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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1545)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call the meeting to order. We have a quorum.

We're anxious to hear from witnesses. I see some old friends back.

Today we have four organizations here. Each organization will have 10 minutes. When you get to 10 minutes, I'm going to put a little red tag up here showing that your time is up. We're always anxious to ask questions.

The order we're going in is the Department of Health, first; the Canadian Institute for Health Information, second; the Patented Medicine Prices Review Board, third; and the Canadian Agency for Drugs and Technologies in Health, fourth. After that, we'll open the floor for questions.

Welcome to our committee. We have a big audience today, so you must be popular people.

Thanks very much.

Go ahead, Department of Health.

Ms. Abby Hoffman (Assistant Deputy Minister, Strategic Policy Branch, Department of Health): Thank you, Mr. Chairman.

Good afternoon, and thank you for the invitation to speak to the committee.

With me are Health Canada colleagues Frances Hall, the acting executive director of the office of pharmaceuticals management strategies; and Scott Doidge, who is director general of the non-insured health benefits directorate in the first nations and Inuit health branch at Health Canada.

I'm going to focus my remarks on government roles, including, in particular, the federal role in pharmaceutical policy and drug coverage; make some comments about drug coverage in Canada today; and conclude with some comments about possible approaches to strengthening drug coverage for Canadians.

Federal, provincial, and territorial governments share responsibilities for pharmaceuticals. The provinces and territories, as you know, are responsible for the organization and delivery of health care services in their respective jurisdictions. With respect to drugs, that includes, at their discretion, providing drug coverage for their eligible populations and deciding which drugs qualify for reimbursement—generally those that are listed on the drug plan's formulary, which may also specify conditions for certain classes or categories of drugs. They also are involved in negotiating patented drug prices with manufacturers through product listing agreements and regulating the prices of generic drugs.

In addition, the provinces, along with medical regulatory bodies, may regulate prescribing and dispensing practices of health care professionals.

While the provinces and territories provide most public drug coverage, the federal government has some unique and important responsibilities with respect to pharmaceuticals.

Through the Canadian Institutes of Health Research, the federal government funds basic research and clinical trials.

We protect intellectual property related to patents and data via the Canadian Intellectual Property Office, associated with Industry Canada, and through Health Canada's health products and food branch.

We assess submissions from manufacturers that wish to sell a product in Canada to determine whether that product meets regulatory standards for safety, efficacy, and quality, and then we monitor the safety of authorized products once they are in the marketplace.

In terms of coverage, various federal departments manage drug plans for so-called federal populations, including first nations and Inuit, members of the Canadian Armed Forces, veterans, the RCMP, federal inmates, and immigrants and refugees under certain terms set by Immigration, Refugees and Citizenship Canada.

As well, in its capacity as Canada's largest employer, the federal government provides drug coverage to public service employees and their dependants.

Finally, as you will hear in more detail in a few moments, the federal government regulates the prices of patented drugs through the Patented Medicine Prices Review Board.

Along with the provinces and territories, we support two key agencies that support work in this area, and you will hear from their representatives in a few moments, as well.

In January of this year, the federal government joined the pan-Canadian Pharmaceutical Alliance, the so-called pCPA. This alliance is an initiative of the premiers, dating back to 2010, and it combines the purchasing power of all government drug plans to negotiate lower drug prices. Drugs recommended for formulary listing by CADTH are considered for negotiation by the pCPA with the respective manufacturers on behalf of all public drug plans. The pCPA has a companion initiative for generic drugs.

As of March 2015, the pCPA had concluded 63 joint negotiations on brand-name drugs and achieved price reductions on 14 generics. This has resulted in an estimated savings of $490 million a year.

Let me turn to some comments about drug coverage in Canada. When I addressed the committee a few weeks ago on the Canada Health Act, I noted that governments in Canada provide insured first dollar coverage for medically necessary physician and hospital services, including drugs used in hospitals; and that the cost of drugs used outside of a hospital setting are covered through a mix of discretionary public plans, private insurance—usually related to one's employment—and out-of-pocket spending by individuals.

Of the $29 billion spent on drugs each year—that is the number for last year—public plans finance 43% of that amount, about $12 billion; private plans, in the range of $10 billion, or 35%; and the remaining $6 billion, or 22%, is covered by out-of-pocket spending by individuals and their families. This may be direct purchases, but it may also be contributions in the form of deductibles and co-payments related to private coverage that these same individuals have.

On the general coverage picture in Canada today, approximately 57% of Canadians have some employment-based or employee-sponsored access to a private drug plan; 21% are covered by provincial and territorial plans, which as you probably know cover specific groups such as seniors, social assistance recipients, and in some cases individuals with particular diseases. The conditions and eligibility parameters vary across jurisdictions. Three per cent of the population is covered by the federal drug plans I mentioned a few minutes ago.

That leaves about 10% of Canadians without any practical form of ongoing coverage. For those individuals, they may have coverage if it's offered by their province or territory for so-called catastrophic coverage. That's coverage that kicks in when drug costs for an individual are very high. The threshold for eligibility for this type of coverage varies, and it may start when drug costs reach a fairly low threshold, 1.25%, for example, of an individual's net family income, but the eligibility threshold may be as high as 12% of net family income. A further 10% of Canadians could generally be considered to be under-insured. These are people who have very high drug costs that exceed the limits of their drug plan, and that leaves them with very significant out-of-pocket costs.

Over time, plans have added elements but again costs and eligibility vary. I'll just give you one example. A couple over age 65 with a net income of $35,000 a year and annual prescription drug expenditures of $1,000 would have no direct costs in the Yukon, but they would pay $1,000 if they lived in New Brunswick or Newfoundland. That's an example of the variability. Similarly, coverage varies among private plans as well. There are thousands of such plans in the country, and while they have some common elements because they are managed by a smaller number of large insurers in terms of benefits, co-pays, deductibles, caps, and so on, they too vary.

Public plans control costs quite well through formularies based on clinical assessment of cost-effectiveness, aggressive price negotiation, and generic substitution. Private plans are more likely to list any drug authorized by Health Canada for sale in Canada and to act pretty much as price-takers.

On coverage, our mixed public and private system provides coverage for the majority of Canadians, but there are significant challenges. Coverage and costs to patients vary; 10% to 20% have no or inadequate coverage; and the multitude of payers limits effective price negotiation. That situation is the backdrop to the government's current commitment to improve the affordability and accessibility of drugs. This issue is one of the priorities that FPT health ministers agreed to tackle this past January in the course of their discussions leading to a new health accord.

I just want to close with what the few costs would be to include prescription drugs as an insured service under the Canada Health Act. Prescription drugs in that model would be treated in the same way as physician and hospital care in Canada, and patients would face no direct cost. Prescription drugs would be publicly funded and drug plans publicly administered. This approach would certainly address the issue of Canadians not filling prescriptions because they can't afford to; access would be based on need not on the ability to pay. However, in this model Canadian governments could assume very significant costs. In our current system where employers and individuals cover 50% of the $29 billion spent annually on prescription drugs, clearly a considerable portion of that cost would fall to governments. While there might be some efficiency gains in administration and lower prices, and certainly greater likelihood of harmonized coverage for everyone in a public system, public sector spending on drugs would increase substantially.

The second broad approach would take advantage of our current mixed financing system. In this model the existing system could be adapted to be more equitable, efficient, and harmonized without such a dramatic change in the level of public financing. Coverage could be extended to close current gaps and incentives could be provided to harmonize coverage across existing public and private plans. All plans could benefit from joint price negotiations, a common system of drug assessment, and a national formulary. Experts you may hear as witnesses later on in this study will no doubt offer their views on the incremental cost and parameters of such an approach. Some may well tell you that this approach might be more feasible and fiscally prudent in Canada.

● (1550)

Of course, there are advantages and disadvantages to any system of coverage. Any coverage model, however, whichever of those two broad paths might be chosen to be viable, needs to tackle the challenges of Canada's high drug prices, making the best use of available funds by discipline when it comes to listing and prescribing drugs and having the information on which to base those decisions.

My colleagues will speak to some of these issues in their remarks.

Mr. Chairman, I'll conclude there and indicate that I'm prepared to respond to your questions later on in this session.

Thank you.

The Chair: You have packed a lot of information into ten minutes.

Thanks very much.

We now have the Canadian Institute for Health Information.

● (1555)

Mr. Brent Diverty (Vice President of Programs, Canadian Institute for Health Information): Thank you very much, Mr. Chairman. My name's Brent Diverty. I'm vice-president, programs, and I'm joined by my colleague Michael Gaucher, who's our director of pharmaceuticals and health workforce. I'm very pleased to address the committee today.

On behalf of the Canadian Institute for Health Information, I would like to thank you for the opportunity to appear before the committee. Since 1994 we've played a unique role in Canada's health sector. Working with a broad range of stakeholders, we are responsible for collecting, sharing, and publicly reporting on health data and information. We recently reviewed our mandate, and that's the beginning of a new chapter for our organization.

We continue to believe that better data contributes to better decisions, ultimately improving the health of Canadians. We are committed to making our information more accessible and easy to use. Working collectively with our stakeholders is critical to achieving our goals, and this plan, our strategic plan, highlights the importance of responding to their needs quickly with innovative tools and approaches.

Ultimately, our goal is to drive health system transformation and improvement across the continuum of care.

Today we're here to give you an overview of the current landscape of drug coverage and spending in Canada. Our data, which is drawn directly from the provinces and territories, and our analytical expertise, mean CIHI is well positioned to provide unbiased information to inform conversations about improving the accessibility and affordability of drugs. Based on data from our national health expenditures database, we know that Canada spends $29 billion, or $814 per Canadian, on drugs. Drug coverage is currently provided by a number of public- and private-sector payers, with 37% financed by provincial and territorial governments, 35% by private insurers. In addition, 22% of drug spending is paid for out-of-pocket by individual Canadians, and the remainder is financed by social security funds at 4% and the federal government at 2%.

Internationally, Canada ranks second behind the United States in per capita drug spending. Among OECD countries, Canada ranks near the bottom in the share of public drug-spending financed by the public sector. In other words, in Canada private insurers and individuals pay a higher share of drug costs than they do in most other OECD countries.

In recent years, growth in drug spending has been slowed by the expiration of patents on many widely used blockbuster medications like statins, which are used to lower cholesterol. In addition, public drug programs have implemented policies, limiting the prices they are willing to pay for generic drugs. More recently, provincial and federal drug programs have come together, through the pan-Canadian Pharmaceutical Alliance, to reach coordinated pricing agreements for selected brand-name and generic products. These agreements have achieved further savings.

CIHI's recent report on prescription drug spending in Canada found that, although these changes have led to significant savings for public drug programs, the savings were offset by increased spending on specialized medications such as biologics to treat conditions like rheumatoid arthritis and Crohn's disease. These and other new drugs, like those used to treat hepatitis C, are putting significant pressure on both public and private drug programs.

As the trend towards higher-cost drugs continues, the need to understand cost drivers and to forecast future trends will become greater, as even a single drug may present significant challenges for the sustainability of drug budgets. CIHI maintains information on public drug programs across the country, and tracks changes in program policies over time. Public drug coverage is available in all provinces and territories, but the design of public drug programs varies widely as to who is covered and how costs are shared between individuals and the drug program.

Some provinces and territories provide coverage to all residents, with the level of coverage depending on a person's income and drug costs, while others provide coverage to particular groups like seniors, people receiving income assistance, and other selected populations. Although some programs cover all eligible costs, generally costs are shared between programs and beneficiaries, and the ways that costs are shared varies.

There are also differences in which drugs are covered, resulting in disparities in access to certain medications across jurisdictions. Each provincial, territorial, and federal drug program maintains its own formulary, which includes the list of drugs it covers and the criteria under which it covers each drug. The benefits and costs of any changes made in drug coverage to improve accessibility and affordability are highly dependent on how they are designed and managed.

Our data and expertise place CIHI in a strong position to support both the evaluation of various options and ongoing monitoring, measurement, and evaluation activities. Since 2004, CIHI has maintained the national prescription drug utilization information system for public drug claims. The system was designed in collaboration with representatives from federal, provincial, and territorial drug programs, along with the Patented Medicine Prices Review Board, to provide information that supports pharmaceutical policy development and the effective management of Canada's public drug programs. It holds pan-Canadian information related to public drug program formularies, drug claims, policies, and population statistics.

● (1600)

Data from public drug programs in all provinces except Quebec, as well as from the federal drug program managed by Health Canada's first nations and Inuit health branch, is available in this database. It will soon hold data from Yukon.

Formulary data that we maintain shows there's a high degree of similarity and drug coverage despite the differences among public drug programs. This suggests the pan-Canadian agreement on the coverage of at least a certain set of drugs is achievable. This high-level analysis does not, however, take into account the details of how drugs are covered by each program. CIHI regularly conducts these types of more detailed analyses and is able to assess the comparability of public drug program formularies across the country.

We share our drug claims data with participating jurisdictions and the PMPRB to support their work. We also provide data to support the work of CADTH, Health Canada, and other national and provincial organizations. To date, CIHI and its network of partners have used CIHI data to support public drug programs to measure the drivers of drug spending; support evaluation of policy options; better understand trends in drug use and spending; and examine safety concerns like potentially inappropriate drug use, prescription drug abuse, and polypharmacy.

What has been learned? In one example, by linking drug data with our other holdings that contain hospital in-patient and emergency department data, we found that seniors were five times more likely than other Canadians to be hospitalized for an adverse drug reaction. In another study we found that two-thirds of Canadian seniors were taking five or more drugs and almost 40% were using a potentially inappropriate medication. Notably, CIHI's drug claims database contains information on more than 70% of Canadian seniors.

But our data remains incomplete. In order to have a complete picture of drug use and safety, and to more accurately forecast and examine policy options, comprehensive data is needed on all drugs used by all Canadians, including people with private insurance or without any drug coverage. The data must also be collected in a way that it can be joined together with other health datasets, such as those for emergency department visits and hospitalizations, to provide a more complete picture of Canadians' encounters with the health system.

Despite this imperative, CIHI currently has comprehensive drug data from just three provinces: British Columbia, Saskatchewan, and Manitoba. We are working with other jurisdictions to collect private insurance data from drug information systems, as well as data on hospital and cancer drugs, but the process is slow and we expect it to take many years. Greater collaboration among governments, health system stakeholders, and the private sector is needed in order to expedite the creation of a comprehensive dataset.

CIHI is able to support the work of the committee and the ongoing discussion around drug policy in Canada, for example, in the evaluation of different program options and their associated costs. Our data and analytical expertise, which enables us to analyze trends and to forecast future drug use and spending, may be useful as you weigh the impact of various policy options and changes.

Going forward, we would be pleased to provide the committee with any information it needs as it considers this important and complex topic.

I thank you again for the opportunity to present this information and I look forward to taking some of your questions at the end.

The Chair: Thank you very much.

Next, we have the Patented Medicine Prices Review Board.

[*Translation*]

Ms. Tanya Potashnik (Director, Policy and Economic Analysis Branch, Patented Medicine Prices Review Board): Mr. Chair, members of the committee, good afternoon.

[*English*]

Thank you for the invitation to appear before you today. My name is Tanya Potashnik, and I'm the director of policy and economic analysis at the PMPRB. With me today I have my colleague, Guillaume Couillard, who is the director of the board secretariat, communications and strategic planning at the board.

I'm appearing today before you on behalf of our executive director who has fallen sick and sends his regrets.

The PMPRB is an independent, quasi-judicial body established by Parliament in 1987 as a result of major reforms to the Canadian drug patent regime. These reforms sought to balance strengthened patent protection for pharmaceutical companies with consumer protection from excessively priced patented drugs. As you may know, in return for these newly strengthened rights, the pharmaceutical industry committed to increase its R and D in Canada to 10% of sales.

Although the PMPRB is part of the Health portfolio, because we are in part an administrative tribunal with a quasi-judicial function, we must carry out our mandate at arm's length from the Minister of Health and other portfolio members.

The PMPRB is composed of approximately 70 civil servants, known commonly as board staff, and five Governor in Council appointment board members. The chairperson of the board is designated under the Patent Act as the CEO of the PMPRB, with the responsibility to supervise and direct the work of the PMPRB. Its work is carried out by board staff under the day-to-day direction of the executive director.

The PMPRB is a consumer protection agency with a dual mandate; first, to ensure that prices at which pharmaceutical companies sell their patented medicines in Canada are not excessive; and second, to report on pharmaceutical trends in general and on R and D spending by pharmaceutical patentees in particular.

In terms of a price regulating mandate, the PMPRB sets ceiling prices based on the factors in the Patent Act and its guidelines for all new patented drugs when they enter into the Canadian market and are continually regulated until the patent expires. There are approximately 1,300 patented drugs under the PMPRB jurisdiction at any given time.

The PMPRB encourages patentees to comply voluntarily with its price ceilings and investigates any suspected instances of excessive pricing. When the result of an investigation is that the patented medicine appears to be priced excessively, the patentee is given the option to lower its price and/or refund the excess revenues through a voluntary compliance undertaking, commonly known as a VCU.

If a patentee chooses not to submit a VCU, the chairperson of the board may issue a notice of hearing. At the hearing, staff and patentees appear as parties before the panel of two to three board members who must exercise their quasi-judicial responsibilities by making a legal finding based on the evidence and the applicable factors in the Patent Act as to whether the drug is priced excessively. If the panel finds that the price is indeed excessive it can order a patentee to reduce the price and/or refund the excess revenue.

In carrying out its quasi-judicial responsibility, the board possesses all the powers, rights, and privileges as are vested in superior court.

● (1605)

[*Translation*]

Since 2008, PMPRB has accepted 67 voluntary compliance undertakings from patentees, for a total of more than $100 million in excess revenue refunded to the Government of Canada.

[*English*]

As of today, the PMPRB staff is overseeing more than 100 investigations of suspected excessive pricing, and there are three active hearings before the board. There are also a number of ongoing Federal Court cases that relate to the decisions of the board or the scope of its jurisdiction. One such case seeks to have the provisions of the Patent Act, which empower the PMPRB to set price ceilings on patented drugs, declared unconstitutional. If successful, this would mean the federal government has no meaningful role to play in controlling drug prices at the national level.

In terms of our reporting mandate, the PMPRB reports annually to Parliament through the Minister of Health on its price review activities, the prices of patented medicines, and price trends for all prescription drugs, as well as R and D expenditures that are reported to it by the patentees.

In addition to its annual report, the PMPRB publishes a multitude of studies every year under the national prescription drug utilization information system that was already mentioned by my colleague. The PMPRB has produced and published approximately 28 analytical studies over the last decade under the NPDUIS initiative.

In the last two years in particular, the PMPRB has worked closely with provincial governments through NPDUIS and directly with lead jurisdictions through the Council of the Federation to provide relevant pricing and market analysis aimed at reducing costs of generic drugs in Canada.

The work of the PMPRB was referenced in achieving price reductions in 18 commonly used generic drugs and continues to inform discussions on generic prices in a national framework.

These are challenging times for industry and pricing and reimbursement authorities alike. While recent years saw growth in drug expenditures stabilize relative to a decade ago, as already mentioned, by any measure Canadians spend an inordinate amount on drugs relative to our OECD partners. While Canada has enjoyed a period of relative stability in the growth of drug expenditures lately, the PMPRB's analysis of the underlying cost drivers behind these trends suggests that increased spending on high-cost specialty drugs, such as biologics, oncology drugs, and orphan drugs, will place increasing strain on the public and private drug plans. Global spending on these drugs is projected to quadruple by 2020. In 2014, Canadian spending on biologics and oncology drugs grew by double digits, and spending on new drugs alone increased tenfold.

The PMPRB's 2014 annual report, tabled in Parliament last December, provides some helpful high-level statistics to explain that spending in context and breaks it down further.

● (1610)

[*Translation*]

Internationally, Canada ranks in the top 10 major drug markets and boasts sales similar to those of the U.K.

[*English*]

Sales of patented drug products in Canada increased by 3.1% in 2014, to $13.7 billion. Although our prices in Canada do not increase beyond the rate of inflation, they also tend not to decrease over time, contrary to trends in many other developed countries. Canadian patented drug prices have thus steadily risen relative to prices in seven countries we compare ourselves to under the PMPRB regulations. We commonly refer to these countries as the "PMPRB7." Whereas in 2005 Canadian prices were third lowest of these seven countries, in 2014 we are third highest, nearly on par with Germany but still well below the U.S., which is a major outlier.

Beyond the PMPRB7, Canadian drug prices are the fourth highest of the 31 countries in the OECD, and on average Canadian prices are 26% higher than the OECD median. Canada spends more on drugs per capita and as a percentage of GDP than most other OECD countries.

On the other hand, R and D in Canada continues to decline and currently stands at 5% of sales. This is the lowest recorded figure since 1988, when the PMPRB first began reporting on R and D. In contrast, the average R and D ratio for the PMPRB7 countries has held steady at about 20%.

The increasing cost pressure of high-cost pharmaceuticals is not a uniquely Canadian issue. All developed countries are struggling to reconcile patient access to promising technologies with finite health care budgets. In recent years, growing concern over sustainability has led many of these countries to introduce measures to address affordability, maximize value for money, and keep pace with a rapidly evolving pharmaceutical market.

The PMPRB has followed these developments closely as it recognizes that its regulatory environment has changed significantly since 1987. It is imperative that its legal framework adapt to these changing circumstances, if it is to remain relevant and effective in protecting consumers from excessive pricing.

To that effect, last December, the PMPRB published its 2015-18 strategic plan, identifying a new vision and a revised mission statement, as well as four strategic objectives that will allow the organization to better leverage its strengths and unique legislative remit to complement the efforts of its federal, provincial, and territorial partners and other stakeholders in advancing a common goal of a sustainable health care system in Canada.

Going forward, consumer-focused regulation and framework modernization will be at the forefront of PMPRB's efforts in ensuring a sustainable pharmaceutical system where payers have the information they need to make smart reimbursement choices and Canadians have access to patented drugs at prices they can afford.

As a first step, in the coming months we will be releasing a discussion paper on guidelines modernization and holding national consultations with interested members of the public and other stakeholders on this subject.

Thank you very much.

The Chair: Thank you very much.

Number four is the Canadian Agency for Drugs and Technologies in Health.

Dr. Brian O'Rourke (President and Chief Executive Officer, Canadian Agency for Drugs and Technologies in Health): Thank you, Mr. Chair, and like my colleagues, I thank you for the invitation to appear before the committee.

I'm Brian O'Rourke, the president and chief executive officer of the Canadian Agency for Drugs and Technologies in Health, and that's the last time I'm going to use the full title because I'll run out of my 10 minutes. Plus, we prefer to be called by our acronym, which is CADTH.

Let me begin by telling you a little bit about CADTH, the work we do, and how that may be of value to your study on the development of a national pharmacare program.

CADTH is an independent not-for-profit corporation established in 1989, and the members—or as we call them, the owners—of CADTH are the federal, provincial, and territorial deputy ministers of health, who fund the agency. That's Health Canada and all provinces and territories, with the exception of Quebec. We're governed by a board of directors that reports to the deputy ministers. Our annual operating budget is approximately $28 million, with 58% of that coming from the federal government and 27% from the provinces and territories, all except Quebec again. As well, 15% of our revenue comes from other sources.

We refer to ourselves as a health technology assessment agency, meaning that we provide evidence-based assessments of the clinical and cost-effectiveness of drugs; diagnostics; medical, dental, and surgical devices; procedures; and programs.

In essence, we have two broad areas of work: our drug portfolio and our medical devices portfolio. We have a number of programs and products in place to support the management of medical devices in Canada. However, I'll focus my comments today on our drug portfolio.

CADTH provides a range of services to support the effective management of pharmaceuticals in Canada: most notably, the CADTH common drug review, well known by its acronym CDR; and the CADTH pan-Canadian oncology drug review, known as pCODR.

The CADTH common drug review program is a federal, provincial, and territorial process, established in 2004 to provide a common approach for reviewing the clinical and cost effectiveness of new drugs and existing drugs that may have new uses. We also receive input from patient groups as part of this review. It certainly is a wonderful example of federal, provincial, and territorial collaboration. The common drug review supports coverage decisions for 18 of the 19 publicly funded drug plans in Canada, including the six plans managed by the Government of Canada for specific populations that Ms. Hoffman mentioned, such as members of the military, veterans, and Canada's first nations and Inuit people.

The pan-Canadian oncology drug review program was established by the provinces and territories in 2010, again with the exception of Quebec, and was transferred to CADTH on April 1, 2014. The federal government joined as a funding partner of pCODR on April 1 of this year. Similar to CDR, pCODR provides a common process for the assessment of cancer drugs and makes reimbursement recommendations to Canada's federal, provincial, and territorial drug plans and cancer agencies to guide their cancer drug funding decisions.

CDR and pCODR programs support funding decisions for individual drugs. We also conduct multi-drug reviews on classes of drugs under the auspices of our therapeutic review and optimal use programs. For example, we've completed therapeutic reviews of biologics used to treat patients with rheumatoid arthritis; we've conducted a therapeutic review on the new drugs that are used to treat patients with hepatitis C; and we're currently undertaking a project to assess the clinical and cost effectiveness of new drugs for the treatment of patients with type 2 diabetes.

These therapeutic reviews and optimal use projects support formulary management decisions, and they provide the evidentiary foundation to promote the appropriate prescribing and utilization of prescription pharmaceuticals. However, we are challenged with keeping up with the demand for therapeutic reviews of prescription pharmaceuticals required to support the public drug plans. They're very valuable to the policy-makers and to the clinicians to help them navigate how new and typically very expensive drugs fit within the therapeutic options currently available. In addition, they help answer questions as to whether or not older drugs are being used in the most appropriate way, based on the evidence.

● (1615)

For example, we have done a number of projects looking at the evidence related to prescription drug abuse. These therapeutic reviews, however, are extremely complex to undertake, and they are very resource intensive. This is, indeed, one area of our pharmaceutical portfolio that could benefit from additional funding.

As another example, the cancer agencies have started to ask us if we could do therapeutic reviews on classes of cancer drugs. That would be extremely helpful for them. However, we're not currently resourced to conduct reviews in the cancer space.

One other service I'd like to mention is our rapid response service where we provide quick evidence reviews of the dauntingly large and complex medical literature. This service is extremely valuable in that it directly addresses urgent needs for evidence that informs both policy and practice.

Mr. Chair, CADTH has well-established linkages with government officials tasked with managing the federal, provincial, and territorial drug plans, and the cancer agencies. For example, we have several advisory committees and working groups with representation from all public drug plans. In fact, that's where I was this morning. We have a meeting of our drug policy advisory committee drug plan managers from across Canada here in Ottawa. And we provide secretariat support for a group that's referred to as the federal, provincial, and territorial pharmaceutical directors' forum.

We have developed partnerships with Health Canada and many other health organizations to promote collaborative work in the pharmaceutical space, and we have created mechanisms to engage patient groups, clinicians, and representatives from the pharmaceutical industry.

We also work closely with and support the work of the drug safety and effectiveness network, housed at the Canadian Institutes of Health Research, and we're open to exploring the transfer of DSEN, the drug safety and effectiveness network, to CADTH as was recommended in the Naylor report.

We also provide drug listing recommendations and additional health economic support to the pan-Canadian Pharmaceutical Alliance that was mentioned earlier, which is responsible for implementing the drug funding recommendations that we make in a consistent manner, and in working with manufacturers to help address concerns that we identified during our CADTH reviews.

Mr. Chair, CADTH's existing programs and services, our linkages to federal, provincial, and territorial drug plans, our partnerships with other health care organizations, and our willingness to interact with concerned stakeholders such as industry and patient groups, certainly could be leveraged to enhance the management of pharmaceuticals in Canada.

We are well positioned to contribute to a national formulary, as was described in the mandate letter of the health minister, and to enhance both the accessibility and affordability of pharmaceuticals for Canadians.

Mr. Chair, that concludes my remarks, and I'm open to answering any questions that may come up.

● (1620)

The Chair: Thank you very much.

Before we turn it over to Mr. Ayoub, are all your organizations stationed or centred in Ottawa?

Dr. Brian O'Rourke: We have an office in Ottawa and a smaller office in Toronto. We also have a liaison officer, a staff member, in all of the provinces as well. It kind of gets our eyes and ears on the ground within the ministries.

The Chair: Thanks very much.

Mr. Ayoub, fire away.

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Mr. Chair.

[*Translation*]

Thank you for joining us. We are very fortunate to have you here with us.

My first question has to do with the fact that it seems a consensus has been reached during the 2015 pan-Canadian ministerial tour on the coverage of drug prescriptions. According to all parts of the government, too many Canadians still have no or insufficient coverage. It seems that if this portion of drug coverage is not reformed, the situation could become exacerbated or take a turn for the worse.

Could you tell me what your thoughts are on the issue?

[*English*]

Ms. Abby Hoffman: Mr. Chair, and Mr. Ayoub, I'm happy to make a couple of initial comments.

I think it's clear, and all of us in one form or another in our remarks have indicated, that there are clearly gaps in drug coverage for Canadians. There are, as I mentioned in my remarks, individuals who have no coverage and individuals who have inadequate coverage. I think it's fair to say there is more to the concerns and challenges in the pharmaceutical sector than simply coverage, as important as that topic is.

There's been mention here of relatively high drug prices that Canadians pay. Yes, it's true that Canadians in general receive less public support for their drug costs than many comparable countries, but our prices are high. The access that Canadians have is highly variable among provinces and territories, and between public plans and private plans.

We have problems also associated with both the underuse and the overuse of medications, and there's often a tendency to focus on the gaps in coverage. By the same token—Mr. Diverty talked about this—we know there are a number of instances where the absence of any degree of control among certain segments of our population, particularly seniors, and particularly seniors in institutions, is quite likely to subject them to what we might call polypharmacy, which is over-consumption of multiple medications for many different purposes. That has cost impacts, but worse it has severe impacts on the health and well-being of those individual patients.

We certainly have huge differences in formularies. It's not just that private plans generally speaking will list and reimburse any drug, while public plans tend to be more restrictive in wanting to have an assessment of the value of a medication before they pay for it. The problem with that is that often the most efficient ways of providing coverage occur in the public sector drug plans, but do not operate at all in the private sector, where basically any individual, if they're prescribed a prescription medication, will be reimbursed by that private plan. We don't make good use of the dollars we already spend on prescription drugs.

Maybe I'll just stop there, but I want to make the point that while coverage tends to be the area of focus, there are many other issues.

The last one I'll cite is that there are multiple reviews of drugs. You've heard from Brian O'Rourke about the common drug review. The PMPRB does its own assessment of a drug to determine whether it's a breakthrough medication when it looks at the price. Health Canada has already done a review to determine whether or not the drug should be made available for sale in the marketplace. Many provinces and territories, even after the CDR, still do their own review.

I don't want to make the situation more complicated than it needs to be, but I will say that there are multiple issues that need to be addressed in this area as you carry on with your work looking principally at coverage issues.

● (1625)

[*Translation*]

Mr. Ramez Ayoub: Thank you for your answer.

I'm from Quebec where the situation is unique. Coverage in Quebec is different from the rest of Canada.

Mr. O'Rourke, what are the best practices in your view? Is Quebec a point of reference? Is it used in the rest of Canada to develop a pan-Canadian plan that will end up serving all Canadians? Will we be able to have the same treatment from coast to coast to coast?

[*English*]

Dr. Brian O'Rourke: The agency in Quebec is INESSS. We have a good, close working relationship with INESSS. They do similar work to what we do for pharmaceutical reviews.

Where Quebec does have a very good system in place is at the hospital level with the hospital formularies and some of the assessments they would do. Our mandate for a Canada is to look at drugs that are used outside of the hospital. Hospitals are meant to look at their own drugs. That's an area of increasing concern for a number of the provinces in that a patient may be started on a drug when they're in the hospital, get released from the hospital, and then that drug isn't covered by their public or their private plan.

That is an area where Quebec is a bit of a leader in Canada.

For the reviews themselves and the patient engagement, I would say we're probably one of the global leaders in how we engage patients into the process and with our connections with industry to allow them to have good dialogue with us, through engaging clinicians, and with the expert committees that we do. I think we have a lot of world-class practices.

[*Translation*]

Mr. Ramez Ayoub: In Quebec, and in other places too, medicine is administered at hospitals and that works well. Patients can continue to take the drugs even outside the hospital. However, if the patients are not properly treated or do not receive follow-up at home and the illness comes back, they return to the hospital to receive temporary treatment before they go back home. I think it is a vicious circle.

What do you think about that? What are the solutions to solve the problem and what are the related costs?

● (1630)

[*English*]

Dr. Brian O'Rourke: Perhaps I'll look at the solutions aspect.

We're already having negotiations with the provincial drug plan managers as to whether or not we should expand our mandate to start looking at the drugs used in hospitals as well, so that the formularies would be somewhat consistent within the hospital sector and the public drug plan sector. That negotiation is happening now.

It would require some additional resources to include an additional number of drugs from the provinces and territories, and all of the drug plans associated with CADTH. As for the actual costs, I'll leave it to our expert from CIHI.

Mr. Brent Diverty: As I mentioned in my remarks, drug use in hospitals represents an information gap for us right now, just like with cancer drugs. An important piece of the evidence in answering questions such as those you've raised would be to have the ability to analyze hospital drug data alongside data from public programs outside of hospitals.

The Chair: Ms. Harder.

Ms. Rachael Harder (Lethbridge, CPC): My first question goes to the Canadian Institute for Health Information.

When I look at the report on prescribed drug spending in 2013 for the top 10 drugs, which represent about 30% of spending, I would say most of these costs are related to complications having to do with either obesity or aging, with the exception of depression of course. If we were to put forward a national strategy with regards to paying for our pharmaceuticals, do you believe that costs would increase with regards to the drugs that are being prescribed in relation to obesity and aging?

Mr. Michael Gaucher (Director, Pharmaceuticals and Health Workforce Information Services, Canadian Institute for Health Information): It's certainly something that we would look at. Offhand, it is difficult to know whether having a national approach would really impact those utilization patterns. They vary right now by province, and a lot of factors come into play such as how they're prescribed, the health status of the population, and demographics.

There are a lot of factors that influence usage and the utilization patterns of those drugs, so it's difficult to know if a different approach could potentially have a positive influence on that.

Ms. Rachael Harder: Based on the stats that I see, obesity is going up and our aging population is going up. We have both of these going up, and both of these are among the top reasons for our drug spending within that top 10 category.

Given those facts, where are we going to start in terms of a cost for a national pharmaceutical strategy? What's that going to look like in 2016 or 2017? What percentage can we expect that cost to increase by based on what I'm seeing in this report with regards to our top 10 spending?

Mr. Michael Gaucher: We have data in our claims database that not only allows us to establish the baseline as to where we are now, but also how that changes each year. That's certainly something that could be monitored over time in terms of looking at what the effect of any change in coverage might be. We have the data and the expertise to track those changes, to monitor them, to report on them, and to see what happens.

It's difficult to know because there are different things at play. For example, with some of the generic pricing deals that are coming into play, which affect some of these drugs, the price may go down, but utilization may in fact be increasing at the same time.

Our data allows us to monitor both, and we have 10 years of data for most provinces, so we can really see what's happening over time and certainly incorporate other factors that might be influencing those changes.

Ms. Rachael Harder: Can it just be clarified for me—maybe I missed this detail—what is the dollar figure? What are we looking at here for one year?

Mr. Brent Diverty: We spend $29 billion on drugs in the country.

Ms. Rachael Harder: So that's the cost the federal government would be looking to assume if we were to move forward with a national strategy?

● (1635)

Mr. Michael Gaucher: It depends on how that is structured and what the approach is. Right now a portion of that $29 billion is already covered by public drug programs that are in place in the jurisdictions and with the federal government, but there is that private sector piece. It really depends what type of model and approach was used for a pharmacare program.

Ms. Rachael Harder: Maybe you can talk to me a little about when drugs are assessed for their effectiveness. We have generic ones and then we have non-generic ones, of course. When that assessment takes place, if provinces had to take the money that we allocate to them to pay for those pharmaceuticals, is it possible that those provinces could choose to pay for, let's say, the less effective one if it happens to be cheaper and still approved rather than paying for the more effective one, which happens to be more expensive? Could we find ourselves in a situation where people are simply prescribed a drug that isn't really effective but that's just the way it is because provinces are looking to save money?

Dr. Brian O'Rourke: I'll take a crack at that one.

We assess the pharmaceutical comparatively. We're looking at product A versus product B. And it's not just on their clinical effectiveness. It also looks at the cost effectiveness. We take into consideration the adverse effects profile, how much more effective one is over the other. We would never recommend a physician or a drug plan to cover a drug that is not effective. It does need to have some effectiveness and it has to demonstrate a greater therapeutic benefit over the existing drugs.

Ms. Rachael Harder: Okay.

I see that pharmacare could be a solution in increasing accessibility to pharmaceuticals for some. However I'll relay to you a recent situation in my constituency.

I have an individual whose daughter has seizures, and the drug she was on is totally off the market in Canada. It's gone, not to be found. Her doctors have prescribed another one, a generic one, which does not work. It's not effective. This little girl is having seizures and as a result, had to be pulled from school. Unfortunately within a month, that generic drug was gone, off the market, so now she has to be switched to a new drug. That drug is not at all effective, which means this girl is not just having minor seizures but now she's having grand mal, which means her entire day is ruined.

In that case a pharmacare program is not going to fix that problem. What's going to fix that problem?

Dr. Brian O'Rourke: I don't have the specifics of that case, but there were some drug shortages in some epileptic drugs, and that's probably what the situation was there, which is a significant problem for a number of drug classes, particularly some generic drug classes where there might only be one manufacturer and that manufacturer has had problems with its supply of the chemicals that might come from other countries around the world. It's a delicate situation for that patient in that we now have to find a therapeutic alternative. That's where to provide the best care the physicians need to look at all the potential products available for that child. Hopefully there is an alternate that will provide some benefit to her.

The Chair: Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): I've seen various statements in this regard, but most of the time I see a statement that says that Canadians pay the second-highest prescription costs in the world. At best, it's third or fourth. Is that correct? Yes.

I guess we don't have a very pretty picture in front of us. We pay close to the highest prices for prescriptions in the world. You've testified that we have very low spending on R and D in this country. If 10% to 20% of Canadians have either no coverage or not enough coverage, that's 7 million Canadians. That's the picture that I see painted in front of us.

Canada has just signed two trade deals, CETA and the TPP, which have new intellectual property provisions. All the literature and opinions I've read indicate that this will delay the introduction of generics to market for some time. I'm seeing estimates of two years as about what it's going to take.

Ms. Hoffman, has the department done some analysis on the likely impact of TPP and CETA, and is it true that those trade deals will likely increase the prices that Canadians pay for pharmaceuticals and add a little bit of mud to that already dirty picture?

● (1640)

Ms. Abby Hoffman: Yes, some analysis has been done. There's a large number of people, not the least of whom are in the generics industry, who are attempting to estimate what incremental costs will be. The maximum amount of extended protection that brand drugs could get in the Canadian marketplace would be two years. In reality, given the intersection of data protection, patent remaining, patent life, and so on, it's likely to be considerably less, on average, for most products. But every day that a patent product remains in the marketplace beyond what is currently the case is a day when the generic equivalent is not in the marketplace. One can calculate the incremental cost.

This is why measures such as the work being done through the pCPA , and some changes that may be in the offing for PMPRB, are so important.

It is difficult to estimate the global cost. We can do modelling based on drugs that are in the marketplace today and try to imagine what would happen with the same mix of data protection and patent life remaining, but we're actually talking about drugs that will be in the marketplace five, six, seven, eight, ten years and beyond. The profiled drugs and their costs and whether or not there even are generics that could replace them will depend on what's going on in that drug marketplace.

Mr. Don Davies: Is it fair to say, Ms. Hoffman, that it's the department's position that those two trade deals will likely increase the costs of drugs in Canada and we just don't know how much?

Ms. Abby Hoffman: That's correct.

Mr. Don Davies: I'm told that Canada is the only country in the world with universal health care and without some form of universal pharmaceutical coverage. On the assumption that this is true, has the department studied any of the many other countries that have universal health care systems and that have some form of universal coverage? Have we done any modelling on how adopting one of those programs might provide a better system for Canada?

Ms. Abby Hoffman: Yes, that was what I was alluding to when I said there are two broad paths based in a way on the same principle: that resources are pooled to share risk across the entire population.

The question is: what is the source of that funding? Is it all public sector dollars, in which case federal, provincial, and territorial governments assume all the costs that are currently contributed by employers, employees, and individuals? Or could there be a financing model that would be progressive in its aspiration to achieve equity while accomplishing universal coverage?

The costs of those who are under-covered or not covered at all represent an incremental cost. But if all drug plans in Canada worked on the basis of the same formulary, and if they were all participants in an aggressive drug price negotiation regime, and if PMPRB were able to land where the strategic plan suggested it could, you could get considerably more value from each dollar spent.

Mr. Don Davies: It's true, because some experts have actually estimated that if we adopted, for instance, the German system, we would save about $4 billion a year of what we're paying now. If we adopted the U.K. system, we would actually save $11 billion a year. I'm reading from the “Pharmacare 2020” plan. Because of the administrative cost savings of a single-payer pharmacare system, it's estimated to be $1 billion to $2 billion less than now.

Independent studies have confirmed this. You add up all those I think they were referred to as efficiencies. If you don't have someone covered for their medicine and they end up in emergency, it is far more expensive. If you add those kinds of savings in, preventative systems, the power of bulk, all of the aspects of it.... It seems to me that the experts who we're going to hear from in this committee will tell us that adopting national universal coverage in this country could save us money over what we're spending now. There's no free lunch, but if we had all those efficiencies we could actually get universal coverage cheaper than what we're spending now.

Is that a possibility?

● (1645)

Ms. Abby Hoffman: I actually think that's a bit of an improbable scenario because we have to take into account the current unmet need. There's certainly a cost. What we would see is that in all likelihood the expenditure per capita might go down. As you've already heard, our spending per capita is pretty high, as well as drug prices being high. You would also expect to see, even with efficiencies, some increase in demand and consumption.

It's appealing to think that somehow or another there would be equilibrium at the end of the day, that all these people who have inadequate coverage could somehow or another find their way into a common plan or at least a common approach for all Canadians at the current cost. I think our sense would be that it would not be cost-neutral. The question is, how do you pay for it, and does it make sense? This is what I was saying in my initial remarks: to continue this system that we have now where individuals and employers also contribute, but to do that on some kind of progressive model where income is taken into account. Today, the co-pays, the deductibles, the eligibility, and all of that does not reflect any kind of progressive financing model.

The Chair: Mr. Kang.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Thank you, Mr. Chair.

I think I will stick with the cost of drugs as well.

From the 2015 study, it was reported that Canada will soon be spending close to $38 billion, or 13.4% overall health care dollars on pharmaceuticals.

Where are the highest drug costs to our system currently located and what barriers have prevented us from adapting our system to lower these costs?

Mr. Michael Gaucher: In our drug spending report we regularly compare provinces, and most recent data shows that there is quite a variability in per capita. It ranges from just under $600 per person in British Columbia, and at the high end, it's Quebec, at almost $1,000 per person. Again, there are several different factors that can influence really why those costs differ. It could be the health of the population. It could be the demographics, the age. It could be the prescribing of the physicians, the patterns of prescribing, and it could be the design of their programs. There are a lot of factors to consider.

In considering those, getting back to your point, certainly there are several different types of strategies that can be used to address utilization and to try to really promote appropriate and optimal utilization of drugs. A lot of provinces are undertaking these different types of strategies. Some of them are policy-related, some of them are more education-related, but different types of strategies have had some success in addressing inappropriate use and high costs.

Ms. Tanya Potashnik: If I could just add, a lot of the high-cost drugs are actually being realized in areas like biologics, oncology drugs, specialty drugs, expensive drugs for rare diseases. We are seeing an unprecedented amount of new drugs that are coming onto international markets at price tags that have never been seen in history. We have drugs that cost $700,000 a year, $500,000 a year—numbers that are hard to understand, if I could be frank with you.

One of the things we do is we compare Canadian prices to international levels. To be honest with you, when we look at international prices, at various models, it doesn't matter whether you have a national pharmacare program or a more public-private mix, every country is struggling with understanding these prices and understanding what's driving those prices. Even in a national program, you're still dealing with monopoly situations where manufacturers are pricing their products at levels that are difficult to understand and difficult to justify, really, and difficult to negotiate because there are no therapeutic alternatives.

The cost pressures are not necessarily coming from the older drugs where there has been genericization and greater therapeutic alternatives. I think the pressures are coming for drugs where there are no therapeutic alternatives, where you have unmet needs, where you have smaller populations. Those are some of the key areas that I think will need focus in the future.

● (1650)

Mr. Darshan Singh Kang: Do the demographics of the population in B.C. and Quebec have something to do with this? It boggles my mind. Why are we paying the second-highest drug prices in the world? Is it our small population base, our buying power?

Ms. Tanya Potashnik: One of the things I want to caution you on in doing these international price comparisons is that every country has gone to an approach that makes it difficult to compare prices, if you will, directly. Every country is engaging in contracting in non-transparent negotiations. When you look at a price, it's no longer feasible in a reliable way to know what any country is paying for a particular drug, because manufacturers have adopted a model of negotiating non-transparent hidden discounts that they provide directly to governments.

The ability to use international prices as a way to assess the fairness of a price within an international context has diminished, if you will, so there are increasing questions about whether this continues to be an effective policy lever.

Mr. Darshan Singh Kang: Is there no legal recourse?

Ms. Tanya Potashnik: Some countries have mandated their manufacturers to provide this data to them. When they look at a price of a particular product in Germany, for example, they have regulations in place that compel the manufacturer to disclose those rebates. That's one of the areas that is of great interest and concern for us.

Dr. Brian O'Rourke: On that, if I may, in Germany they did institute a law on negotiations about four or five years ago. In the German culture, they need to have access. If a physician prescribes a drug, they are entitled to get that drug. For one year after the launch of that drug, it's whatever price the manufacturer has. Then the assessment by their agency—similar to us—takes place, and then they set a price. When the company doesn't like that price because of international reference pricing, there have been a number of cases where the company has decided not to sell their drug in Germany because of that.

In Canada, I think the public plans...because of the pan-Canadian Pharmaceutical Alliance, we've taken good steps to try and manage the pricing. Where the situation is difficult is with the private payers. They don't have a negotiation strength with the manufacturers. They simply take whatever price is offered to them by the manufacturer.

For the public drug plans, they have the information we present to them, so they go into the negotiations from a position of strength. They know what a cost-effective price is and they have a sensitivity analysis of where that price point would demonstrate cost effectiveness. The private payers have access to our information publicly, but they're not able to do those good negotiations with the manufacturers at this point.

Mr. Darshan Singh Kang: In other words, the private payers are subsidizing the public system in some way?

Dr. Brian O'Rourke: They could be.

Mr. Darshan Singh Kang: My next question is about generic pharmaceuticals, which have been touted as a cheaper but equally effective alternative to brand-name drugs. What are some of the challenges and benefits in drug innovation when considering a movement towards those generics?

Dr. Brian O'Rourke: On generic drugs, let's talk about two separate classes of drugs here, because I think it's important to talk about the biologics and the subsequent entry biologics as well.

The chemically synthesized drugs, where scientists and chemists get together and manufacture a drug, are very easy for the generic manufacturers to replicate. This goes to normal patent laws in any country. At the end of their patent life, the generics will take over. The company then moves on to other novel medicines they've developed. That's just normal business in the pharmaceutical world. There are now good systems in place here in Canada, again, for price negotiation on generics. The provinces and territories, in the public plans, have done some good co-operation to lower the prices of generics.

Subsequent entry biologics are another case. These are biologic products from plants, etc., and they're very difficult to manufacture. On the prices that we're starting to see with these subsequent entry biologics, we're not seeing significant decreases like we do with generic drugs. We're also seeing cases where we've done a number of reports to counter some of what the pharmaceutical industry might say, which is that their brand-name product is better than a generic product. We've looked at it and the Health Canada regulator looks at it, and they are equivalent. We've produced a lot of information for patients and for clinicians to demonstrate that clinical effectiveness and comparison.

The subsequent entry biologics are just new, with a number of them coming onto the market in Canada. There's a situation that I've just heard about where the manufacturer of the brand-name product is going into the hospitals and basically giving away their drug. They're charging at one cent for the injectable, so the patient starts on that subsequent entry biologic, and then patients are frightened about changing the subsequent entry biologic, again because of marketing information that it is not the same as the brand-name product. I think we have a long way to go in getting some sort of a clinical equivalency and understanding from the patients on those subsequent entry biologics.

● (1655)

The Chair: We're going down an interesting road here, it seems to me.

I just had a question before we go to the next round of five-minute questions.

Are you aware of non-transparent transactions or hidden rebates in Canada? Do they do that in Canada? I don't know whether you were talking about other countries. Do some companies have these? Actually, the one you just referred to is kind of a non-transparent discount. Are you aware if that's a common practice in Canada?

Dr. Brian O'Rourke: Most of the provinces have moved away from doing the rebates, but all of the price negotiations, the prices that are paid by the provinces through their negotiations of the pCPA, are non-transparent. Those are not publicly available prices.

The Chair: Okay, thanks very much.

Dr. Carrie, you have five minutes.

Mr. Colin Carrie (Oshawa, CPC): Thank you to our witnesses here today.

I've been listening quite closely. I want to point out the wisdom of Dr. Hoffman when she said that this is a complicated thing. At the end of the day, this is about the Canadian health care system. We're looking at the patient. What is the appropriate treatment for that patient and what kind of outcome are we getting?

I think Brent was saying seniors were taking five or more drugs and that almost 40% were using inappropriate medication, and that concerns me because, when the government starts to take a look at national pharmacare, it is a lot of money, and there are a lot of patients who may be treated inappropriately. If we're looking at some simple number such as $10 billion, and 40% is inappropriate, that's $4 billion that the Canadian taxpayer may be picking up for treatment that is not effective and not appropriate for the client.

I am concerned about market distortion because we may end up favouring one modality or one drug over another. My background is that I'm a chiropractor. I didn't prescribe, but I certainly had a lot of patients who, for some reason, did better on one drug versus another. It might have been the Rx&D drug versus the generic. Sometimes it's not a one-size-fits-all for different patients. I'm concerned about distortion of the market and choice for patients and I was wondering if you have done any cost-benefit analysis about job losses if we go towards one system.

I know in Ontario years ago the NDP government wanted to do universal auto insurance through the government. They abandoned it because it would have cost a lot of jobs and would have taken away choices for clients. With this type of initiative going forward, would there be jobs lost, say, in the private sector if we moved towards one model, like Dr. Hoffman said, versus the other model? What about choices for patients for a medication that may be better suited for that individual patient?

Brent, do you have those numbers, or has anybody done it?

Mr. Brent Diverty: We haven't done that type of analysis ourselves. We have seen studies that would suggest that there would potentially be an economic impact, perhaps upwards of $4 billion a year, but those aren't studies that we've done ourselves.

One of the things that I would emphasize to the committee is that, if we have the correct data, we can model a lot of this ahead of time. We would certainly advocate, not just for an investment in data and analysis, but also in the willingness of the various partners to provide the data. I mentioned that our data is strong around public programs; therefore, it's strong for looking at seniors and low-income populations with much less rich data on privately funded drug programs and some of the costs associated with that.

The other thing we have opportunities to do is to bring data together or link data to look at the relationship between use of pharmaceuticals and visits to hospitals, etc. We can do more studies, such as the one I mentioned, with a stronger information base. A lot of these questions can be analyzed.

● (1700)

Mr. Colin Carrie: If the government's moving down this route, would you be able to advise the government? Maybe somebody should take a look at these data and see how they will affect the market. Brian mentioned the example of Germany where perhaps certain drugs would not be available if Canada's market is closed and we don't have a little bit of competition maintained in the market. At the end of the day, we're all thinking about the patients, and I am worried about market distortion here. Do you think that it would be a good idea for you to propose that to the minister?

Mr. Brent Diverty: What I think is, there are a lot of opportunities to model different policy options and also the implications of those going forward, and a strengthened information base will help with that.

Mr. Colin Carrie: I'm curious to note as well, and I think somebody mentioned, are we number two in the world in pharmaceutical utilization, or something along those lines? We're already taking a lot of drugs.

I'm also worried about appropriate prescribing. We had the minister in front of us a few days ago, and I was a little disappointed. She has reversed where we were going as far as tamper-resistant opioids, for example, and the diversion with that.

If we went into a national pharmacare program—and as I said, now we're going back to a non tamper-resistant type of OxyContin, I believe the generics are going out—what do you think would happen to the diversion of these drugs?

I believe Brian talked about you having done some studies about the appropriate prescribing and utilization of prescription pharmaceuticals and a number of projects looking at the evidence related to prescription drug abuse. I'm concerned that if physicians are able to do the easy prescription and it's going to be covered by the government, what is the likelihood of diversion, and what's the cost to the Canadian taxpayer if we have a cheap OxyContin, for example? Is it going to be diverted to the Canadian market? Is it going to the United States? Have you looked into that at all?

Dr. Brian O'Rourke: We haven't looked into that specifically. Our work was more focused on what are some effective systems to deal with the issue of over-prescribing of some of the drugs of abuse. We looked at initiatives that were under way in Australia, and throughout Europe, etc., and that helped inform some of the policies that Health Canada was looking at.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): [*Technical difficulty—Editor*] department. I practised emergency medicine for 20 years.

Of course we write a lot of prescriptions, and as you've said in your presentation, approximately 10% of prescriptions aren't filled. There is data from emergency departments that suggest 60% of prescriptions written in emergency departments aren't filled. There is a lot of speculation. Much of it is that there are many people with much lower incomes who receive all of their care through emergency departments, and it's not a reach to say that it's the poorer patients, and therefore they can't afford these.

Has there been any data, or does anyone have any data, on a system where through emergency departments—say, if there are prescriptions written through the hospital base, or a not-for-profit pharmacy—there would be a saving at least for this population of patients? Has that ever been looked at?

Ms. Abby Hoffman: I'm not aware of specific studies on that, but I think as a general point—and this is not speaking specifically to the use of prescription drugs or prescribing practices in ERs—certain initiatives, such as the choosing wisely initiative, have demonstrated with the over-prescribing of just about every health care intervention, those prescriptions aren't filled. It would be useful to know how many of those prescriptions ought to be filled in terms of looking for optimal therapeutic benefit for the patient.

I want to go back to something we talked about before with this implication that somehow if the public sector took over private plans —which I don't think is really in anybody's sight lines, but even if it were—this would curtail patient choice. I think it would create a greater possibility of more consideration of efficient and appropriate drug use. There would be a fiscal incentive to make sure there were common formularies, that prescribing practices were positive, and so on.

I'm sorry, it wasn't a response to your question, but I wanted to make that comment.

● (1705)

Mr. Doug Eyolfson: That's great because that was the answer to one of my later questions about the possible impact of prescribing practice guidelines. You've saved me the trouble of asking another question, which is good.

Another thing I'm wondering is if there has been any data on any stratified drug plan that is related to income. For instance, we know that for people on social assistance, welfare, very often a lot of drugs are covered. Has any jurisdiction that you're aware of come up with some sort of coverage plan where, if you demonstrated you had an income below a certain level you'd be issued some sort of card or some sort of identification when you met the means test and that your prescriptions were covered? Those who could afford would pay, and those who couldn't afford it would have a portion or all of the expenses covered. Has that been looked at anywhere that you're aware of?

Ms. Abby Hoffman: It is a reality now, as you've mentioned, that individuals on social assistance do have coverage in most provinces and it's generally pretty good coverage. Certainly in the case where seniors are covered, which is also the case in the majority of provinces and territories, there is some degree of income testing, but for reasons you can all imagine it's not that easy from a political standpoint to introduce a really progressive kind of regime where the beneficiaries are actually paying some portion of the cost in accordance with their income. So even though the co-pays and deductibles may vary a little bit with income, probably in an ideal world those regimes could be a little bit stronger.

I mentioned catastrophic coverage. We have looked in the past at different approaches for those individuals who do not have good coverage on an ongoing basis and where their costs relative to either their own net or their own family income are relatively high, and we have looked at different models of providing catastrophic coverage based on the proportion of drug costs as a percentage of income, and the cost will vary widely. At that time, and this was now a number of years ago, catastrophic drug coverage to close all of the current gaps in Canada, depending on which model you choose, could have varied from a couple of hundred million dollars a year to many billions. It's entirely dependent on the model you choose and the degree of progressivity in the financing arrangement.

The Chair: Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair, and thank you to the panel for also being here today and in particular, Dr. Hoffman, for being here a second time.

I want to direct my question towards you, Dr. Hoffman, because frankly I'm a big fan of yours. I watched your career in athletics for years. I watched you at the Pan American Games and at the Olympics. You were a household name in my household at least. I wanted to be able to tell my family that I got to ask you a question.

In your presentation, Dr. Hoffman, you had mentioned that the federal government has some unique responsibilities when it comes to public drug coverage. There are various federal departments that manage drugs for the so-called federal populations such as the first nations, the Inuit, members of the Canadian Armed Forces, veterans, RCMP, and a few others here. Just recently in the media there was a report that in particular among veterans the use of medicinal marijuana has increased significantly within the last year. It's actually quite shocking how it's increased. I'm just curious, first of all, to get your insight on that, and then the data on these other departments such as for federal inmates and such. I would like to know if the medicinal use of marijuana is increasing very significantly in these other areas as well.

Could you talk a bit out that, Dr. Hoffman?

● (1710)

Ms. Abby Hoffman: As a matter of fact I don't actually have data specifically on the use of medical marijuana in the various federal programs, or among the so-called federal populations. I think it would be information held by the responsible departments. If you wish we could commit to getting that information and providing it to you. I don't have it on hand here.

Mr. Len Webber: If we could get that it would be wonderful.

The Chair: Thanks very much.

Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair, and thank you to all of the panel for being here today. I'm sharing my time with the parliamentary secretary, Kamal Khera. My concern is that many Canadians struggle to pay for the medicine that is needed to ensure a better quality of life. Who are some of the groups that are most disadvantaged by how we currently supply drugs? What is the approximate cost to the Canadian health care system due to patients being unable to afford the drugs they need?

Ms. Abby Hoffman: Maybe I can start answering that one.

On the second part, the cost as a consequence of people not filling prescriptions, there is not to my knowledge any good data that explains what those costs are. We do know that individuals who forgo medications, particularly for chronic diseases, and others, but particularly chronic diseases, do run the risk that their condition will deteriorate and that they will make demands as a consequence on other aspects of the health care system, be it emergency room services, surgeries, and so on.

In terms of those who face the most difficulty in terms of access to drugs because of our current coverage regimes, social assistance recipients are eligible in most provinces for coverage. It's those individuals with relatively low incomes—I won't call them the working poor—who have inconsistent affiliation with a workplace. They may work multiple part-time jobs. They may be working part-time. But the nature of their employment is such that they do not have an employer-based supplementary benefits program.

Those individuals are among the ones who face the greatest difficulties. They may also have their situation compounded by being single parents or circumstances of that nature. It's generally people of working age, because seniors are generally covered, with enough income to have passed the income thresholds for eligibility, so they're not eligible for fully subsidized coverage and they don't have any access through their employment. That's the sort of broad category of people who lack appropriate coverage.

Ms. Sonia Sidhu: As we are heading to an increased proportion of the population being over age 65, do you think changes need to be made to better serve the aging population in Canada? What changes would need to be made?

● (1715)

Ms. Abby Hoffman: Again, across most of the country, seniors have coverage through public drug plans. As for seniors who have been in the workforce for a long time, this is not the entire seniors population, obviously, but a significant portion may still have access to the health benefits program in their place of employment even after they retire. This pertains particularly in the case of public sector workers, but not only public sector workers.

The issues for seniors are twofold. One is steps to ensure that there is appropriate use because this kind of over-prescribing has been described in some detail in front of the committee today. The other issue is, if there's a wish to move forward on universal coverage, what should the payment model be?

Right now, what seniors might pay is subject to a certain amount of income testing, but often the caps, the deductibles, the quarterly eligibility characteristics, and so on, don't necessarily take good account of relative income. As I mentioned, it's very difficult politically to imagine introducing higher co-pays, premiums, or something of that nature.

The reality is that we have some relatively well-off individuals over age 65 who are getting very good access to coverage for their drug costs, whereas that 30-year-old, I mentioned a few minutes ago, the single parent with a couple of children, making a very modest income, and with somewhat erratic employment in terms of regularity and access to employer-based benefits, may be getting no coverage at all.

One has to weigh up at the end of the day, is that really a reasonable way to approach an efficient coverage model in Canada?

The Chair: We have time for one more question.

Ms. Khera.

Ms. Kamal Khera (Brampton West, Lib.): Thank you to all the witnesses for being here.

It's important that we look at other systems to evaluate our own. How do our pricing standards compare internationally to other countries with regard to drug costs? I know you've all touched on that, so if you can elaborate a little bit on that.

Ms. Tanya Potashnik: There are differences, certainly, from the federal regulator perspective as to how we look at prices. That's one of the reasons that we are looking at framework modernization and examining the best practices internationally.

I can tell you, for example, that one of the things we look at when we look at a new drug that comes onto the Canadian marketplace is other therapies in the Canadian marketplace that have the same indication. When we do that examination and identify those drugs that have the same therapeutic indication as the new drug, we then look at the prices of those drugs in Canada and we allow the new drug to price up to the level of the highest priced drug in the therapeutic class.

That's just an example of what we do at the federal level. Obviously, when the provinces negotiate prices through the pCPA they would be looking at all the prices in all of the drugs that treat that condition. At the federal level we really let the highest priced drug that's already on the market set the bar, if you will.

In other countries there's a much more sort of average look, so there's an identification of all the therapeutic classes or all the therapeutic drugs that are in that class, but if there are alternatives—in Germany for example—they will include potentially generics in assessing what would be the appropriate or acceptable price for that new therapy. That's one example.

The other example is the way we consider international prices. Again, after the introduction we allow prices in Canada to go up to the highest international price after some years, whereas other countries will look at reviewing their prices on a more regular basis and achieve cost savings through price decreases over time. As time goes on, even if Canadian prices are in line with international standards, over time the gap tends to increase, as the data shows.

The Chair: Thanks very much.

Mr. Davies, you can go over a little bit.

Mr. Don Davies: I think it was Mr. Diverty who talked about the data? Yes.

Do you have any estimate how much money it would cost to provide accurate data to the government to model the various costs of universal pharmacare coverage in Canada?

● (1720)

Mr. Brent Diverty: It's a question with many answers, I think.

The costs of improving the data relative to the costs of the program are quite small. In fact, our entire organization runs for $100 million. We're covering health data across all of the different domains of health care, health expenditure, health workforce, etc.

In terms of improving the data there's a small incremental cost. It may be in the small millions of dollars, sort of thing, to improve it. But there's also, more importantly, the non-monetary costs. It is the willingness of various organizations to provide data. I think that's a really important piece, and also the opportunity that we have through digital health, through eHealth, to capture data more naturally as services are being provided as opposed to as an administrative add-on after the fact. I think that's something we need to capitalize.

If we had national standards in the electronic health records across the country, and a requirement to capture all this data in one place according to one standard, the ability to look at the costs and the implications and the opportunities, I think, would be much greater around all of the issues we've talked about—health outcomes for people, waste duplication, inappropriate prescribing, all kinds of things. That's a real opportunity.

Mr. Don Davies: Could it be done? If the government said there's $5 million or $10 million or $50 million and wanted you to specifically gather all the data you could possibly get and do modelling to tell us whether or not universal pharmacare would save Canada money...because there's different opinions. I've heard Ms. Hoffman's opinion, but we're also going to hear in this committee from other experts who will be adamant that adopting other systems will save us money in the long run. The only way to really anticipate that, I would imagine, is to get as accurate data as we can and model different things. At least it would give us a better idea. Could that be done?

Mr. Brent Diverty: It depends on the question you're trying to answer, the extent to which how well it can be done. I certainly think there are opportunities to model and explore the implications of different options. The information base we have today, particularly for certain provinces, is pretty strong as well. If we can look at samples or opportunities in certain particular jurisdictions we may be able to apply those to a national model. I think it really depends on the questions we want to answer as to how easy or difficult or expensive it would be to answer them.

Mr. Don Davies: I am going to read a little quote here, again, from “Pharmacare 2020”. It says:

> In terms of drug prices, Canada’s multi-payer system is among the most expensive systems in the world, because it diminishes our purchasing power. The prices of generic drugs in Canada are nearly double (79% higher than) the median of prices found in other OECD countries and more than four times (445%) higher than the best available prices in the OECD.
>
> Similarly, the prices of brand-name drugs in Canada are 30% higher than in comparable countries like the United Kingdom.

The source for all those numbers is Ms. Potashnik's group, the Patented Medicine Prices Review Board. It says:

> Take the blockbuster drug Lipitor, for example. A year's supply of the brand-name drug in Canada costs at least $811; in New Zealand, where a public authority negotiates prices on behalf of the entire country, a year's supply of the brand costs just $15. Even the generic version of Lipitor costs at least $140 in Canada, more than nine times more expensive than in New Zealand.

This report goes on and itemizes all the different aspects of a universal pharmacare system, where you contain costs, work with the prescribers, and do the bulk buying and negotiating. It takes all the pieces together to get an efficient system.

My final question—and I know I'm going to run out of time—is this: If some authors think that we clearly can, through a variety of approaches, make sure every Canadian gets the coverage they need at a cheaper cost than we are paying now, but there is a disagreement over whether that is possible, shouldn't we be exploring how to resolve that very important health policy question?

● (1725)

Ms. Tanya Potashnik: We recently published an updated study that looked at where Canadian generic prices are, relative to international levels, and I can say there is some good news on that front, in that the efforts of the pan-Canadian Pharmaceutical Alliance have closed some of those gaps.

The report that we do is fairly comprehensive, so it doesn't pick and choose those examples, because there are examples of both extremes.

I just want to caution that when we looked at New Zealand and compared prices in New Zealand with prices in Canada, we found that there was a much smaller sample of drugs with which we could compare. That suggests that there is potentially a lower supply of generic products, so there is potentially a risk that adopting a certain model could result in less choice.

What the impact of that is for therapies is a different question, but it is certainly something that needs to be looked at.

The Chair: Thank you very much.

We don't have time for another round, but we have one member who hasn't had a chance to ask a question. I wonder if we could give him three minutes. Is that okay with everybody?

Mr. Oliver, go ahead.

Mr. John Oliver (Oakville, Lib.): Thank you very much for that.

I'll begin with a quick reaction to something Dr. Hoffman said. I understand there are many problems here, but for me coverage or access is fundamental. The costs and utilization are important but secondary, just in terms of fairness and equity, to think that some Canadians don't have access when others do. I think we solve the other problems on the way to solving access.

My questions are focused more to CIHI. There are 35% covered by private insurers. I would assume those are mostly employers. What is the advantage to employers if we move to a universal model? On top of the drug costs that you identified, they would have an admin fee with their insurers associated with that. Do you have any sense of the order of magnitude of that admin fee?

Mr. Brent Diverty: No, that's not something that we have looked at. Offhand, I couldn't provide you with an answer to that.

Mr. John Oliver: The 35% are generally employers, is that correct?

Mr. Brent Diverty: Yes, it is employers' insurance, provided through employers. That's the majority of it.

Mr. John Oliver: That would be about $10 billion that we.... Depending on how this progresses, we would be assisting private sector employers who are currently insuring the population.

Ms. Abby Hoffman: I think that it's fair to say, though, that at the end of the day it may be the employers who are actually paying the premium to the insurance companies, but this is all part of the calculation of the pay packet for employees.

I think the benefit to employers and to insurers is that drug coverage costs are escalating, and in these—I'll call them, for lack of a better term, non-managed—privately financed drug benefit systems, this is getting to be an increasingly heavy cost burden for employers. Insurers find it difficult to offer major employers good drug benefit regimes, because of the costs they are facing.

Some of the efficiencies in the public plan—the formularies, some oversight on prescribing practices, price negotiation, generic substitution, all of these things—I think employers would welcome. They could certainly imagine—I don't want to say readily—scenarios where they could be offering exactly the same benefits to their employees at considerably lower costs. Even with no change, you could argue this might allow them perhaps to extend benefits to some of their part-time or non-unionized workers.

Anywhere there are savings opens up at least the potential that some of the coverage gaps.... You quite rightfully say—

Mr. John Oliver: If we went to universal coverage, there would be a major advantage to employers, because that cost would transfer from their costs to public purse costs, is that right? That would be a way to talk about that.

Ms. Abby Hoffman: Yes, but not necessarily.... Again, just to hark back to those two theoretical models that I put on the table, and I think it's worth looking—

Mr. John Oliver: That's what triggered me, to be honest.

Ms. Abby Hoffman: Yes.

In some of these other countries where we use the term “universal coverage” rather loosely, it does mean that everyone has coverage, but it does not mean that public authorities pay the full cost. Public authorities have oversight of the parameters for drug coverage, and it is useful for the committee to look at the range of these models that are out there that all have, at the end of the day, universal coverage.

Mr. John Oliver: With regard to a formulary across Canada, is there an organization in Canada that would be positioned to think about a national formulary and what would be included in that?

● (1730)

Dr. Brian O'Rourke: Yes, and we would be very pleased to try to take that on.

The Chair: Thank you.

On behalf of all the committee, we want to thank the panel. You have given us a wealth of information, and I suspect we'll be inviting you back because I think you have most of the answers we need.

We are going in camera for a few minutes to discuss some budgets and issues, so we'll take a little break. The meeting is suspended.

[*Proceedings continue in camera*]