.

2.11 In 1961 we built our own pharmaceutical plant.

2.12 Our company is a veteran of a large number of patent suits, some of which have been settled by negotiation, others by licensing, ten patents have been declared invalid and some are lying dormant.

2.13 Gilbert has been or is being sued by:

1. Parke-Davis
2. Poulenc
3. Pfizer
4. Frosst
5. Horner
6. Ciba
7. G. D. Searle
8. American Cyanamide
9. Schering
10. Hoechst
11. Merck
12. Upjohn

Gilbert is suing:

Smith Kline & French.

Several other companies did not complete their threats of legal action.

2.14 The writer became a Canadian Citizen in 1966, so that we can now proudly say that we are wholly a Canadian Company.

2.15 *Comment:*

With this background we can lay claim to being conversant with every phase of the pharmaceutical industry, be it Control-Research—Synthesis —Compounding—Accounting—Marketing—Patents.

When we discuss a problem, we hope that we can view each problem from the standpoint of its relationship to the entire industry, and not just as an isolated phenomenon. Unlike the P.M.A.C., and its members, we are not here in the public interest, to protect the public's right to pay "fair prices" based on the man hour rate in Canada. Candidly, we are here to protect our way of doing business. If our actions happen to be *pro bono publico,* then we are pleased.

3. *Copiers and innovators*:

3.1 Before we discuss the SKF allegations we feel that we should explain our stand on Copying and Innovation.

By American Cyanamide's definition our company falls into the classification of a Copier. We state with *pride* that we are not only Copiers, but good Copiers. While we have a few unique formulations, and we have been known to supply special preparations for research activities, also contributed money towards research—the contributions have not been significant.

Copying is a Public Necessity. If no Copying existed there would be no area for competition. The Innovator could set up rules for his own benefit and the public detriment.

What is good for the Innovator is not necessarily good for the public.

3.2 When we copy a product we try to give a good performance, and lean over backward to give better than full value.

3.3 *Placebos in Medicine: Reason for copying*

It is recognized in medical practice that there is often a psychosomatic effect in taking medication. This is mostly prevalent in the Tranquilizer group of medication. Double Blind Studies must be run in order to separate truth from fancy. The patients are separated into two groups, one of which is given the medication and the other is given an identically appearing product with milk sugar as the active ingredient. This procedure rules out, or balances, the effect of merely taking a pill. Many products do not reach the market because the Placebo has proven as effective as the drug.

We emphasize this Placebo effect because when a patient is accustomed to a certain size, shape, and color of a tablet, it becomes an important part of his treatment, and a doctor will often resist the introduction of a new, even though innocuous factor, in the treatment of his patient. This is why we try so hard to emulate—the physician can now make a transition without difficulty to his patient while saving him 50 per cent of his medication cost. Ergo; if the Ethical Niceties recommended by the innovators are observed, the patient, the hospital, and the doctor may be deprived of the benefits of an Economical Therapy.

3.4 *Innovation*:

This, to our mind, means the introduction of something which has not been done before. Innovation is not always patentable. We do not wish to detract from the value of true Research, when the fruits of such Research reaches the public domain. Our company has taken a stand on the subject of monopolies in the Drug Industry—whether such monopolies are obtained by Brute Merchandising Force or Patent Created Monopolies, the results are equally bad. In 1957, we publicly stated, that there is not a truly valid drug patent written, and we have stood by our convictions, and still see no reason for retraction of this statement.

Our company is an Innovator, in a sense, in that it has taken a fresh stand against established practices, which, by usage, have lulled the public and medical profession into acceptance of these practices. This Innovation has become a matter of great concern to the P.M.A.C., who have paid and suborned intellects to justify their monopolies. They will fight to the last dollar of the Public's money, to protect the Public's Right to pay a "Fair Price" for drugs, scaled to the earning power of Canadians.

3.5 We feel that whether a company is an Innovator or a Copier, their primary interest is profit. We know of no Innovator who has not started out as a Copier.

4. *Smith, Kline & French of Canada:*

4.1 Our first experience with SKF was in 1947, which might be too long ago for the current generation of SKF executives to be aware of this incident.

An SKF representative was sent to our company to ask us to remove the product Amphamine (amphetamine sulfate) from the market. They considered it unfair competition to use a name so close to the official name. While SKF used a totally different name, 'Benzedrine', and thus felt they ethically protected the doctor and the patient. This, of course, is a ludicrous non-sequitur, and requires no further elaboration. This incident is related to demonstrate that SKF possesses a congenital impairment which is still in evidence in 1966. Competition frightens them into poorly considered actions and half-truths.

4.2 *SKF Allegations*:

The allegations regarding Gilbert as appearing on pages 44 and 45 of their submission follows verbatim:

> "In recent weeks the firm of Jules R. Gilbert, Ltd. has started to sell in Canada, trifluoroperazine tablets made from imported raw materials 'with no knowledge as to how the said substance is manufactured', according to the company's own admission. Assays of these Gilbert tables have shown variations in potency as well as a generally lower level of potency than 'Stelazine'. Yet the selling price appears to be only slightly below those of our product. In fact, the cost per mg. of active ingredient is higher with the Gilbert Tablet than with 'Stelazine'. In addition the Gilbert tablets are so colored that they closely resemble 'Stelazine' lacking only the initials S.K.F. and the number designating product strength.

So far as trifluoroperazine is concerned, products of this calibre could not appear on the Canadian market if the drug were classified by the Food and Drug Directorate as a New Drug. An administrative procedure which we believe would conform to the spirit and intentions of the Hilliard Committee. However, the Directorate does not believe it has the legal right to take this step.

We would ask your committee to assess carefully the teal value to Canadians of obtaining the price reductions presented by the Paul Maney and Gilbert products." (end quote)

4.3 *Analysis of SKF's allegations:*

4.3.1 *Knowledge of method of manufacture*:

Where there is a British or U.S. Pharmacopea Monograph on a product, there are specific tests for minimum and maximum standards that must be complied with. Since the product trifluoperazine was innovated by SFK, they undoubtedly wrote the standards or supplied the information for these standards to the British Pharmacopeal Committee. Under these circumstances, we believe that SKF would set these standards as high as possible. When acceptable standards have been set there is no reason for uneconomic duplication of work that has already been performed, unless, of course, for the specific purpose of throwing roadblocks in the path of prospective competition. There is nothing mysterious about the chemical Trifluoperazine HC1; it is only one of a large group of phenothiazines which are used as tranquillizers. It is a finite chemical which is specifically described. Further, since the product has been described in the B.P. in both its chemical and tablet form, it follows that it has been sold long enough and in sufficient quantity so that a New Drug status is no longer necessary. The objection of SKF is not as to the purity of the Gilbert product 'Triperazine', since this aspect is not questioned; the objection is that we are able to market the product too soon for their competitive comfort.

4.3.2 *Assays*:

SKF positively states that they have run assays on our products. There is nothing in their submission or in their testimony to prove this. All we can recall is assays on the Paul Maney products, with inferences but no facts, that the Gilbert products are similar. We know further that they have instigated investigations by the Directorate to check our quality and labelling. The ironic consequence of this investigation is that we now find that Stelazine, the SKF product, has been misbranded, and is still improperly labelled.

As of this writing we have received no report from the Food and Drug Directorate that our product has been either mislabelled or found to be substandard. It should be noted that the Food and Drug Directorate does not issue certificates of compliance for any drug products.

We requote:

"Assays of the Gilbert tablets have shown variations in potency as well as a generally lower level of potency than Stelazine."

S.K.F. has deliberately made a statement without basis in fact.

4.3.3 *Stelazine is deceptively branded:*

If there is a difference in potency from the S.K.F. product it is because the S.K.F. product is misbranded.

We demonstrate an example of carelessness:

(a) by S.K.F.

(b) by the Food and Drug Directorate in allowing misbranding.

The S.K.F. label reads as follows:

STELAZIN

1 mg.

Trifluoperazine tablets B.P.

This clearly reads to any physician or technically knowledgeable person who might refer to the B.P. monograph, that each tablet would contain 1 mg. of Trifluoperazine HCl. However, this is not so. In small print on the side of the label they state that the product contains sufficient Trifluoperazine HCl to be equivalent to 1 mg. of the base. This would require information on the molecular weights of the products and a laborious mathematical procedure to determine how much Trifluoperazine HCl is actually contained in the tablet. Furthermore, Trifluoperazine as the base is never used and little is known as to its characteristics. As a basis of comparison, we submit our labels on our products TRIPERAZINE, 1-, 2-, 5-, 10 which leaves no question in the professional mind as to what he is getting in the tablet he is using. Therefore, if there is a deviation of 20% between Stelazine and the Paul Maney product, it is because S.K.F. did not make their position clear.

4.3.4 *Potency:*

Our laboratory reports indicate that we work within a ± 2% range of labelled potency with the emphasis on the + 2%.

4.3.5 *Selling prices:*

"Yet the selling prices appear to be only slightly below those of our product. In fact the cost per mg. of active ingredient is higher with the Gilbert tablet than with Stelazine."

This is a deliberate misrepresentation of facts, or to put it charitably, an inability to add and multiply. We only hope in the public interest, that they do not use similar mathematics in their production formulae.

To set the record straight, we are using, as an example, the S.K.F. price for 50 tablets and we equate it to 100 tablets which is our smallest commercial package. The comparison follows:

Strength	*S.K.F. Stelazine*	*Gilbert Triperazine*	*Ratio Stelazine: Triperazine*
1	$ 5.70	$ 3.00	190%
2	7.50	3.60	208%
5	10.56	5.25	201%
10	14.04	7.20	195%

Since the 2 mg. Tablet is the largest seller, it can be readily seen that the S.K.F. price is more than twice that of Gilbert. We would like S.K.F. to define the meaning of "slightly lower". Anyone reading the press releases would infer that our product had a price differential of 5% besides being a substandard product. It is worthy of note that no actual figures were quoted by S.K.F. on the Gilbert Triperazine.

4.3.6. *Price per mg. equivalents*:

We are surprised that S.K.F. mentioned it. The brief of the P.M.A.C. and its members all stress that they never make more than a normal profit in their operations and they always steer clear of mentioning the actual cost of the drug in their product. We wonder if this would be considered a serious infraction to the Sacred and Private By-laws of the P.M.A.C. Since they have raised the question of Mg. equivalent, we would like to oblige them by showing in figures that our mg. equivalent is not more, but "slightly" less than that of S.K.F. In order to simplify the calculations we shall calculate costs on the basis of 1 mg. base content.

In round figures the landed purchase price of 1,180 grams Trifluoperazine HC1 equal to 1,000 grams of base is slightly under $200.00.

	Price to Pharmacist	
Quantity	*Stelazine*	*Triperazine*
100 mg.	$ 5.70	$ 3.00
1,000 mg.	57.00	30.00
1,000 gms. (1 kilo)	57,000.00	30,000.00

We now find that $200.00 of raw material will proliferate enough product to the pharmacist to provide S.K.F. with $57,000.00 and will ultimately cost the public $95,000.00. Looked at another way: at $2.00 per hour it would take Canadians 47,500 hours to buy the Stelazine emanating from $200.00 worth of Trifluoperazine HC1. At this point all percentages become meaningless. Such a profit would understandably require a lot of protection such as the Hilliard Recommendations and a special Food and Drug Act to be interpreted on their behalf.

4.3.7 *Similarity of Triperazine and Stelazine:*

We are flattered that S.K.F. recognizes the similarity in appearance of the two products. We really try hard to emulate. We feel that with the placebo phenomenon, previously explained, in effect the medical profession could now make a transition without difficulty to his patient while saving him 50 per cent of his medication cost. We do object, however, to the insinuation of counterfeiting in support of which they cite the U.S.A. Act. The U.S. Act clearly states that counterfeiting consists of duplication of label and markings so that the products appear to be identical. At no time can S.K.F. claim this about our product. Our label and name are distinctive and we already have plans for individually

identifying each tablet with our own mark, so that there can be no mistake as to the source of the product. This is another example of S.K.F. "reaching" to create a false impression.

4.3.8 *S.K.F. and the Food and Drug Directorate:*

Quote: "However, the Directorate does not believe it has the legal right to implement this step." The step referred to is the implementation of the Hilliard Recommendations in behalf of their product Stelazine.

The implication contained in this seemingly innocuous statement speaks volumes to our company. It means that S.K.F. is strongly in favor of the Hilliard Recommendations. It also means that they had meetings and discussions with the Directorate regarding the possibility of maintaining the "New Drug" status of Trifluoperazine. It also means, in accordance with the S.K.F. statement that they had a willing and sympathetic ear in the Directorate, but there was no legal loophole by which they could oblige S.K.F. The Food and Drug Directorate has it in their power, by exercising their right to do nothing, to aid and abet the maintenance of high drug costs, by so collaborating with the "Innovators". It is important that the Directorate report to the Committee the nature of the presentations of S.K.F. and the nature of the reply by the Directorate. In the general scheme of things, we consider this matter to be of gravest importance.

4.3.9 *Mr. Henderson and Injurious Falsehood:*

In closing the subject of S.K.F., we wish to quote from P. 245 in Vol. 5 of the Minutes of Proceedings and Evidence. "Mr. Henderson: Mr. Mackasey, I get the distinct impression that the detail man is acting in a legal vacuum, and he has certain legal requirements that he should meet. This of course applies generally, not just to this industry, but he has to operate within the laws of Injurious Falsehood, which still are with us.

That I admit, has the element of malice and it is not always easy to prove. In addition to that there are the laws of unfair competition which are found in the Trade Marks Act, and misleading statements relating to the products of a competitor will give rise to liability."

In view of our analysis of the S.K.F. presentation, and the statement by Mr. Henderson on behalf of the P.M.A.C., we must conclude that S.K.F. believes that it is operating in a legal vacuum.

5. *The P.M.A.C. Brief and Economics in General:*

5.1 *Allegory.*

Once upon a time there was a lady tourist visiting Navajo Reservation. She came upon two piles of pottery spread out on separate blankets. A sign over one pile read $3.95 each. The other pile had a sign which read $1.95. Liking the pottery and wanting the better value, she asked the old Indian Attendant, "What is the difference between these two piles of pottery? They look alike to me." He replied, "Nothing Lady, there is no difference but some people like to pay $3.95 and some people like to pay $1.95.

This may be an oversimplication of the facts in the drug industry but we believe this is the essence of the controversy. The $3.95 group, represented by the P.M.A.C. are making heroic efforts to maintain their pricing system by endeavoring to change the rules in the middle of the game. The $1.95 group want things as they are and would like to see the $3.95 group maintain their prices.

5.2 *National Labor Cost as a Measure of Prices*:

This is a weighted, one-sided measure to prove that Canadians are not overpaying for drugs. If one were to use the same scale against the lowest prices available in Canada, then by far the Canadian prices by the Copiers would be the lowest in the world. We feel that the labor cost measure is not even worthy of discussion and was dreamed up by some economist in order to earn a fee.

5.3 *Merchandising as a Means of Monopoly*:

The ability to spend several million dollars in an all-out merchandising effort to launch a new product is the "secret weapon" of the Innovators. This is their PATENT. This merchandising, in spite of, and also because of, the medical profession, will determine the course of treatment and medication that your family and our family will have to take. The intrinsic value of the product is secondary. This is where the detail man comes into play. The industry knows that by exerting pressure on the medical profession they can force the use of their particular products. We have many instances of identical medical products being marketed under a variety of brand names and a generic name. What motivates the choice of a doctor as to which product to use? Especially since he has no knowledge of the individual makeup of the various products and HE HAS NO VALID MEDICAL REASON FOR MAKING HIS CHOICE. The answer is again, MERCHANDISING PRESSURE.

The Innovator, not content with this great advantage, which is paid for by the public, now wishes to legislate competition out of the business by means of patents and special New Drug Regulations which they admit having framed.

If the Committee will question us they will find that generic marketing has not decreased the sales of the major brands. Recorded sales by Parke Davis in the number of Chloramphenicol capsules sold have shown an increase in spite of generic competition. It is again a question of selling and a company's following. A salesman tries to sell what he has. The public will buy because they are there.

5.4 *Extrapolation of P.M.A.C. Combined Statement*:

We have taken the trouble to examine the figures of the 41 companies who submitted their financial statements and have extrapolated their figures based on a plus or minus 5 per cent of sales volume. This was done in order to get their true working profit after their basic costs have been met. We think this is a fair and plausible assumption because a deviation of plus or minus 5 per cent in sales for a given merchandising expenditure is possible. The starred items in the adjoining table have been prorated in the comparisons. The other items have remained constant.

INCOME STATEMENT OF 41 COMPANIES

	Actual 100%	*Calculated* 95%	105%
Revenues			
*1. Sales (F.S.T. & E.T. not included)	$ 107,784,504	$ 102,395,278	$ 113,173,729
*2. Other Income	2,680,893	2,546,847	2,814,936
*3. Total Revenue	110,465,396	104,942,125	115,988,665
Expenses			
*4. Cost of Goods Sold	35,399,032	33,629,080	37,168,983
5. Distribution including Warehousing	4,254,333	4,254,333	4,254,333
6. Marketing	32,286,618	32,286,618	32,286,618
7. R & D	7,119,529	7,119,529	7,119,529
*8. Royalties	3,367,893	3,199,498	3,536,287
9. Administration	11,586,050	11,586,050	11,586,050
10. Interest Charges	309,435	309,435	309,435
Total Expenses Fixed	55,555,965	55,555,965	55,555,965
Total Expenses Variable	38,766,925	36,828,578	40,705,270
Total Expenses	94,322,890	92,384,543	96,261,235
Gross Earnings	16,179,030	12,557,582	19,727,430
Income Tax	8,115,632	6,299,008	9,895,476
Net Earnings	8,063,398	6,258,574	9,831,954

The starred items are treated as variables and are pro rated.

On a sales reduction of 5 per cent or $5,389,225 the difference in profit before taxes was $3,621,448. On a sales increase of 5 per cent or $5,389,225 the increase in profit was $3,548,400 which shows that the profit margin on the increased sales was 66 per cent or almost 33 per cent after taxes ... a far cry from the 8 per cent claimed. These results are based on the composite figures shown. If the increase was based on a product like Stelazine, the true after-tax profit would be in excess of 40 per cent.

These figures may explain our theory that the Innovators budget to a profit. If it appears that the after-tax profit will approach between 10 or 15 per cent then they will increase their expenditures by golf tournaments and free gimmickry.

5.5 *Manufacturing costs of a small drug company*:

In order to meet the Food and Drug Regulations required of a manufacturing plant it is necessary to provide properly ventilated, clean premises, and proper equipment. A minimum number of personnel are required for executive, quality control, production control, statistical control, production, packaging, shipping and bookkeeping.

To properly cover these aspects will require a payroll of $150,000 for which it is required to do about $300,000 in sales at a gross profit above material costs of about 60 per cent just to break even. The gross profit may be attained by doing custom manufacturing and marketing of their own products at the wholesale and retail level. Until the basic costs are met it is meaningless to talk about the profit on a particular item. Even if the product cost them nothing, a company could still lose money if sales did not cover the basic cost of operating.

We have a business to run and we cannot afford the time to provide actual figures to support our thesis. We hope that the Committee will accept our premise as a guide line and as being good "guestimates" of the actual situation.

5.6 *Drug costs and the wealth of a community*:

Let us assume the existence of a community of 5,000 people without a drug manufacturing plant in its midst. A physician of that community uses furodantin (Nitrofurantoin). When purchased under the brand name the cost of the product to the pharmacist will be about $225.00. Under its proper name the same quantity of tablets could be brought in for $18.00. $207.00 leaves the community forever. This money could have either recirculated or brought in an additional $207.00 worth of goods to enrich the community. When these instances are multiplied by the number of brand name drugs on the market today it can be seen that it is possible for a community to save considerable amounts on the money drawn away from the community just for importation of drugs.

5.7 *Cost of drugs versus choice of drugs*:

Twenty-five tablets of Furadantin costs the patient about $10.00. Knowing this, the doctor hesitates to prescribe this excellent drug. If it were to cost the patient $3.50 per 100 tablets there would be considerably more of this product used, because then the cost would be no more than an ordinary sulfa drug. Because of the Copiers in Canada, this latter situation is possible—yet—only about 15 per cent of prescriptions are written for the equivalents available.

5.8 *Equivalency of brands and generics*:

The P.M.A.C. claims that there is no equivalency between brands and generics. A recent survey in the U.S.A. reported that 8.8 per cent of Brand named drugs and 7.7 per cent of Generics failed to meet Food and Drug specifications. The incidence of failure is 14 per cent higher for the Brand Names. Even though the difference is significant and points up that a brand name or a generic designation carries no inherent indication of quality . . . to our company it means that both Copiers and Innovators must exercise greater care in their production.

We can speak only for our own manufacturing operation and our desire to give full quality and value to the public. This is our only basis for survival.

6. *Research and Research in Canada:*

Research in Canada is minimal. The recent increases in expenditure for research was stimulated by the 150 per cent tax credit and this has enabled several companies to buy real estate and buildings for 25 per cent on the dollar.

Thus $100,000 spent on a research building will allow a 150 per cent tax credit or $150,000 which would normally result in a saving of $75,000 plus, in taxes. Thus the true investment in research of the company would be $25,000. A cheap price for a valuable addition to the company's assets. This is reminiscent of the $40,000,000 worth of drugs the major drug companies donated to Cuba, and were able to take the wholesale value as a tax deduction. We now have the paradox that a million dollar donation at a true cost of about $150,000 would result in about a $350,000 net profit to the company because they were able to save $500,000 in taxes.

6.1 *Research in general:*

Some research is good and valuable. Some research is necessary. Many sins are committed in the name of Research. Research expenditures are used as the raison d'être for the maintenance of drug prices, and this is magnified in advertising and publicity. The sword of research is double edged. If a company needs a "me too" product they become molecule manipulators—produce another product and then go on a big fanfare because now 50 mg. of this product is as good as 100 mg. of the product being used. The merchandising and detailing techniques are such that the company can predict how much of this new product would be used by the medical profession. Whether the product is good or indifferent it will be used. Much of research is devoted to market protection through the iniquities of the patent situation.

Research expenditures are used for the maintenance of drug prices. The importance is then magnified in their advertising media.

Research serves two purposes:—

1. Development of a new marketable product...one that is preferably patentable.

2. Maintenance of the competitive position of the company.

(a) by creating a reserve of products when there are dangers to an existing product;

(b) by maintaining for themselves certain areas of development to prevent competitive encroachment.

Much of research is devoted to market protection, made possible through the iniquities in Patent Law. A company which has succeeded in marketing a drug will, by patents, isolate the molecular area involved so that all research for betterment of medication is automatically eliminated as being fruitless. Thus the use of a single compound which must have been made by arbitrary selection when patented, will be patented in such a way that millions of possible compounds are removed as medical and commercial possibilities.

It is our thesis that no more than 20 per cent research done, eventually accrues to public benefit. A portion of the remaining 80 per cent may even be used for commercial benefit to the company, but against the public interest. We have previously estimated the value of research as follows: for each $1.00 spent in research, $4.00 is spent in telling about it and the public is charged $10.00 for listening. We believe it is the ambition and desire of anyone associated in medicine to want to develop new and worthwhile medication. Our company has contributed time, money and materials whenever the opportunity has presented

itself. There is no question in our mind that we would give anything to become an innovator. However, the climate for our existence must be fought for and protected. If not, the "Innovators" will have it all their own way.

6.2 *The cost of research:*

We studied the balance sheets of the "Innovators" and as yet have not been able to find a figure in the asset column, which will treat as an asset, the value of research done concerning a new product which may be on the production line. All Research Expense is written off in the fiscal year that these expenses are incurred. The major drug companies' returns are considered among the highest in industry. The public has already paid for this research in the products they buy. We cannot understand what these companies mean when they say they have to recapture their Research costs. In addition to paying for the successful research, the public has also been charged for the failures.

The "Innovators" belabor the fact as to how much they pay for research and in the same breath how much they pay in Excise and Income taxes. Where does this money come from, if not from the public? Of all industries, the major drug companies have the greatest capacity for financing their own growth out of profits without outside assistance.

6.3 *Conclusion:*

Research, while necessary and laudable, has enough balancing iniquities. The company performing this research does so because it pays in prestige and profits. We therefore feel that the industry deserves no special consideration for that which they do by choice and for expedience. The cost of the research is charged for in the price the public pays.

7. *The food and drug act:*

We feel that the Food and Drug Directorate is in a state of flux and development. They are and can be a powerful influence for protection of the public and for keeping up the standards of drug manufacturing in Canada. The ever present danger is, that there is only one active Lobby—a Lobby located in the same city and perhaps in the same building where the nerve center for many Food and Drug Decisions are made.

Public danger lies in the definition of a New Drug. This is a Regulation established by a power granted in the Food and Drug Act under section 25.

Analysis of the definition of a new drug will show—that any inspector, regardless of ability and training—can summarily stop a manufacturer from marketing a product.

The regulation goes to such an extreme—that a mere change in the pressure used in making a tablet may be grounds for calling a product a new drug and a criminal charge can be laid against the "offender". The Regulation does not define sufficient quantity or length of use.

The Regulation refers to changes of specific components in a manufactured drug, but in the event that they may have left something out, they also include the words "or any other component". This renders the definition infinite in scope. The wording of this Regulation gives the Directorate a total police power in the industry.

The Directorate is relatively new and is gradually consolidating its information and policies. They have a mammoth job, and we believe, that they mean well. Regardless of the best intentions, we would like to examine the potential dangers such as demonstrated by the S.K.F.'s attempt—by their own admission —to administer the Hilliard Recommendations in the case of our Triperazine. The intimation was, that the Directorate had no legal right to interfere.

7.1 *Civil Servants have definite earning limitations*:

It is understandable that at some future time they would like to get a higher paying position with greater possibilities in Industry. We know of an instance where an individual has achieved this position. We find that the Directorate has been over zealous in the protection of a particular company's products. This would mean that Drug Control is not routinely regulatory, but instigated by outside pressures.

Since Hoffmann La Roche in their submission has elected to list names and to indicate unfair pressures, we would like to return the compliment. The Directorate has paid particular attention to any copier of Hoffmann La Roche products. We would not like to think that the Directorate is running errands for the P.M.A.C. so that it has little time left for basic Regulatory Activities.

7.2 If the P.M.A.C. can properly influence the Directorate, the Hilliard Recommendations would be redundant. Any Drug may have New Drug Status as long as the Directorate desires it to be a New Drug. There is no provision, that we know of, for official or automatic release of a drug from its New Drug Status. A drug may be classified as a new drug forever or until someone questions the status of that particular drug.

Actually the New Drug Classification provides the Innovators with greater protection than the Patent Act. You can contest a patent but there is no provision for contesting a Directorate Decision unless they lay a criminal charge.

7.3 *Recommendations*:

We, as a manufacturer, would like to see the New Drug Regulations expressed clearly and concisely, so that when the law is read, a manufacturer can determine for himself whether he abides by the law.

The law as written may affect the cost of drugs to the public. Any changes in the Regulations should be made with the balance of interest in favor of the public. This should be done without relaxing any quality controls.

8. *Patents and Patent Law:*

8.1 *Genesis of a Patent Application:*

For a patent to be granted there should be a spark of genius to warrant the franchise to the inventor. In actual practice if a chemical compound has not been classified before, a patent for that compound, when made by the process described, will be granted. It is very seldom that any process described has any originality. Aslo, it is very seldom that any genius is involved in the production of a new compound. The principles of chemistry have advanced to such a stage that at this point the laboratories routinely make, test and discard new compounds—until the routine testing shows up a product that is different. This procedure is even more prevalent in the antibiotic field. This is known as

Shopwork Technique and the invention is generally arrived at by the elimination of the failures. Finally, one compound is selected out of a group for a patent.

The "Inventor" not content with merely patenting the compound he discovered, now proceeds to hide this compound in a generic claim which not only covers the marketable product but also all his failures in the same class and attributed the marvellous properties to all the compounds. If all the combinations and permutations in the generic claim were listed, we would find that millions of compounds have been patented which the inventor has no intention of using and which automatically eliminates the entire category from further research by an outsider.

8.2 *Patent Validity:*

It is patents such as these, that are being contested and being held invalid, because they do not conform to the Patent Act.

How has this relaxation of the Patent Interpretation come about? The Innovators who have processed patents are not ignorant of what they are "getting away with". The situation suits them, and until Gilbert came along, it was never questioned.

It stands to reason that the members of the Establishment who own Patents, are not going to contest each other's patents on the basis that they did not conform to the law. This would break up the racket. Therefore, any contests would be simply on the question of priority of invention, or the actual description of the patented compound somewhere in the literature. In the case of American Cyanamide and Pfizer re Tetracycline, the case was settled by collusive agreement between the two companies. We've often made the statement—that a Patent Attorney confuses what he is getting away with, as being the law.

The question of intrinsic validity of patents should be given serious consideration by this Committee because the Innovators already possess a tremendous advantage in their Merchandising Power. Too many laws are engendered by, and made for, Existing Power.

8.2 *Compulsory licensing and the Hilliard Recommendations*:

With all due respect to Mr. Henderson, Sec. 41 (3) of the Patent Act clearly states that compulsory licensing should be granted, with proper regard to the cost of drugs to the public. This is the entire motivation for Section 41 and this seems to be ignored by Mr. Henderson.

The Innovators have accomplished a great deal by contesting Licensing Applications all the way to the Supreme Court. It is still an expensive procedure to obtain a Compulsory License which is provided for by law. What happens when a Compulsory License is obtained?

(a) The cost of the licensee's product is outrageously high and not made generally available, i.e. $228.00 for 1 kito Chloramphenical when the product is available in Europe at $19.00 a kilo.

(b) The Licensee uses the product for their own production and will not sell to other manufacturers.

(c) We do not consider the Act liberal enough to achieve the purpose intended!

8.4 *Recommendation on compulsory licensing:*

(a) The licensed product should be made freely available to manufacturers at a price no greater than twice the duty paid price of a reliable import plus the royalty that would have to be paid the Patentee.

(b) The Patentee shall be barred from seeking a review of the Commissioner's decision in the Courts.

(c) The Applicant shall have the right to request review of the Commissioner's decision in the event of denial of application.

8.5 *The cost of Patent Suits:*

The granting of a Patent is generally the result of negotiations between the Patentee and the Patent Office. In effect, a Patent is a franchise which permits a Patentee to sue an infringer for injunction against sale and for subsequent damages. The burden of proof is on the defendant to demonstrate the invalidity of the patent. To properly defend an infringement action requires the assistance of expert counsel knowledgeable in chemical matters, the assistance of one or two experts in the chemical and pharmacological fields plus intensive research work in the history of the patent, also investigation of the actual development of the patent. Of course, the Paintiff does not make things easy, because every delay allows him to lengthen his utilization of the patent and related profit picture.

The Defendant must anticipate out-of-pocket costs of between $30,000 and $50,000 in the completion of a patent action. In the case of Hoechst vs. Gilbert there were 10 patents which were contested on the product Tolbutamide. The Action was decided in favor of the defendant with costs. These costs allowed were $9,750.00, the expenditures were in excess of $30,000.

Tolbutamide is now freely available to any manufacturer in Canada.

Neither Hoechst or Horner have reduced their prices on their branded products. Hoechst, aside from losing the franchise, never had to pay back one penny of its royalties received or the monopoly income they had during the life of the patent. They are still receiving royalties from Horner, which is a paradox considering the invalidity of the patent.

8.6 *Patent Litigation Recommendations:*

1. We recommend that the defendant in a patent suit, if successful in patent impeachment, should be awarded triple damages based on actual out-of-pocket costs. This would discourage false patents. This would make a patentee stop and consider before instituting long and costly proceedings for patent infringement.

2. Patent Actions should only be tried in the Exchequer Court of Canada, otherwise the patentee can choose from one to ten provincial courts to have an action tried.

8.7 *The Hilliard Recommendations:*

We consider these Recommendations to be redundant and they have nothing to do with the granting of a patent or a compulsory license.

The Directorate in its New Drug definitions already provides greater protection than that required by Hilliard. It not only covers patented products but also unpatented products. We do not consider the Patent Office qualified to pass on the safety requirements and preparations required of a drug.

If the Patent Office sets up regulations to cover the area of Drug Safety, they will be setting up regulations in a field already assigned to another Government Agency—The Food and Drug Directorate. One law will interfere with another law, therefore it must be considered ultra vires. The very nature of the patents give insufficient information to the proper preparation of a patented product. On the contrary, in the interests of public safety, the patentee should be required to pass on the necessary technical information to the licensee so that a proper product is insured.

In view of the debatable validity of drug patents, it is undesirable that additional hazards should be placed in the path of obtaining a compulsory license.

The law is clear on the subject of Compulsory Licensing, yet all applications wind up in the Supreme Court.

8.8 *Patents and the Canadian Public Interest:*

It is difficult to recognize the forest because of the trees. Better than 90% of all drug patents issued in Canada originate from outside Canada.

In Switzerland, only a Swiss Citizen could obtain a drug patent. This has made a major drug producing country of this miniscule area.

The foreign ownership of patents (the Swiss are not prohibited from applying for foreign patents) has enabled the Innovators to control better than 85 per cent of the drug business in Canada.

We are drug Importers and held subject to the monopolistic pricing powers of the P.M.A.C. Group.

The very name of the group means Pharmaceutical Manufacturing Association of Canada.

They are not Canadian Manufacturers nor do they propose to be that, unless forced to do so.

This appalling and unbelievable situation, as viewed by someone on the Moon, staggers the imagination.

This foreign group has banded together and is now endeavoring to hog-tie the patent office, the Food and Drug Directorate and the Canadian public. Their concern for the future of the Canadian public is posed as follows: You Canadians are a young and virile people. It is in your interest that you put yourselves completely in our hands, and we will nurture you and treat you fairly. We will train your sons as scientists and chemists and then send them abroad to join the ranks of our Innovators in our extensive laboratories. In the meantime, drug prices will be held at a level that they feel Canadians should pay.

8.9 *The drug industry in Italy*:

We draw conclusions diametrically opposed to that engendered by the P.M.A.C.

The elimination of Drug Patents in Italy has resulted in:—

1. The development of a powerful synthetic drug industry with all the necessary manpower and skills to manage a highly technical industry.

2. The Italian drug industry has resulted in providing the only real competition to the Innovators. (Yet the Innovators have their own plans and marketing organization in Italy. The Innovators are still interested in the welfare of the Italian people. They have not deserted them as they threaten to do in Canada.)

3. The tremendous growth of the Drug Industry in Italy has resulted in the growth of a number of drug manufacturing Giants who now can afford to be concerned with the public interest. They now want a patent law established so they can protect the public against improper competitive pricing and perhaps forestall the advent of any new Copiers that may come into being.

8.10 *Recommendation*:

A Moratorium on Drug Patents for ten years with a seven year option for renewal of the Moratorium.

Let us suppose, that as an emergency measure, this Act was passed in Parliament in order to give Canada a breathing spell for internal development of a Drug Industry.

There is no higher authority in the world that can forbid Canada to pass such a law. It may not be cricket—but it is possible and practical.

8.11 *Predictions*:

1. There would be an immediate reversal of the Brain Drain. There would be an immediate influx of capital and personal skills from every patent-constrained country in the world.

2. Within five years we would be manufacturing for internal consumption and for export all vital drugs.

3. In ten years a pressure group will arise demanding patent protection for Canadian industry.

4. The balance of interest for this recommendation resides in Canada.

May the Good Lord protect us from our friends, for we can deal with our enemies.

THE CLERK OF THE HOUSE,
LEON-J. RAYMOND,
Ottawa.

OFFICIAL REPORT OF MINUTES

OF

PROCEEDINGS AND EVIDENCE

This edition contains the English deliberations and/or a translation into English of the French.

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Translated by the General Bureau for Translation, Secretary of State.

LÉON-J. RAYMOND,
The Clerk of the House.