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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I'd like to welcome everybody to meeting number 9. Today is a special day because it's the birthday of Darshan, one of our committee members.

Although we sang Happy Birthday for the Queen the other day, we're not going to sing Happy Birthday for you, but we do wish you well. Many happy returns of the day, Darshan.

We're going to do a little committee business first. We have two issues to deal with. One is a motion by John Oliver.

John, could you read your motion?

Mr. John Oliver (Oakville, Lib.): Thank you very much. It reads:

> That, in relation to Orders of Reference from the House respecting Bills,
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> (a) the Clerk of the Committee shall, upon the Committee receiving such an Order of Reference, write to each Member who is not a member of a caucus represented on the Committee to invite those Members to file with the Clerk of the Committee, in both official languages, any amendments to the Bill, which is the subject of the said Order, which they would suggest that the Committee consider;
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> (b) suggested amendments filed, pursuant to paragraph (a), at least 48 hours prior to the start of clause-by-clause consideration of the Bill to which the amendments relate shall be deemed to be proposed during the said consideration, provided that the Committee may, by motion, vary this deadline in respect of a given Bill; and
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> (c) during the clause-by-clause consideration of the Bill, the Chair shall allow a Member who filed suggested amendments, pursuant to paragraph (a), an opportunity to make brief representations in support of them.

Mr. Chair, this is following a prior committee process. It ensures that MPs from non-recognized parties will be able to move amendments during the committee process and gives MPs from non-recognized parties a much bigger role in committees. That's the intent of the motion.

The Chair: Thank you very much.

Is there anyone at the table who would like to address this?

Ms. May.

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Thank you, Mr. Chairman.

We spoke briefly earlier and you said not to take too much time. Do you have a rough idea of how much, so I can keep track of my time?

The Chair: Yes, just a couple of minutes, please. We have witnesses.

Ms. Elizabeth May: This motion is being presented to this committee as though it somehow advances the rights of people who are members of Parliament in my position, that being a member of a party with fewer than 12 MPs, or an independent MP. It is in fact exactly the contrary. It is all about an abuse of power by a majority party to restrict the rights of smaller parties.

In the last Parliament, members of the Liberal Party and members of the New Democratic Party voted against this very same motion restricting the rights of people in my position, people who are members of a party with fewer than 12 MPs.

As for the origins of this, to go back to it briefly, the ability to present amendments at report stage used to be unrestricted for any member of Parliament, but in 1999 the Reform Party brought forward over 700 amendments. They were mostly frivolous and dilatory, but their intention was to stall the Nisga'a treaty.

It took a couple of years for the governing party of the day, the majority Liberals of the day, to change the rules to say that if you, as member of Parliament, had an opportunity to put forward a motion, an amendment, in committee, you did not have the right to put forward an amendment at report stage. Just to repeat that, members of recognized parties at that stage had the rules changed so that you could not put forward a substantive amendment at report stage because you had a right as a member of a committee. That meant that those of us in smaller parties who can't sit on committees as full members still had this right to bring forward a substantive amendment at report stage.

I think I'm the only MP who ever discovered that this was the case, and I used it in the 41st Parliament to bring forward important amendments. As I said before, my rights in this regard were supported by the Liberals and the New Democrats.

In the fall of 2013, the Conservative majority brought forward this new idea. Rather than change the rules as we find them under O'Brien and Bosc, every single committee passed an identical motion. The effect of this was that I and all members of Parliament in my situation would then be invited to show up to committee. This was really coercion, not invitation. I would present amendments, sometimes with 60 seconds to defend my amendment, and was not allowed to answer questions about it after the fact.

The effect was that if two committees were meeting at the same time at clause-by-clause, which often happens, I'd be running from committee to committee to try to meet the invitation from committees to get my amendments in and considered. It is an enormous imposition of additional work for the sole purpose of depriving members of Parliament from smaller parties of being able to present amendments at report stage.

It's an abuse of power, and I have to say that it's heartbreaking to see it being done again. Such motions by the committee die at the end of every Parliament, which is why every single committee is being asked today to pass the former majority Conservative motion through committee. I would beg of you: please don't pass this motion.

● (1535)

The Chair: I just want to say that perhaps you and I are the only ones on the committee who have been in your position as either independents or as members of a one-person party. It is really difficult. I can sympathize with your position. You just can't be everywhere, as parties with dozens of members can be.

It's not possible to make it easy for you. I know how hard you work and how committed you are to everything. All I can tell you is that if this motion passes today, this committee will hear you and give you the opportunity to speak generously at any time. That's the only thing I can offer you.

It's just not possible for Parliament to accommodate one person, either you or me, in the same way it accommodates parties with dozens of people. That's all.

Ms. Elizabeth May: With your permission, I'm not asking for special accommodation. I'm just asking for the rules as they currently are in the rules of *House of Commons Procedure and Practice*. Our rule book, O'Brien and Bosc, is fine with me. I can present amendments at report stage, and I will not abuse the right to present amendments at report stage. However, report stage happens once a day in one place, not in multiple places at multiple times on multiple bills simultaneously.

This is a very damaging motion to the rights of MPs in smaller parties. Or, if any of those currently sitting with a party should become independents over the next period of years, which is the experience that you've had, Mr. Chair, it will definitely not be easy. This makes it so much harder.

I'm very bitterly disappointed that the government House Leader has made this decision to ask all of you to pass this. I would ask you, please, to demonstrate to Canadians that we don't have a lot of clouds on sunny ways.

The Chair: Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): I have a couple of comments and an important question. With great respect to my colleague, Ms. May is not the only person who has proposed amendments at report stage in the House. I don't think I'm hurting her to say this, because other parties, including the New Democratic Party and probably members of all parties, have proposed amendments in the House at report stage, but I'm sympathetic to her point here.

My question has to do with this: I'm unclear, if this motion were to pass, whether it means that members of Parliament may only present amendments to legislation at committee and therefore are totally precluded from doing so at report stage in the House—which I believe, if I'm not doing violence to Ms. May's position, is her position. She she may be right, but I have checked with our parliamentary advisers, who suggest to me that this is not completely the case: it's only those amendments, they say, that are presented at committee that can no longer be moved at report stage in the House, meaning that other amendments could be moved at report stage in the House, as long as they were not made in committee.

I had a chance to chat with Ms. May, and if I understand her position correctly, she thought that if this motion were to pass, it would mean that a member would be precluded from moving any amendments at report stage in the House because they had had a chance to move them in committee.

I wonder whether anybody knows the answer to that, because it would make a difference to of how I view this—

The Chair: John, do you have a comment?

Mr. John Oliver: Mr. Chairman, I read the motion. It specifically deals with members of caucus who are not members of an established party, so I think it's a fairly narrow motion, as written, for that group.

The Chair: That's my understanding, yes.

Ms. Elizabeth May: May I attempt to answer Don's question?

I've lived with this, and believe me, after several points of order and arguments with the Speaker in the 41st Parliament, there's a distinction at report stage between a substantive amendment and a deletion.

Any member of Parliament, including a member of a non-recognized party, after the so-called opportunity created by this oppressive motion, will still have the right to present deletions at report stage. With this motion in place, no member of Parliament would have the right to present substantive amendments at report stage, whether they had been tabled before committee or not. That's the distinction.

The ability that was supported by the Liberal and New Democratic Party, for instance, with regard to the spring omnibus budget bill of 2012.... This motion is the direct result of an attempt to punish me by the previous Conservative majority for fighting effectively against Bill C-38 in legion with Liberal and New Democratic Party MPs who did not want to see the damage that would happen due to Bill C-38. I put forward 423 amendments to Bill C-38, the omnibus budget bill. The Speaker grouped them and we voted. Voting took 24 hours straight, and that's why they brought forward these motions.

First they—in this case Peter Van Loan—tried to get the Speaker to rule that members such as me would have one amendment pulled out of the pack. If that one amendment failed after being put to a test vote, none of the rest would be heard. The Speaker said that it violated the principle of this being a parliamentary democracy, and so that was rejected.

However, the Speaker opened the door by saying, well, if there's some opportunity created.... We've now tried this so-called opportunity and the Speaker said it would have to be satisfactory to members. It's certainly not satisfactory to me. I've lived with it since the Fall of 2013 and it's really very difficult running from committee to committee.

I hope that answers Don's question. Yes, anyone can put forward amendments as deletions at report stage, but nobody can put forward substantive amendments if this motion passes.

● (1540)

The Chair: Mr. Oliver.

Mr. John Oliver: We have an extensive committee meeting before us. We have panellists here to speak. There's been a very generous opportunity for the member to express her views and concerns regarding the motion. At some point, we need to move forward with the planned agenda of our meeting.

The Chair: Mr. Davies.

Mr. Don Davies: I totally understand Ms. May's description of it, but, again, I'm receiving different information from that. I would suggest that we stand this motion to our next meeting, so that we can clarify what exactly are the rights of a member to table motions at report stage. It would make a difference as to how I might vote on this. I don't see any particular urgency on this issue.

I would propose, with respect to Mr. Oliver's comments, that we get to the matter at hand and simply put this over to our next meeting.

The Chair: Is that a motion?

Mr. Don Davies: Yes, it is.

The Chair: All in favour of the motion to stand this and carry it on at a future meeting?

All against?

(Motion negatived)

The Chair: We will now move to the motion.

My understanding is that this motion allows you, or any independent member, to make written submissions to any committee, defend them, and then propose amendments. You cannot do this now. It may restrict you in some ways, but it gives you a whole lot more open ability to speak your mind. Many people say that members of Parliament do their best work at committee.

Ms. Elizabeth May: Not handcuffed, but that's okay.

The Chair: We've heard the motion.

All those in favour of Mr. Oliver's motion?

All against?

(Motion agreed to)

The Chair: All I can tell you is that if you ever come here, the Chair will be very generous in hearing your points.

The second issue is that we have to decide whether we're going to consider the appointment of Dr. Siddika Mithani to the office of president of the Public Health Agency. Our committee can debate that appointment, analyze it, and pass judgment on it, or not.

Is it the will of the committee to have a debate on that appointment?

That said, there doesn't seem to be any interest in that. I'm going to assume that's a nay and we will not question her appointment.

We're going to move to our agenda. Today, we have Mr. William Dempster, CEO of 3Sixty Public Affairs; Mr. W. Neil Palmer, president of PDCI Market Access; and Dr. Graham Sher, CEO of Canadian Blood Services.

Whoever wants to go first, you have 10 minutes. When your 10 minutes are up, we'll ask you questions.

Mr. Palmer.

● (1545)

Mr. W. Neil Palmer (President and Principal Consultant, PDCI Market Access): Thank you, Mr. Chair. I'll be going first. Then it will be Mr. Dempster, and Mr. Sher will be batting cleanup.

Good afternoon. My name is Neil Palmer. I am president of and principal consultant with PDCI Market Access. Appearing with me today is Dylan Lamb-Palmer, manager of health economics and analytics at PDCI.

The opinions expressed today are strictly our own. We are not here to advocate on behalf of any third party. Although our clientele are often pharmaceutical manufacturers, we are not advocates for the pharmaceutical industry; however, our consulting work provides first-hand insights into the mechanics of pharmacare in Canada, experience that underpins our policy and research activities, including our studies on the cost of national pharmacare.

By way of background, I have more than 30 years' experience in the health care sector, including six years with the Patented Medicine Prices Review Board, where I was involved in the development and application of the PDCI pricing guidelines, most of which are still in effect today. I also have significant experience with the international pricing and reimbursement of pharmaceuticals and give lectures on that subject matter at the University of Southern California graduate program in health care decision analysis.

As you know, PDCI was commissioned by the Canadian Pharmacists Association, or CPhA, to prepare a cost study of national pharmacare and address the findings of the Morgan et al analysis that was published in the CMAJ and reproduced in the Pharmacare 2020 report. We also assessed pharmacare alternatives that provide universal coverage without dismantling or disrupting our current pan-Canadian health care system.

In our view, the national pharmacare discussion should be based on thorough and thoughtful analyses informed by a range of perspectives, expertise, and experience, and open to respectful consideration of a range of policy options. We believe it's important to begin by identifying the problems that national pharmacare is intended to solve, so let's start where there is general agreement.

First, there is a coverage gap. Not all Canadians have access to the prescription drugs they need, and costs may be a barrier for patients, even those with basic coverage. Figures of 10% to 20% with no coverage or inadequate coverage are frequently cited. However, the underlying data supporting these figures is weak and generally based on unreliable opinion surveys. That 10% to 20% could be underestimate or an overestimate. Either way, we need to know.

We need to know because it's not possible to make informed policy recommendations and decisions when there is such uncertainty. This is an area where the federal government can make a vital contribution. The federal government should commission Statistics Canada, Health Canada, or an appropriate outside agency to conduct a thorough, comprehensive survey of prescription drug coverage in Canada. The study should also examine the extent to which deductibles and copayments are barriers to access.

Second, prescription drug coverage should not depend on where you live. Comparable coverage should be available throughout Canada, but coverage need not be identical. Much like our provincial health care systems, which all respect the core principles of Canadian medicare, they are similar but not identical.

This is an important point. Unlike other countries, Canada does not have a national health care system, and here there is a disconnect. National pharmacare makes sense in the context of a national health care system, but we do not have a national health care system. Moreover, national pharmacare is proposed with further decoupled responsibilities for drugs from health care funding. This will only exacerbate the silo funding mentality. The more detached pharmacare is from the provincial health care system it serves, the less informed its decision-making.

Next, I would like to discuss the concept of a national formulary, something that is often proposed as an integral part of national pharmacare. Our analysis suggests that greater than 90% of drug products are common to all plan formularies or are made available through alternative programs in the particular province, such as through a cancer agency, so a national formulary would largely replicate what is already in place.

Nevertheless, it would be useful to conduct a thorough comparative analysis of benefits on provincial drug benefit plans and programs to assess the degree of commonality and identify the therapeutic areas where there is discordance. This is a study that could be undertaken by the national prescription drug utilization information system, NPDUIS, by the Canadian Institute for Health Information, or by IMSL.

The third area of agreement is that the selection of prescription drugs for reimbursement should be evidence-based. In fact, to varying degrees, the provincial drug plans have always applied an evidence-based approach. Since 2003, new drugs have been reviewed—except in Quebec—by the common drug review of the Canadian Agency for Drugs and Technologies in Health, or CADTH. The process of CDR consists of a thorough examination of clinical and cost effectiveness and provides consistent evidence-based listing recommendations to the provinces. In Quebec, INESSS provides a similar evidence-based approach for listing drugs in that province.

● (1550)

The fourth area of agreement is that significant buying power is essential for negotiating the best prices for the public drug plans. With modest beginnings in 2010, the pan-Canadian Pharmaceutical Alliance or pCPA now negotiates prices on behalf of all public plans, including those in Quebec and the federal plans. In fact, the pCPA is a remarkable yet unheralded public policy success story. Till recently, the pCPA had no dedicated resources and relied entirely on the drug plan managers in each of the jurisdictions, who through good will and collaboration have developed organically what has become a world-class mechanism for negotiating product listing agreements. The pCPA has completed over 100 negotiations and saves almost half a billion dollars annually, savings that will only continue to expand as every new drug is added to the pCPA process. Moreover, the pCPA is now conducting class reviews of established drugs and has lowered the prices of generic drugs to between 18% and 25% of the original brand price in most cases, benefiting all Canadians. In fact, the pCPA has become so successful that private drug plan insurers want in as well.

To date, the pCPA has not opened its doors to private insurers, perhaps because the private plans are primarily for profit, and are quite capable of negotiating their own listing agreements. For example, new initiatives to control private drug plan costs, such as Manulife's DrugWatch program, are sparking considerable interest and some controversy.

And what of the public versus private debate? Proponents of national pharmacare suggest that eliminating private drug plans could be achieved with only modest cost to government. We disagree. If public, private and out-of-pocket expenditures were to be combined into a single national plan, we estimate that the total cost savings of approximately $1 billion could be realized over total expenditures, but there would be a significant shift of spending to the public sector of approximately $8 billion in 2015.

Nationalizing private drug plans in the name of national pharmacare would not only shift significant cost to the public sector, it would also be highly disruptive for employers and employees, and at the same time provide no improvement in health status. Moreover, these benefits are negotiated in collective agreements. Unions would be unlikely to give up their drug coverage without something in return.

Morgan et al. suggest that by combining public and private systems, it would be possible to achieve Canadian prices as low as those in the U.K., even though the U.K. has a much larger population and a much different mechanism for funding drugs. In England there are 209 clinical commissioning groups or CCGs. CCGs are physician-led statutory health organizations responsible for the planning and commissioning of health services for their local area. Each CCG maintains its own formulary and is assigned a fixed drug budget. There are some concerns with the U.K. approach. Although fixed budgets help control costs, they can be a barrier to the uptake of new medicines. As a result, U.K. physicians are slower to adopt new medicines into their practices, and this has been an area of concern, particularly for cancer drugs.

In the face of considerable ongoing criticism, the government was forced in 2010 to establish a special cancer drugs fund in addition to the regular funding mechanisms in England. The impact of poor access to drug plans regularly makes headlines in the U.K. including those in a recent article in *The Guardian* that highlighted the findings of a comprehensive review article in *The Lancet*, a leading medical journal. The *Lancet* study concluded that five-year survival rates for U.K. patients across a wide range of cancers trailed those for most leading nations, including Canada.

It's important to consider international price comparisons in context. Morgan, citing PMPRB, points to prices in the U.K. being 23% lower than in Canada. This 2013 figure is highly sensitive to exchange rate yet accounts for almost two-thirds of the savings proposed by Morgan. One year later, in 2014, U.K. prices were 14% lower than Canadian prices, according to the PMPRB, a change of 9%, or almost $2 billion of Morgan's savings lost in just one year.

A more robust analysis would have taken into account the volatility of exchange rates and considered purchasing-power parities instead of market exchange rates.

To the extent that pharmacare policy decisions are to be informed by international price comparisons, it's critical that there be proper context with transparent discussion of the underlying exchange rates, health care systems, and appropriate sensitivity analysis. The PMPRB already limits Canadian prices to international comparators. The PMPRB also limits prices of new drugs to prices of other drugs in the same therapeutic class, and limits price increases to inflation. In fact, Canadian price increases typically average less than one percent each year.

However, to some the PMPRB has lost its relevance. Nevertheless, the PMPRB is an important component of pharmaceutical cost-containment in Canada. The federal government can do its part by clearly defining the PMPRB's mandate so that it realigns its priorities to be in line with the priorities of the provinces, pCPA, private plans, and consumers, and by removing the jurisdictional uncertainty that leads to unproductive litigation. Parliament and not the courts should determine PMPRB's mandate.

● (1555)

In summary, we have an evolving pan-Canadian version of pharmacare, one that's integrated into the underlying provincial-territorial health care systems that pharmacare serves. There's still much work to be done. All Canadians must have access to affordable drug coverage, and as I have already suggested, we need a comprehensive study to assess and address that coverage gap.

Similarly, we need to assess if there are any important disparities in terms of drugs that are covered across jurisdictions. These are initiatives where the federal government can take a leadership role.

Finally, the focus of Canadian pharmacare discussion should be to extend and improve coverage to those within adequate coverage, not weaken the drug benefits of the large majority of Canadians that currently have good coverage.

Thank you.

The Chair: Thank you very much.

I have one question. What does PDCI do?

Mr. W. Neil Palmer: We do a range of things, typically for pharmaceutical manufacturers. We prepare the submissions of clinical and cost-effectiveness evidence that are submitted to the common drug review, INESSS, and the pan-Canadian oncology drug review. We provide similar types of information to the PMPRB. We help the manufacturers assemble the evidence they need to get their drugs listed as benefits on formularies.

The Chair: Mr. Dempster.

Mr. William Dempster (Chief Executive Officer, 3Sixty Public Affairs): Good afternoon.

My name is Bill Dempster and I'm CEO of 3Sixty Public Affairs, a health policy and advocacy consultancy.

My colleagues and I have practical experience with pharmacare programs, government policy, and pharma industry stretching back to the mid-1980s. We contribute to peer review publications, policy magazines, and industry journals on a range of issues relevant to this study.

[*Translation*]

I want to thank the committee for inviting me to share my point of view on a national pharmacare program.

[*English*]

I've been invited here to talk in particular about bulk purchasing and cost containment. I'm here as an individual to share my personal observations, and I want to focus my remarks on a lot of what Neil touched on in regard to the pan-Canadian Pharmaceutical Alliance, by reviewing where the pCPA fits in the process, how it works, and the impacts it has as a cost-control tool and policy. I'll also touch on how other payers, including private insurers and hospitals, control costs using similar mechanisms. I'm going to make some references to some figures and graphs that I've prepared in a PowerPoint deck in both languages.

Hopefully, I'm going to help the committee better understand the evolution of pCPA and how it can fit into the federal government's approach to pharmacare and understand a little more about how other payers also control costs using similar mechanisms.

I would invite you to look at page 2 of my handout which shows where the pCPA fits. You've already heard from Health Canada and the federal price watchdog, the PMPRB, as well as the Canadian Agency for Drugs and Technologies in Health, or CADTH. It is after the review by CADTH or Quebec's health technology assessment agency, INESSS, where pCPA picks up a new drug for potential negotiations with manufacturers.

Operationally, the pCPA secretariat is housed in Ontario's health ministry, with five staff, but the bulk of the work takes place across the country, as every week federal, provincial, and territorial public drug programs hold teleconference calls to discuss current negotiations and review recent evaluations to determine whether or not to enter into talks on a new medicine.

If pCPA decides to negotiate, one representative jurisdiction is chosen to lead the talks and be the primary point of contact with the manufacturer. It's like collective bargaining or multi-level negotiations. That lead jurisdiction actually has to get the consensus of all of the other jurisdictions that are involved in that discussion in order for a deal to be secured. I use the term “deal” loosely because there is no legally binding agreement. They are negotiating a letter of intent that all participating governments are expected to implement.

Most deals are a simple price discount, which operates as a rebate that will be paid back to each jurisdiction. However, it's not always about price. I think there's room to expand what the pCPA can do. In fact, the pCPA has said it is open to and has concluded negotiations on issues like health outcomes and utilization caps for ongoing research.

What are the primary interests of the parties in these negotiations? Well, beyond patient access to new health products and improved health, which both parties are looking for those, the drug plans want greater budget and clinical certainty and, ideally, savings. The manufacturers are looking for a fair price and greater revenue certainty. The time it takes to negotiate varies widely from a few months to over a year in some cases, and now there is a large volume of new products coming through the system, which is already stretched. This is causing a backlog. There are around 20 drugs that have CADTH recommendations, but there's no decision on whether to negotiate.

The pCPA is also looking at multiple products in the same class of drugs, some of them older medicines that have been on the formulary or that have come due for renegotiation. The pCPA is also responsible for administering the reimbursed and transparent prices for generic drugs; and as my fellow panellists said, prices for generics are set at progressively lower percentages of the innovator price. It can be as high as 85%, but it can go down to 18%. Most payers benefit from these transparent generic drug prices.

How do other payers, including private insurers and hospitals, operate? Well, there are just three private health benefit providers that account selectively for two-thirds of the big private market, and there are dozens of smaller private insurance companies. All of them are ramping up negotiation capacity on their own, as are smaller providers.

Private insurers can offer literally hundreds of different types of drug benefit plans based on the needs and capacities of their clients, which, in general, are employers, unions, and affiliated groups, but they can also be individuals. Private payers have also long used the valuation committee to provide reimbursement advice, and manufacturers prepare and submit lots of data to these payers as well.

● (1600)

Not all private plans are open formularies. As you might have heard previously, a growing number are actively managed with a range of cost-control mechanisms.

Private health benefits are highly valued by most Canadians. They cover 24 million of us, including, I would imagine, every person around this table. For employers they're an essential part of a competitive compensation package. How about hospitals? Well, they too have drug evaluation committees and can often negotiate alone or as part of group purchasing organizations, depending on the province.

Let's go back to the pCPA and talk about what it has achieved. As my fellow panellist said, as of last month the pCPA had successfully negotiated a milestone 100 medicines and uses of medications. The half a billion dollars in annual savings announced last year has to be much higher today. There are 40% more negotiated products through the system and there are even more generics listed at the lowest price level.

To get a snapshot of these savings, I'd ask you to turn to page 3 of my handout. As you can see, we compared the provincial reimbursement rates today with those of a decade ago, in 2006 before the introduction of any provincial capacity to negotiate with manufacturers. Ten years ago, 103 new drugs, drug uses, or formulations had come to market in the previous 24 months. For those, only two provinces had reimbursed or listed more than 30% on their public drug programs, and the average was less than 20%.

Fast-forward to the end of last year with the pCPA in full swing. There are at least three things that I think we can pull from this data. First, a lot more products are coming to market, nearly 200 compared to half that a decade ago. Second, Canadian patients can now access many more new drugs, double the number of 10 years ago, and the proportion of new drugs has jumped from less than 20% to over 30% on average. Finally, there is more consistency across the plans. Look at the line graphs on the right and you will see that there is much less variability across plans today. This is looking a lot like a de facto national formulary.

However, these graphs don't tell you the aggregate value or price reductions. Those are really hard to figure out, because a lot of the prices are confidential. These are based on individual negotiations, but for a glimpse of that, I would direct you to page 4 of my handout. Let's look at the total amount spent by provincial governments on prescription drugs in recent years. You'll see that since 2011 when the pCPA really started, spending by governments levelled out and even dropped as a share of total health spending. So governments are spending roughly the same amount, or even less when you consider inflation, population growth, and aging, but Canadians who depend on public drug plans have access to many more medicines. It tells us that prices must be coming in at significant discounts.

We've talked about how the pCPA works and shown how the pCPA adds value, achieves better prices, and increases consistency across government programs, but I want to provide a quick analysis of the pCPA beyond economic issues.

Here are some other positive aspects of pCPA. In addition to taking part in government collaboration, the office is willing to consult and engage with all stakeholders, and it has set out some very patient-centric principles drawing on the cancer review system. However, the pCPA still has some challenges, and I'll just touch on a few. First, in terms of transparency, the public doesn't know which jurisdictions have taken part in any given deal. Second, there are no timelines for the various steps, although the office of the pCPA is developing a negotiations playbook, and they hope that some elements and timelines are clarified in that. Third, provinces don't always reimburse quickly or at all following the conclusion of a negotiation. For them the negotiated deal or letter of intent appears to be an option to reimburse and not a commitment to reimburse, and that probably limits the level of discount the manufacturers can offer. Fourth, the backlog I spoke of earlier is delaying access to important new therapies and there is a cost to patients and the health care system in those delays. These issues need attention.

Now that the federal government is involved in the pCPA and more engaged with the provinces on health care in general, Ottawa could inject funds to increase the capacity of the pCPA to move products through the system, improve transparency, improve timelines for quick reimbursement decisions after negotiation has been completed, and even play a role in closing important national access gaps, such as an approach to funding drugs for rare disorders.

What does this have to do with national pharmacare? National pharmacare as a policy proposal appears to work in other countries in context, but I think there's a lot of analysis to do before we can say that it works in practice in Canada. In the meantime, all public jurisdictions are steadily building and adapting the pCPA to the Canadian federal reality. This relatively young initiative is an important and evolving contribution to national collaboration on pharmacare.

● (1605)

I'd like to thank all of you again for inviting me here today. I look forward to hearing from the next panellist and answering your questions.

Merci.

The Chair: Thank you very much.

I'm just wondering. Does this system make sense to you? Is this a good system?

Mr. William Dempster: As my fellow panellist said, it's an organically evolving system. I've been writing on it since it started in 2011, and at least every two years we publish an article on it. It's getting better year over year.

Is it a good system? Yes. Could it be a lot better? Oh yes.

It's definitely not perfect, as I think I've laid out, and it's not the full nationalized pharmacare program, but it certainly is stepped to national collaboration and general frameworks for it that everyone can draw on and access prices that they otherwise couldn't.

For Atlantic Canada, where I understand you're from, Mr. Chair, I think it's been an amazing success. The listing rates in Atlantic Canada have gone up significantly because they can get access to better prices, which they just couldn't get under the previous system.

The Chair: Thank you.

Dr. Sher.

Dr. Graham Sher (Chief Executive Officer, Canadian Blood Services): Thank you very much, Mr. Chair, and committee members. Thank you very much for the opportunity to be back in front of this committee, this time to talk on the important topic of pharmacare.

We are here before you today because we view Canadian Blood Services' national formulary of plasma protein drugs as a made-in-Canada model that may be useful to inform the committee's discussion on national pharmacare. We believe our approach shows that bulk purchasing of pharmaceuticals can be done transparently and successfully on a national pan-Canadian scale while maintaining product choice and ensuring security of supply for all Canadians. We've also supplied the committee with a written brief that includes more details about the information I'm going to summarize today.

Let me begin by explaining what plasma is and providing a bit of context on how plasma protein drugs are made. Plasma is the protein-rich liquid in blood that helps other blood components circulate throughout the body. Plasma protein drugs or plasma protein products are a highly specialized class of drugs made from human plasma.

Pharmaceutical companies that manufacture these derivatives are called fractionators and are typically found in the United States and Europe, where these products are made by pooling large volumes of plasma donations from thousands of screened plasma donors. The pooled plasma then goes through a series of rigorous processes and tests to eliminate pathogens and other contaminants, making the finished products extraordinarily safe. A number of these plasma protein products are now synthetically manufactured by genetic recombinant technology and all of the drugs in this class of products are deemed to be expensive biological drugs for lifesaving indications.

Our organization has the sole responsibility for bulk purchasing and managing a pan-Canadian formulary of 45 brands and classes of plasma protein products. We do this on behalf of all the provinces and territories with the exception of Quebec. These drugs are worth over $600 million a year and are essential medicines in Canadian hospitals and clinics, and around the world. They are used to treat patients with bleeding disorders such as hemophilia, as well as patients with inherited and acquired immune conditions, burn, trauma victims, and many other clinical indications.

Advocates for a national drug program have argued that the lack of broad national bulk purchasing capacity creates a serious value gap for Canadians. We would agree.

While governments have indeed been able to lower the cost of some drugs through the pCPA, as we heard from both previous speakers, price is only one part of the equation. Our supply chain management and bulk-purchasing program addresses, in addition to pricing, patient outcomes, health system performance, as well as cost, and delivers layers of added value to Canadians in the process.

We achieve these benefits in several ways. Firstly, wherever possible, we carry multiple brands of a single product class. We buy these brands and classes in smaller, diverse lots. We negotiate essential safety stock agreements with every manufacturer to mitigate against any potential shortfalls or supply disruptions. Most importantly, we do this without resorting to single sourcing. At the same time, because of the national bulk purchasing power, we ensure that the prices we pay are highly competitive internationally.

Another very important factor in our process is that we build into the process input from stakeholders at all steps of the procurement process. Our program engages and involves patient groups, as well as the prescribing medical community, and gives them a voice in the decision-making on product selection and procurement, and aims to offer and ensure a reasonable degree of product choice.

As part of our product selection process, we also collaborate and draw on the expertise of the Canadian Agency for Drugs and Technologies in Health, CADTH, from whom you've heard, to provide the necessary pharmacoeconomic analysis whenever we consider adding a new category of drug to our formulary.

This collaboration is an important part of the procurement program and ensures that we add the right types of drugs to the formulary for Canadian patients. It also ensures shorter and more efficient approval times for review and ultimate decision of listing of drugs onto our formulary making access times for some of the drugs on our formulary amongst the shortest in the country.

● (1610)

One of the greatest successes of our program is the use of open, competitive, public tendering to get the best possible prices through multi-year requests for proposals for a single product or group of products. This public tendering process and the economy of scale we achieve by purchasing for all the provinces and territories have brought significant cost savings for funding governments. For example, in a recent round of tendering for a suite of plasma protein products, we negotiated a $600-million reduction over a five-year period for less than a dozen drugs. More recently, we were able to negotiate an additional $60-million annual reduction for two hemophilia drugs. Today we've been able to negotiate the price of drugs down to below 2009 pricing levels. These examples clearly underscore the value of a national bulk-purchasing program of expensive pharmaceuticals and, more importantly, this value is achieved without sacrificing either product choice or diversity of supply.

Once these products are purchased and available, how they're used also becomes important. We collaborate with experts in transfusion medicine and physicians and provincial-territorial governments across the country to develop clinical practice guidelines and to promote optimal utilization practices for these drugs. Our model also allows the provinces and territories to introduce their own access guidelines for individual products, which they can then manage themselves at the regional health authority or institutional level. Canadian Blood Services and national physician groups affiliated with the blood system can also develop national criteria for use. These options give the treating jurisdictions flexibility in how they manage their use of these essential, yet expensive, biological drugs.

Canadian Blood Services also independently qualifies new suppliers and audits them periodically. This process adds an additional layer of vigilance and product safety for patients. Our contracts with suppliers require them to report early and regularly any issues in bringing product to the marketplace, and to ensure they maintain adequate safety stocks in the country. This information enables us to act on any supplier issue quickly and helps mitigate the risk of product shortage.

Our procurement and legal groups are well versed in the specifics of bulk buying, which we leverage to the advantage of all the provinces and territories. These steps are an important additional layer of value in managing a national bulk-purchasing and distribution program on behalf of all jurisdictions.

Collaboration with the prescribing medical community and the hospital sector in which these drugs are used has clearly been an important part of the success of our program. We have hospital liaison specialists who maintain strong relationships with the treating community and manage any issues related to supply, product choice, or adverse events. Our on-staff medical directors provide expert advice when a physician encounters an issue with a patient who could benefit from the perspective of an additional specialist.

These cornerstones of our bulk-purchasing program are the elements that have enabled it to succeed. Taken as a whole, our model supports a level of health equity that remains out of reach for many other patient groups served by individual provincial health systems, and who may face an all-too-common postal code lottery when it comes to accessing certain medications, particularly expensive ones. In contrast, whether the patients we serve are in Vancouver, Iqaluit, or St. John's, Newfoundland, they have access to the same reliable supply of high-quality drugs at all times.

In summary, Canadian Blood Services has been providing universal and equitable access to plasma protein drugs at no cost to patients for nearly two decades. Our approach to bulk purchasing is not a cookie-cutter solution for many of the substantial challenges that must be resolved should governments enact aspects of the national pharmacare program. Rather, our experience shows that bulk purchasing can be done transparently and successfully, while maintaining product choice and security of supply.

We brought these points to the committee today to demonstrate that pan-Canadian collaboration in the complex area of drug acquisition, distribution, and utilization, can be done in a way that responds to the concerns raised by many stakeholders to the pharmacare issue.

● (1615)

As interested parties continue to study this complex issue, we would be pleased to answer their questions as well as this committee's and to explore any ideas further, if they are of interest.

Thank you very much.

The Chair: Thank you very much, all of you, for shedding light on some of these issues, which are a little complicated, if you're not familiar with them.

Mr. Kang, happy birthday. You get to ask the first questions.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Thank you, Mr. Chair, for the birthday wishes.

Conflict of interest is my greatest concern. My first question is for Mr. Palmer.

Have you received any financial compensation in the past 12 months from clients in the pharmaceutical industry or special interest groups with the specific purpose of influencing federal pharmacare policies in their favour?

Mr. W. Neil Palmer: I'm sorry, you're going to have to repeat the question. I couldn't hear it very clearly.

Mr. Darshan Singh Kang: Have you received financial compensation in the past 12 months from clients in the pharmaceutical industry or special interest groups with the specific purpose of influencing federal pharmacare policies in their favour?

Mr. W. Neil Palmer: From the pharmaceutical industry, no, sir, I have not. The only funds we've received are from the Canadian Pharmacists Association for preparing the study that I believe you have a copy of.

Mr. Darshan Singh Kang: Have any groups you represent been invited to appear before this committee to talk about national pharmacare, and if so, which ones?

Mr. W. Neil Palmer: Has anybody...?

Mr. Darshan Singh Kang: —any group—

Mr. W. Neil Palmer: The Canadian Pharmacists Association will be appearing here.

● (1620)

Mr. Darshan Singh Kang: Okay, thank you.

Mr. Dempster, I have the same question for you. Have you received financial compensation in the past 12 months from clients in the pharmaceutical industry or special interest groups to lobby the federal government on their behalf for pharmacare policies that would benefit the way they do business?

Mr. William Dempster: Yes. I am a registered lobbyist in three, possibly four, jurisdictions, including Ottawa; Queen's Park in Toronto; and I think Alberta, depending who we have working out there at any given time; and Quebec.

It's advocacy. Lobbying is, I would say, a third of what 3Sixty Public Affairs actually does. I'm here today, though, to express my personal views.

We also do a lot of analysis and writing. Technically it is for the pharmaceutical industry. We write a 500-page review called PharmaFocus for IMS Health, which is the world's biggest health analytics company, and it looks at all of these issues across the country.

I'm not here to advocate any particular issue, but I'm more than happy to let you know these details, and it's on the public record in several jurisdictions.

Mr. Don Davies: Mr. Chairman, I have a point of order.

In fairness to the witness, let me say that I'm unclear about something. Twice now he has said that he's here in his personal capacity, but the witness list and also the document that he passed out says William Dempster, CEO, 3Sixty Public Affairs, and it's on 3Sixty Public Affairs letterhead. I'm just curious or unclear about this. I'm trying to square the testimony that he is here on his own behalf with his having indicated on a number of occasions that he's here on behalf of the organization of which he's the CEO.

It's not that there's anything wrong with either of these cases; I'm just trying to clarify why this would be the case.

The Chair: Mr. Dempster.

Mr. William Dempster: I'm CEO of 3Sixty Public Affairs. We engage in advocacy activities and support interest organizations in understanding and building bridges with governments. We also do a lot of analysis and research on those issues to help prepare them for building such bridges and understanding how to come up with good public policy.

Today—this may have been something to do with some interaction with the clerk—we're not representing any of our clients. Perhaps I should have clicked a box saying that I'm representing 3Sixty Public Affairs, although I have to say, Mr. Chair, that even within my organization, on all of these issues we have excellent debates and discussions. I don't want to say that my personal views are those of everyone I work with or of my colleagues at 3Sixty Public Affairs.

I don't know how I can be more specific. I'd be happy to take this off-line or let you know more about what we do and how we do it.

The Chair: Mr. Kang.

Mr. Darshan Singh Kang: That was going to be my second question. You said you were here personally and not on behalf of your company, so there could be conflict or a perceived conflict in this.

What should we make of this?

Mr. William Dempster: I think I understand what you're suggesting. The work that I do with clients, who are only in the health sector, and who range from innovative pharmaceutical manufacturers and biologics to medical device companies to patient organizations to health care professionals and so on, has certainly helped educate me on a lot of these issues and has put me in a position, I think, to provide some figures in front of the committee on how the pan-Canadian Pharmaceutical Alliance works, but I'm certainly not advocating on behalf of any of our clients today.

Mr. Darshan Singh Kang: Mr. Sher, very briefly, I have the same question for you.

Dr. Graham Sher: Very briefly, I would say no. As the CEO of a publicly funded national not-for-profit organization, I can say that we follow all public procurement and tendering processes and I have no conflicts to declare.

Mr. Darshan Singh Kang: Thank you, sir.

Mr. Sher, I would like to go slightly off topic from pharmacare briefly and ask you a question about plasma donors being compensated, given the attention that has received lately and the vocal activism we have seen opposing the opening of certain paid donation facilities.

However, at the same time I understand that a significant portion of Canadian plasma products have long come from paid sources in the U.S., and safely. Can you inform the committee where Canadian Blood Services stands on the role of paid plasma here in Canada?

● (1625)

Dr. Graham Sher: Thank you very much, Mr. Kang, as I anticipated that this question might come from someone at the committee.

I'll be very brief, Mr. Chair, because it's an important, but obviously complex issue and it has played out significantly in the media this past week.

Canadian Blood Services follows the principle of voluntary non-remuneration of its donors, meaning we do not pay any of our donors for any of the products we collect from them whether blood, plasma, platelets, stem cells, organs or tissues. We have adhered to that policy at all times.

It is true that the amount of plasma that we collect in this country meets only about one-quarter of patient need for the important class of drugs called immune globulins, and we have to purchase the remaining required three-quarters on the international market, with most of those plasma derivatives coming from the commercial paid for-profit plasma industry in the United States.

If you look at the finished drugs that patients in Canada receive today, about three-quarters of those drugs come from paid donors and about one-quarter come from our plasma, which is from unpaid donors.

There is no safety concern with respect to the difference between products from paid and unpaid donors. The technologies, from a processing and a sterilization point of view, are exactly the same in all industries and there has not been a single case of disease transmission through paid plasma products or unpaid plasma products for the last three decades, almost 30-plus years now.

The issue that has been very dominant in the media of late hinges on two things. Firstly, a—

Mr. Don Davies: Mr. Chairman, I have another point of order. I'm sorry to do this again, and I was hesitant to raise a point of order at the question, but I should have.

The witness is getting into the issue of paid plasma, which is a very important issue but has absolutely nothing to do with the study before this committee.

If I were to ask questions, I would have 20 questions to ask this witness on the safety and efficacy of paid plasma, but obviously I won't have the opportunity to do so because he's been called here today not to testify on that issue but to talk about his experience with bulk buying in a national pharmacare plan.

I'm going to ask that the witness not continue on in this regard. If he wants to come back and if this committee wants to study the safety and risk issues of paid plasma products in this country, I'm certainly willing to do that, but that is far beyond the scope of the study before us.

The Chair: The questions are on all our minds, but it doesn't matter because the time is up.

I'm going to move to Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): That's a very political response, Mr. Chair. I appreciate that.

I did want to point out, too, that recently we had three witnesses who wrote “Pharmacare 2020”, and they actually came as individuals. That's just to the point of Mr. Kang about how the people come.... I don't think that's as important as what they contribute to this study, and I want to thank all the witnesses for being here today, because one of the things....

We might as well talk about those other witnesses. What I was worried about with regard to their testimony is that they seemed to be leaning towards how perhaps the government should be working towards monopolizing a pharmacare program. I am concerned about anti-competition and less choice for individuals. I come from a union town in Oshawa, and one of the things with collective bargaining is that they do manage to get a really great health care program out of it.

As for some of the testimony we've heard in the past, I think it's good that it's balanced, and I'd really like to question you a little deeper with regard to the pCPA. I think it was Mr. Palmer who said that it has been a success. You're saying that half a billion dollars has already been saved. I believe it was Mr. Dempster who said that there have been about 100 medicines finished through that. How many medicines are out there to go through?

The backlog you mentioned was significant. If we were able to get through all the medicines that are out there—there must be thousands—what kinds of savings do you think we could get out of that? I know that I'm asking you to pick it out of the air, but compared to the percentage that's out there, could we find out?

The Chair: We have a point of order.

Mr. Darshan Singh Kang: Mr. Carrie, on why there is a conflict of interest issue in the committee, we should be clear on everything. I don't want something to come back and haunt the committee in the future whenever we come out with a report. For all the stakeholders, I think it should be made clear that there's no conflict of interest, in case we as a committee come out with something.

Mr. Colin Carrie: I appreciate that very much.

Can I hear my answer?

● (1630)

The Chair: I want to say, too, that we're very interested in hearing all the answers, but if a witness is here and is just giving us his own personal thoughts, that's different from representing the industry or whatever. Just as long as we know where everybody fits, we're very interested in hearing them.

Dr. Carrie, you're back.

Mr. W. Neil Palmer: My answer—and I suspect Mr. Dempster's will be similar—is that these are objective answers that are not opinions or advocacy. That's in response to the question.

There are probably about 100 new products a year. It varies. It could be 50 or 150 that are approved in Canada every year and are new chemical entities. All or most of these, if they're outpatient drugs, would work their way through this common drug review or the pan-Canadian oncology drug review process—one or the other—or the INESSS process in Quebec.

If they get a positive recommendation—let's say two-thirds of them end up with a positive recommendation—then they would move on to the pan-Canadian Pharmaceutical Alliance for a price negotiation. In terms of new medicines every year, a ballpark estimate is that there are somewhere between 50 and 150 new products every year, which the jurisdictions would sort through, depending on how many of these come up.

In terms of the older products, I think Ontario has something like 3,000 or 4,000 products on its formulary. I'd have to go back and check. Most of those are old generics. As Mr. Dempster and I mentioned, there are pricing rules that are in place covering all of those.

For some of the other drugs that are off patent, likely they're subject to generic competition. That leaves some drug categories that the pCPA is now looking at in terms of class reviews. They're taking DPP4s, which are a form of diabetes drugs, and looking at a class now, and they're negotiating with all of the manufacturers that market drugs in that class to come up with lower prices.

They're doing it strategically. They're doing all new products, and then they're looking back strategically at some older products in classes. That's the approach they're taking.

In terms of what the reaction in the pharmaceutical industry is, I think there's a tepid acceptance of the process for new drugs, in the sense that they hope it advances the process for getting a drug listed. There's a lot of anxiety about looking back at some of the classes and negotiating prices after the fact. I expect that you may hear some testimony on that at some point.

Mr. Colin Carrie: You would say there is potential for significant savings there.

Mr. W. Neil Palmer: Oh absolutely.

Mr. Colin Carrie: When you look at it for availability, I believe the U.K. and New Zealand have attempted these monopolies and it really gets to a point where sometimes the patients can't even.... You mentioned new cancer drugs, I think. Sometimes they can't get them.

Mr. W. Neil Palmer: Right. There's a different approach there. In Canada and some other markets—France would be another one—sometimes there are what we call price-volume agreements, where they actually negotiate prices drug by drug. In the U.K. and New Zealand, they set budgets, and if there isn't any more room in the budget, they don't list the new drug.

In England, it's a little trickier because they have all these clinical commissioning groups, each one with its own budget. They have to find the money to start paying for new drugs. They use budgeting, as opposed to this overall price negotiation. That's not to say that they don't have one-off negotiations for some new drugs, but they don't do it overall. It's primarily budget-setting that keeps the costs lower in those markets.

Mr. Colin Carrie: I appreciate the explanation, because previous witnesses were trying to compare apples to apples, but I realize after your testimony that really we're looking at apples to oranges, because the entire system is different, and we really have to take a close look at this when we're discussing national pharmacare.

Mr. Dempster, I'm sorry I interrupted you, but could you add to my question?

Mr. William Dempster: I would agree with Neil. Last year, for example, 50 products were reviewed by the common drug review. Forty of them got a "list" or a "list with criteria or conditions" recommendation from the health technology assessment agency.

They determined that 10 of them were just not clinically valuable, and there was nothing you could really do on the economics to actually support a negotiation, but a full 40 of them got some kind of yellow light or green light to go forward on negotiations.

Last year, 2015, was a big year. The federal drug administrations in the U.S. and Canada actually approved or authorized more drugs than they had in the previous 12 years—45 drugs in the U.S and 43 in Canada.

A big volume of very interesting, and I think valuable, products are coming to market every year, and that's a testament to what they are coming out with at the common drug review, which says that they are clinically useful, and that something should be done about the price, or maybe that the clinical criteria should be changed. That isn't what Health Canada says it should be set up for, but the pCPA is now struggling with that volume of new products. Maybe there's a role for the Government of Canada in helping to facilitate that and improve how the pCPA works.

● (1635)

Mr. Colin Carrie: Excellent.

The Chair: You're done.

Mr. Davies.

Mr. Don Davies: Mr. Dempster and Mr. Palmer, would you be able to provide the committee with a list of your clients in the pharmaceutical sector after this? Would you send it in to the committee? Would you be able to do that?

Mr. W. Neil Palmer: I'd have to think about that. Some are protected by confidentiality agreements. Others are probably in the public domain. I'll see what I can do. I can tell you, sir, that most of the major pharmaceutical companies we've done work for at one time or another. That helps answer your question.

Mr. Don Davies: Mr. Palmer, my research indicates that at least three times in the last 20 years, in 1997, in 2002, and in 2016, the firm that you have worked for has produced a report arguing that a universal public drug plan would not be affordable in Canada.

Is that the case?

Mr. W. Neil Palmer: We have produced reports in those years. That's correct.

Mr. Don Davies: I'm going to state the obvious. I take it it's your testimony before the committee that you believe a universal prescription pharmacare plan in Canada is not affordable. Is that your position?

Mr. W. Neil Palmer: There would be a significant cost to the federal government to do that if the federal government were to take that on. Whether you say affordable or not affordable, there would be a significant shift in costs to the public sector.

Mr. Don Davies: We've had evidence before this committee that 20% of Canadians—you talked about people around this table having coverage—either have no coverage whatsoever or have inadequate coverage for prescription care. That's seven million Canadians.

In your view is that an acceptable public policy position for our country?

Mr. W. Neil Palmer: As I testified, sir, it could be more than that; it could be less than that. We really don't know. That 20% number is not very good.

Again, I would recommend that the federal government could make an important contribution there towards really understanding who these Canadians without coverage are.

Mr. Don Davies: I want to be clear. Are you disputing the 20% figure, or do you...?

Mr. W. Neil Palmer: I'm saying that the 20% number is weak. It could be more, sir. It could be less. I don't know. In fact no one knows for sure. That's the real problem.

Mr. Don Davies: I take it, sir, that you're probably aware that in the 1960s there was a raging debate in this country about whether or not we could provide universal health care coverage for every Canadian so every Canadian could go to a doctor or go to a hospital, and exactly the same arguments were being made then as you are making here today, that it's unaffordable and it ought not to be pursued.

Would you agree with me that the issue of affordability is only one aspect of this, but also the public policy benefits of making sure that every Canadian can get access to the medicine they need regardless of their ability to pay is also an important factor?

Mr. W. Neil Palmer: It was certainly an issue in the 1960s. My father was a physician, and I think physicians were very conflicted about the benefits or the harms as Canadian medicare was being rolled out.

An important difference then, sir, was that each province had its own plan. There was no national health care. Still today there is no national health care. Each province has its own system, and if back in the 1960s we had said we would have a national system, it would be a lot easier today to have a national pharmacare system, because we wouldn't have the patchwork of provincial systems the same way we have patchworks of physician systems and everything else from province to province. They are not the same from province to province.

Mr. Don Davies: I was going to ask about that. I thought you made the comment that we do not have a national health care system. Your position is that we do not have a national health care system in Canada?

Mr. W. Neil Palmer: That's correct. We have a medicare system that has five principles that the provinces respect in putting their own health systems in place, but if you move from one province to the next, it's not like it's automatic. You have to apply to get onto the next health care system.

Mr. Don Davies: We've heard from some prominent physicians and health policy leaders—for example, Dr. Irfan Dhalla from Health Quality Ontario and St. Michael's Hospital, and Dr. Danielle Martin from Toronto Women's College Hospital—that a national formulary and universal coverage would improve patient health. Would you agree with that?

Mr. W. Neil Palmer: I haven't seen the evidence to support that.

Mr. Don Davies: The committee also heard from Dr. Katherine Boothe, who's currently a pharmaceutical policy expert at McMaster University. She stated the following: “Both the U.K. and Australia have universal single-payer programs for pharmaceuticals and they both do a better job at containing costs than Canadian drug plans do currently.”

Do you disagree with that statement?

Mr. W. Neil Palmer: I would agree that costs are lower in those markets. The question is whether or not there are drugs available here that are not available there. You have to look at both aspects, but certainly costs are lower in those markets—again, through budgeting.

● (1640)

Mr. Don Davies: Dr. Sher, it sounds as though you've had some success in providing a universal publicly funded system through bulk purchasing for particular products important to Canadians—plasma products. Is there any reason, in your view, that the success you've experienced could not be replicated on a national basis for a broader range of medicines?

In other words, you've done it successfully: universal, free provision of these products to Canadians in bulk buying for plasma. Is there any reason we couldn't broaden that to more products?

Dr. Graham Sher: It's a very good question, Mr. Davies. My answer, just very briefly, as certainly I am no expert in national pharmacare in all its various dimensions, is that I do believe the model we operate is worthy of extensive analysis and research. I believe it is replicable in some ways for certain classes of drugs. It is not the panacea to every issue that a national pharmacare program needs to grapple with, and it's not just about bulk purchasing and price benefits. It's really those other dimensions that I spoke to: ensuring security of supply and patient choice and physician input, and equitable access right across the country.

I think there are several dimensions. We're simply offering our model, open to all those interested, for worthy analysis. I do believe components of it are relevant for some of the debates around national pharmacare.

Mr. Don Davies: Fair enough. I understand you when you say that it's not replicable for everything, but certainly you can envision other products, pharmaceuticals that Canadians need, being covered by a similar system.

Dr. Graham Sher: Absolutely, and particularly for expensive drugs for less common diseases. I think there's tremendous merit in examining our model for that.

Mr. Don Davies: I see. We do have, I think, some witnesses coming on Wednesday to testify about rare diseases.

Dr. Graham Sher: I believe you do, yes.

Mr. Don Davies: We'll follow up with them on that question.

The Chair: Mr. Oliver.

Mr. John Oliver: Mr. Palmer, I just wanted to focus in on some of your testimony. The coverage gap, which Mr. Davies referred to as well, is one of the biggest concerns I have. We don't have universal coverage for pharmacare, and some Canadians, depending on their employment, either do or don't have coverage. About six million, or 22% of Canadians, right now are privately insured. They're paying out of their own pockets. Another significant portion are uninsured, and because many don't fill prescriptions as they can't afford them, we really don't know the extent of those who are under-insured or unable to provide.

We've heard other witnesses state that the catastrophic drug coverage programs really don't work—there was very good and compelling testimony on this—and that the public-private mix isn't working. What is your answer? You were very critical of a comprehensive pharmacare program in Canada. You were quite critical of it but there was no response to the coverage gap. How would you actually address that?

Mr. W. Neil Palmer: As I testified, sir, I think the first issue we have to get a handle on is with regard to who doesn't have coverage. Most of the information that's been gathered to date has either been part of an opinion survey or an add-on question in some health surveys where there wasn't a lot of follow-up to understand who these individuals are and what type of coverage they don't have. It's often a question like, “Have you not filled a prescription because of cost?” Similar questions asked in New Zealand got a 6% positive response, and there they have universal care.

We need to understand what drugs are not being covered, and for which people. If you asked half the university students here if they had drug coverage, the answer would probably be no, in many cases, when in fact they do. They don't know they have coverage. So who are these people? We need to understand that.

Then we need programs put in place. It could range from the P.E.I. program, which provides coverage for generic drugs for anybody in the province with a provincial health card. That at least gets them over the basic coverage. Then we need to look at the catastrophic plans like Trillium, which is essentially a copay of 4% of income, and bring that number down to something that's more affordable.

What is that percentage? I don't know. That's what we need to do. We need to do the work to understand that.

Mr. John Oliver: I have to say that all the things you're describing still result in inequitable coverage for Canadians, depending on their employment status and their private insurance, so that concerns coverage.

Mr. W. Neil Palmer: I'm not sure how it's inequitable. It's somehow very good—

Mr. John Oliver: We've heard from other witnesses that catastrophic coverage still leads to incredible costs for people who aren't working and are unemployed or poor.

The second question I had was dealing with a statement you made in your report that unions will not be happy exchanging "their private drug plan for an inferior public plan". I was curious about why you had concluded that a public plan would be inferior.

I'll make this a two-part question. I'm assuming that you perceive a private plan with an open formulary to be a better plan, but we've heard from other witnesses that these lead to over-prescribing or inappropriate prescribing. I'm wondering how you reconcile that with the public plan's being inferior and, if you're going down the road of better availability of drugs, how you deal with the open formularies and the problems with open formularies.

● (1645)

Mr. W. Neil Palmer: Let me start with the beginning of your question, which is why unions would reject it.

We don't have to look any further than British Columbia. Some of the unions there, the public service unions, accepted what they called a pharmacare tie-in type of plan, all being told that the plan was just as good as what they already had, and quickly found out that this wasn't the case. There were a large number of grievances, payments, and exceptions made to the so-called pharmacare plan because some members didn't have it.

What I'm suggesting, sir, is that if you take the plan away, people aren't just going to agree with it.

In some cases with the private plans, is it possible to have more appropriate prescribing? Certainly, and it's the same with the public plan. I don't think that's necessarily determined by whether it's public or private.

To come back to your earlier question, I think that, whether through the private sector or the public sector, every Canadian should have access to an affordable drug plan. I leave it either to this committee's making recommendations or to the individual provinces getting together, but there are clearly coverage gaps, and they need to address those. I think there's a great opportunity for the private insurance industry, which frankly I think has missed the boat on this, but as well for the public plans to provide a basic plan.

In Alberta, anyone can sign up to the provincial drug plan just by paying the premiums. Quebec has coverage. Now, they have issues with their model, but.... There are models out there, and I think we can get to a point where everybody has coverage.

Mr. John Oliver: In your costing analysis, one of the costs that you didn't build in is the administration cost that private companies pay to their insurers or their agents to manage the accounts for them. What would you estimate that cost to be, and what percentage of the total cost of drugs in Canada is actually for administration through those private firms?

Mr. W. Neil Palmer: We didn't take it into account; nor do most other studies really take that into account in any significant way. But it's a few percentage points; it's not a significant number.

Mr. John Oliver: I've heard that ranges of 12% to 14% markup on drug costs is the administration fee that—

Mr. W. Neil Palmer: That would seem very high.

Mr. John Oliver: Okay. So you don't know what they are?

Mr. W. Neil Palmer: It would be single digits.

Mr. John Oliver: In your report, you also said that the 2020 study didn't "consider other qualitative consequences that loss of private drug plan coverage will have on Canadians including", and then you said the "impact on the ability of pharmacists to serve patients". Why would you conclude that the basis on which a pharmacist is being reimbursed, whether through a public plan or a private plan...that the public plan would impair their ability to provide service to Canadians?

Mr. W. Neil Palmer: Currently the public plans pay a lower professional fee in most jurisdictions than the private plans may pay; it could be $7 instead of $10. Even though the Morgan study assumed that the revenues would all be the same, in practice they pay a higher dispensing fee for private plans, and certainly cash-paying customers pay more, so there's going to be a loss of revenues to pharmacists.

Mr. John Oliver: Do I have time for another question?

The Chair: No, your time's up, I'm sorry.

Mr. Webber, you have five minutes.

Mr. Len Webber (Calgary Confederation, CPC): Mr. Chair, I'm such a kind and giving individual, I'm going to give my honourable doctor colleague the first couple of questions.

The Chair: You're very kind. He needs all the help he can get, though.

Mr. Len Webber: Exactly.

Mr. Colin Carrie: I want to say, too, that I appreciate your comments, Mr. Palmer, on the administrative cost of private versus public plans, because I've really never heard of government in many ways administering things a lot more cheaply than the private sector without competition. It's nice to get some realistic numbers there.

● (1650)

Mr. W. Neil Palmer: If I may add, most of the provincial plans use private administrators to adjudicate most of their plans.

Mr. Colin Carrie: Okay. Thank you for that.

You did mention something about private versus public. I think you mentioned that right now, private coverage is about $8 billion, so that if we went to a monopoly model, we would shift $8 billion to the public plan. Is that accurate, that governments around Canada or the taxpayers would have to come up with $8 billion?

Mr. W. Neil Palmer: That's assuming that all the private coverage moved over. There would be some savings because some drugs on private plans would no longer be covered. Depending on the national pharmacare model you put in place, $8 billion or so, in 2015 dollars, would be shifted over to the federal government. Now, to the extent they can find savings, maybe that number would go lower, but it would be a significant move, assuming it's the federal government. I guess the concern is, what are you getting in terms of health outcomes by making that shift? You're simply moving all the dollars and costs over, and everybody has the same plan. It may address that equity question, but it's certainly not improving the health outcomes generally for the people who already have coverage.

Mr. Colin Carrie: One of the things I think I'd like to find out is what it would cost if we move in this direction. When you were talking about defining the problem, you mentioned the national formulary. I think you said there was already 90% similarity and that it would replicate something already in place. What would be the cost to taxpayers if we did replicate something like that? Do you have any idea?

Mr. W. Neil Palmer: I think you could create the national formulary. The question is, what do you with it?

Mr. Colin Carrie: Would it cost more or, as you said, would it replicate what's already in place?

Mr. W. Neil Palmer: There are a lot of practical problems. For example, with some cancer drugs, each province has specialized cancer protocols it puts in place. In British Columbia, there's the British Columbia Cancer Agency. In Ontario, it's Cancer Care Ontario. Down in the eastern provinces it's a bit different. If a national formulary is intended to be mandatory—thou shalt follow whatever is here—that's going to cause a lot of disruption in the sense that, for some of these highly specialized technologies, people will have to change their protocols and the way they administer care. If, on the other hand, it's simply a reference guide, well, it's not going to cost a whole lot. It's fairly easy to put forward. We can list all the drugs that people have in common and the way they're funded.

I'll add another example. In Ontario the exceptional access program is used to stay on top of drugs that are highly specialized for multiple sclerosis, pulmonary hypertension, and a variety of other conditions, to make sure the province can track patients as they progress. That's how Ontario does it. Multiple sclerosis in Nova Scotia goes through a clinic at Dalhousie. They do it differently.

Will a national formulary force everybody to do it the same way, or will those decisions on who gets what drug be made in Ottawa? I think it would be significant. Those are where the costs would be. If it's simply a reference guide that these are the drugs that should be reimbursed, and the provinces still decide, then it will be fairly inexpensive. It might be informative to the extent that it identifies where there are some discrepancies across the jurisdictions.

Mr. Colin Carrie: Okay, thank you.

Mr. Len Webber: Great. I do have a quick question for Mr. Dempster on his graphs. Thank you for them, as I'm very much a graph person myself.

On one particular graph on page 3, I see that B.C. has a significantly lower number of new medicines added. Under a national formulary, provinces like B.C., which have such a low number, would likely benefit the most then from this new national formulary or national drug program. Is that correct?

Mr. William Dempster: That's a great question and a very good observation. Especially on the far left, at 14%, it looks like the proportion of products that B.C. is reimbursing hasn't changed compared to a decade ago. I had this conversation with a senior drug plan manager in B.C. a couple of weeks ago, and asked him just that. He said that of all of those drugs that are available elsewhere, closer to 30% are actually available. They're just not listed publicly. It's a matter of individual adjudication and getting special forms filled out by doctors. However, they are reimbursed. These just don't actually show up in this data source, which is IMS Brogan's health analytics, the PRA quarterly data source.

Mr. Len Webber: Thank you.

The Chair: Your time's up. Thanks very much.

Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): In regard to the comments about the percentage of people who can't afford their medications, I would point out that from my 17-year career working in the emergency department, it is estimated that about 60% of emergency department prescriptions are not filled. The reasons are many, of course, but much of it is that there are many indigent people who receive their only primary care from the emergency department.

Whether you can make the assumption or bit of a leap of faith that this is due to cost, I would think that a substantial part of it indeed is. We do know there are substantial costs to the system from non-compliance. I've been throwing the following example around liberally, and pardon the pun, but if someone can't afford insulin, one hospital visit for DKA will probably pay for a lifetime of insulin. If you add the costs of limb amputations, blindness, and the fact they need to be on dialysis, the savings become much more apparent.

Therefore, when you talk about the cost to government of doing this, has there been any thought of factoring in the potential cost savings by recognizing that these indigent people, who are a small proportion of the population, account for a large health care expenditure?

● (1655)

Mr. W. Neil Palmer: I think I'll start with the beginning of your question to the extent that it's indigent people. They almost universally have coverage. Every province in this country provides indigent people with coverage. They may not know they have it, or they don't know how to get it, but they have coverage. If you're essentially eligible for welfare, or social assistance, then you have drug coverage. You're entitled to all the products on the provincial drug formulary and at almost no copay or deductible. If there's any copay or deductible, it is the lowest one. They already have it, so there's something more going with those individuals not getting over to...whether the answer is that the hospital pharmacy needs to dispense it on their way out so they have it, and hopefully take it, or....

For people who don't fall into the indigent category, for the working poor—you can call them that, certainly—there's a cost barrier. They may not fill their prescriptions, or they may not take all of them, or they may do whatever. There's certainly an issue.

Mr. Doug Eyolfson: I would agree. The working poor are a large proportion of whom we see, and probably a greater proportion than indigent patients. With indigent people, from our professional experience, it's certainly the case that coverage is not as accessible as we sometimes assume. There are administrative barriers to their coverage. If someone goes from one province to another there can be delays of months, so there's still a barrier with indigent people.

In one of the comments in your report, you gave some examples of some drugs covered by private drug plans but not currently being included as benefits. You give a couple of examples: nexium, moxifloxacin for conjunctivitis, and eletriptan for migraines. Do we have evidence for each of those drugs that outcomes are better with those more expensive drugs than with the cheaper alternatives? Do we know that esomeprazole gives better outcomes than omeprazole? Do we have evidence that eletriptan gives better outcomes in the treatment of migraines than sumatriptan?

Mr. W. Neil Palmer: I would suggest, sir, that these are just additional choices that would be available. Esomeprazole is available as a generic, and so are some of these others. They're not funded in most provinces. They're simply additional options that could be available and aren't—

Mr. Doug Eyolfson: They're options, but does it matter if they're available if they are not any more effective than the cheaper options?

Mr. W. Neil Palmer: If they are part of a private drug plan, these are options that are available for physicians to prescribe. If, in their professional judgment, patients may benefit from those drugs, then that's reasonable.

Mr. William Dempster: Do you mind if I add a point on that?

In certain drug classes—I'm thinking about mental health or pain, for example—physicians, and you're one, need access to a range of products. Although you'll see some statistics like 80% of these products not adding any additional therapeutic value, often that's at a population level. Some patients do not well tolerate one product, and they need to try something else, especially in mental health, pain management, etc.

There are some very good organizations that are doing comprehensive studies on things like this, and I gather you heard from Dr. Dhalla earlier. The Ontario Drug Policy Research Network does very interesting class reviews. They did one on triptans as well, so I might direct you to that. CADTH does them as well. Those are the places where you can have these discussions in a science-focused way and look at the costs as well.

● (1700)

The Chair: Your time is up.

Ms. Harder.

Ms. Rachael Harder (Lethbridge, CPC): Thank you so much for being with us today. We certainly appreciate the insights you're providing. I believe they certainly add to this dialogue.

My first question would be for you, Mr. Palmer. I realize that we're putting you on trial quite a bit here. I guess your company advises drug producers with regard to how much they can charge for a pharmaceutical. That's basically my understanding.

Mr. W. Neil Palmer: I would put it differently.

In terms of pricing, we would explain the rules that the PMPRB has. While you would hope that they would be simple, they are not. Similarly, where there is a common drug review or the pan-Canadian oncology drug review or INESSS, we explain, assist, and put together the documentation submission, including cost-effectiveness analyses, clinical summaries, and putting together the very comprehensive submissions that have to go in. We provide advice around that whole process.

Ms. Rachael Harder: I think your company comes up against a few allegations. One of them, I think, is that we've heard Health Canada officials say that they can't understand the justification for drug prices in Canada, based on comparisons with foreign jurisdictions. We've heard multiple researchers and physicians accuse your clients of price gouging.

I'm wondering if you can give me some comments with regard to these allegations. Are they true? Are they false? Can you make sense of that for me?

Mr. W. Neil Palmer: I know that the former health minister and current interim leader of the Conservative Party made that statement. I believe that the current health minister has made similar ones.

To the extent that there is price gouging, whether it's the PMPRB, or the pCPA, or the provincial drug plan managers, they need to take action. They have the power to do so, and they should act on it. We don't advise clients to charge excessive prices. We advise them to follow the rules. Some don't always take our advice.

It's not our advice that they should be gouging. We explain how the common drug review and the rest of them work. They want cost-effective pricing, cost-effective in the Canadian context, and the provinces are concerned about their budget impact. Those are the parameters that we bring to the table. We help to explain those to them so that they hopefully will set prices that are cost effective. If they're not, well, presumably the PMPRB, the pCPA, or the provinces will take appropriate action.

Ms. Rachael Harder: With regard to your relationship with the Canadian drug suppliers, do you see a possibility whereby Canadians could lose access to treatment options under a national pharmacare program, perhaps because drug suppliers will consider that Canada is not necessarily worth the work to negotiate with?

Mr. W. Neil Palmer: We hear from pharmaceutical manufacturers from time to time that they're not prepared to come to Canada. This is something that they put out there.

They won't like me saying this, but there aren't a lot of very good examples out there. As for the few examples of products that haven't come to Canada, frankly, there are already alternatives on the market at low prices. The real reason they aren't coming, I believe, is that it's a not an opportunity for them to compete in Canada. They're not prepared to compete. I don't think there are a lot of examples.

If you pushed us to the New Zealand model, for example, that could be a real problem. There are some very important cancer drugs that aren't available in New Zealand unless you pay cash. There are limits.

Ms. Rachael Harder: Do you feel that the methodology for determining prices would be affected significantly under a one-buyer system?

Mr. W. Neil Palmer: I guess there are two elements to that. There's the maximum price allowed by the PMPRB, which is.... Depending on how the PMPRB evolves over the coming time, we don't know their role.

For most of the prices, whether it's a national pharmacare program, there's going to be a confidential listing agreement. There's a whole series of reasons for that, particularly for the newer products. I don't think there's going to be a big difference between what the pCPA does now and if everything were to be under a single plan. I don't think there would be a big difference.

Ms. Rachael Harder: Mr. Dempster, I have a quick question for you. I want to make sure I understand the following. I thought you made a comment with regard to private drug plans versus public drug plans. You made a comment something along the lines of how private drug plans “want in”. Can you help me understand that statement?

● (1705)

Mr. William Dempster: In 2013, the Canadian Life and Health Insurance Association put out a report saying that they wanted access to the pCPA prices. I don't think they've figured out how they can actually do that in practice.

There are a couple of challenges in making that happen. One is price confidentiality. The second one is practical, in that you already have 14 plans negotiating together in multi-level negotiations, so when you add all the private payers in there, it gets extremely complicated.

Those are just a couple of the challenges. Can it be done? Possibly, but we haven't really seen how that can work in reality.

The Chair: Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Are there any international models we should look at in terms of initial implementation of pharmacare? While we have heard many times that going with a fully universal model of pharmacare would save money in the long term, there must be ways to keep the initial price tag down, in terms of transitioning to the new model. What countries do you think of when you think of properly implementing this for the first time?

Mr. W. Neil Palmer: I can speak to countries where the population is quite heavy. France is an example. A lot of people wouldn't be happy with the French model even though, if you did a survey of the population, it's probably one of the most liked.

They have a significant copayments, but most of the population has private insurance through Mutuelle de France.

They cover many more drugs than most other markets, but they have a very significant process for negotiating agreements with the manufacturers. They negotiate price volume agreements. I think one thing they do quite well in France—and we're starting to see it in Germany and some other markets—is to assess the relative value in two ways for drugs.

First, they look at the basic benefit of the drug, which they call *service médical rendu*, and then they look at the improvement the drug offers, called *amélioration du service médical rendu*. They use these two elements to decide what price point they will accept, and whether or not the drug should be reimbursed. They've been doing this for a long time, and they do a very good job of it. Most drugs end up being reimbursed there, with the exception of some very expensive drugs which get funded through an alternate process. It's quite different.

The Germans, and some of the other markets, have a social insurance type of system. As a result, almost all of the insurers are private—most of them not-for-profits. It's the same, I believe, in the Netherlands and Japan. In many other places, they rely on that completely. In Germany, if a drug is approved by the European Medicines Agency, it has to be reimbursed. All they can do is negotiate the price, and they do that.

I'm not suggesting that there's one country we should emulate, but there are best practices in many of these markets we can look at, not only in terms of getting cost-effectiveness in Canada and limiting the budgetary impact, but also to ensure that there is good access to drugs. Every system has pros and cons, strengths and weaknesses.

Mr. William Dempster: I would just add to look for countries that have a sophisticated negotiation capacity, which can actually negotiate value-added deals.

We heard Dr. Eyolfson talk about adherence challenges, and keeping people on the medicines. There are systems for negotiating that into these contracts that go beyond the price-volume agreements. Especially for drugs for rare or really complex disorders, I'd look to Italy.

Germany has a very good system for stepwise negotiations. There's a set of six. You're expected to come to a deal at the end.

Figure out the ones that actually work best for all of the vulnerable populations and not just for the working poor, as you've called them. Let's talk about the people with rare disorders as well, and some of the smaller patient populations.

Ms. Sonia Sidhu: My next question is for Dr. Sher. You seemed to suggest that there are advantages to provinces working together on health product purchasing policies. I have two related questions.

First, could you explain the federal government's role in the financing and administration of Canadian Blood Services, and in financing the cost of the related services and products provinces procure through the CBS?

● (1710)

Dr. Graham Sher: The federal government has virtually no role in funding or financing the operations of Canadian Blood Services. We are funded by the collective of the provinces and territories for all the products and services that we provide to Canadian patients. The sole exception to that is that the federal government is in a cost-sharing agreement with the provinces for the national organ donation and transplantation program that we administer for the whole country. There's a fifty-fifty funding agreement between the federal government and the provinces and territories for a total budget of about $7.5 million a year. All the drugs that we acquire through the $600 million a year formulary are provincially and territorially funded, not federally funded.

Ms. Sonia Sidhu: Second, related to that, do you think the Canadian Blood Services model of financing and of governance is a model for pharmacare?

Dr. Graham Sher: If I understand your question correctly, as I said to Mr. Davies, I do think the model that we use for procuring, acquiring, distributing, and monitoring the utilization of these expensive biological drugs is a model that could be replicated for other drugs in the country, although not necessarily for every pharmaceutical that is prescribed. I think there are unique aspects to the program that we administer, but I do think it is worthy of exploration for a series or a class of other drugs that are not dissimilar to the 45 on our formulary.

Mr. W. Neil Palmer: I'd like to add a comment. My understanding is that most of the products that go through CBS are not the kinds of products you'd see at a retail pharmacy. They're more like hospital products, which go through a specialized procurement process already in many cases, not the single one country one, but perhaps group purchasing organizations or hospital-by-hospital contracting. But I don't think—

Dr. Graham Sher: I'm not sure that's entirely accurate. None of our products go through retail pharmacies. That is correct, but all our chemotherapy drugs are administered in hospital, so I think there are many other classes of drugs that are quite similar to those we distribute.

Mr. W. Neil Palmer: I agree, but not in regard to the traditional retail pharmacy type, because there's a whole set of distribution that is completely different.

The Chair: The time's up.

Mr. Davies, you have three minutes.

Mr. Don Davies: The one thing that we haven't really mentioned here. We have talked about the problem, and the reason this committee is studying national pharmacare is that the status quo is not acceptable. As I said, at least 20% of Canadians have no coverage. That's not acceptable in a country like ours, at least in my and my party's opinion, but in addition to that, we've heard rock-solid evidence that Canadians are paying the second-highest, sometimes fourth-highest, drug prices in the world. We're actually paying through the nose for a system that can't provide universal coverage. That's the context that underpins this study. We also have understood that Canada is the only country in the world with universal medical care without some form of universal pharmacare.

As a result, we're putting these things together and looking for a way to improve coverage for Canadians and maybe tackle the costs. What we've been hearing so far in testimony from proponents of a national pharmacare system is that we need a combination of things. We need bulk buying and national market access for successful low bidders like they have in New Zealand. In New Zealand, if a low bidder gets the tender, they get access to the whole market for their drug. We also need a streamlined administration instead of having thousands of administrators across this country in private plans. We need an evidence-based formulary, and the cost savings that come with timely universal access to medicine, as Dr. Eyolfson has described.

You put all those things together and we have heard proponents say that if Canada moves to a model like that, taking best practices from around the world, we could actually achieve universal coverage for Canadians and save billions of dollars at the same time. In fact, Dr. Morgan has estimated that if we adopted the German system or the U.K. system, we would save $4 billion or $12 billion and make sure everybody's covered.

Mr. Dempster, I'll give you a chance to respond. What's your comment on that scenario?

Mr. William Dempster: I think any time you look at what another system accomplishes, you have to take it in its cultural reality and its health system reality. You really can't just drop it into Canada and say it's going to work exactly the same here. We're right beside the United States. It's a different reality from Germany or Austria or France or whichever model they want to actually replicate here.

In terms of the specific elements of the proposed Pharmacare 2020 model—and I was there when it was launched in 2013 in B.C.—with tendering for single source products across a given class, you will only end up with one or two choices of which bidder actually wins that. It really is a challenging system to put into place for all single-source products. I'd say that you can't do it. You can do tendering for generic drugs. Ontario tried to do it in 2008. It does work in some other markets and I think there might be some savings that you could actually get from there, because you're tendering for the same versions but different suppliers and you can control for supply issues, as Dr. Sher said earlier.

We've already talked about administration a little bit. I think that more data could be brought forward to the committee. As for an evidence-based formulary, all of the formularies that are in place in Canada at the public level are presumably evidence-based. They rely on CADTH, they rely on INESSS in Quebec, and then they have their own formularies in each province, and many of the private plans do as well.

Therefore, I think we already have that element in many ways. I would just want to see what that looks like in its entirety if you brought it in and modelled it out, and I encourage shops like Neil's and others' to do that. I would also encourage Professor Morgan to continue to work on and refine his numbers further to see what the impact would be. I would caution against completely bringing holus-bolus an entire system into Canada and saying it can work here.

● (1715)

The Chair: Your time is up.

Thanks very much.

Who actually writes cheques to pharmaceutical companies?

Mr. W. Neil Palmer: That's a great question.

If you look at a traditional pharmaceutical that goes through a retail pharmacy, the manufacturer would sell it to a wholesaler or distributor. The distributor in turn would sell it to the retail pharmacy. The retail pharmacy would sell the drug to the patient, and that patient would be reimbursed by the public or private plan, or would pay cash.

The money to the pharmaceutical company comes from the wholesaler or distributor. In some cases they'll sell directly to the pharmacy. They typically may sell directly to the hospital or a hospital buying group. Usually they sell into the distribution chain and it's usually a distributor or wholesaler or potentially a hospital that cuts the cheque.

The Chair: Does any level of government ever write a cheque to a pharmaceutical company?

Mr. W. Neil Palmer: They would at the hospital level, but I should add that it's only indirectly. There are some products that provinces will pay for that aren't approved in any of the normal systems, and they may cut a cheque for those. There are some rare diseases for which drugs are imported through the special access programme. However, those would be the exception.

Mr. William Dempster: Vaccines is one example.

Mr. W. Neil Palmer: Vaccines and public health is a good example.

Mr. William Dempster: Public Health at the federal level actually can take care of not just vaccines but also antiretrovirals to have a stockpile in case of an emergency.

The Chair: The federal government would pay directly to the pharmaceutical manufacturer.

Mr. William Dempster: In that way, that's an actual bulk purchase.

Mr. W. Neil Palmer: We tender every three years.

Mr. William Dempster: The whole term “bulk purchasing” actually doesn't really apply to a lot of what you're going to end up with, no matter what you're looking at. It's about reimbursement and pharmaceutical and health benefits. It's not really bulk purchasing.

The Chair: We've heard a couple of different numbers. What is the total cost of pharmaceutical purchases in Canada and what's the breakdown among the provinces, the federal government, the insurance companies, and retail patients?

Mr. William Dempster: This is a forecast, because we don't have the exact numbers yet, but in 2014, for prescription drugs it was $28.8 billion in total. If you add over-the-counter drugs it's going to get up to more than that. The private sector share is divided between out-of-pocket contributions—and I believe we made reference to $6 billion before—and private insurers with $10.1 billion of that. Provincial drug plans spend $10.4 billion, which is 36% of the total. Then the federal drug benefit plan is 2.1% of the total, and that's $600 million. Then there is some other publicly funded drug expenditure.

Also, we were looking at data about out-of-pocket expenditures. We said $6 billion, and that's the number we saw earlier. I saw that number jump drastically back in 2010 to 2011, I think. I've been talking to the health information people about what happened there. I think a lot of what gets categorized as out-of-pocket expenses is coming from the pharmaceutical industry in another form of rebate that they're giving to individual consumers to be able to offset what they would otherwise pay in terms of copays at the pharmacy. So, it would be interesting to unpack those out-of-pocket contributions a little bit more, too.

Sorry, I went a little bit further.

● (1720)

Mr. W. Neil Palmer: If you look at table 3 on page 20 of our report, we unpack those numbers using 2015 figures. It includes actual public, provincial, and NIHB expenditures and estimates of private expenditures, by using CIHI numbers. Then we unpack the pharmacist fees and the copays.

The Chair: Mr. Dempster said $6 billion private. Is that just in retail sales?

Mr. William Dempster: That's $6 billion in out-of-pocket contributions. That would be individuals with copays.

The Chair: Okay.

Then $10.1 billion would be by insurance companies.

Mr. William Dempster: That's correct.

The Chair: Also, $10.4 billion would be for provincial drug plans.

Mr. William Dempster: That's right.

The Chair: As well, there's $600 million for the feds. What's that?

Mr. W. Neil Palmer: That would be the non-insured health benefits plan, Department of National Defence, Veterans Affairs, Correctional Services, Immigration and Refugees and Citizenship Canada—

Mr. William Dempster: Most of it's NIHB.

Mr. W. Neil Palmer: —and RCMP. NIHB, the non-insured health benefits plan, is a huge one.

Mr. Darshan Singh Kang: Does the $6 billion include deductibles, too?

Mr. William Dempster: That's right. That would actually capture deductibles that people have to pay before their insurance kicks in.

Mr. Darshan Singh Kang: So that's not only people who pay from their own pocket, who don't have the coverage.

Mr. William Dempster: That's right. That accounts for 20%—

Mr. Darshan Singh Kang: It's a combination of both? Right?

Mr. William Dempster: That is correct.

Mr. Darshan Singh Kang: Some people who don't have the coverage and...

Mr. W. Neil Palmer: The other pocket includes deductibles and copays.

The Chair: I want to thank all of you for helping us with this, because it is complicated. I was looking at this chart. I used to be in the car business. We had a factory, and then there was me, the dealer, and then there was the customer. We had three boxes. You've got nine boxes to deal with on your page and it's hard to know why or how they all fit together, but you're helping us.

Mr. William Dempster: That's as simple as I can make it, I'm sorry to say. It is complicated.

The Chair: It is complicated, but you're helping us and we appreciate it very much.

Thanks very much for your contribution.

The meeting is adjourned.