HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 008 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Wednesday, April 20, 2016

Chair

Mr. Bill Casey

Standing Committee on Health

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● (1540)

[*English*]

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

I apologize to our guests who have come from far and wide to provide us with information, but we are in the middle of a vote. There is going to be a vote in 25 minutes. We'll have to leave in about 15 or 20 minutes. We want to give you as much of a chance to give us your presentations as we can. We're going to go vote and hopefully we'll be able to come back, but we are not sure what is going to happen, so we'll start with that.

I need unanimous consent to proceed with the meeting while the bells are ringing.

Okay, I have unanimous consent. Thank you very much.

We'll start with Ms. Boothe.

Dr. Katherine Boothe (Assistant Professor, Department of Political Science, McMaster University, As an Individual): Thank you for inviting me today. I am very pleased to be here.

My name is Katherine Boothe. I am a professor of political science and a member of the Centre for Health Economics and Policy Analysis at McMaster University. My research expertise is in the area of comparative public policy, and I study the development and reform of pharmaceutical policies in Canada, Australia, and the U.K.

I was asked to speak to you about cost containment, drug cost-effectiveness research, and formulary listing decisions. I'd like to start with three key messages on these topics as they relate to my expertise.

First, in Canada we have a history of talking about pharmacare as if it is a program that poses unique challenges for cost containment, but this is not supported by evidence. In fact, it's wrong. Evidence from similar countries demonstrates that pharmacare does not mean uncontrollable costs, and universal systems actually have access to much better tools for cost containment than our present fragmented system does.

My second message is that a key tool for cost containment is a national or nationwide formulary. This is a list of drugs eligible for reimbursement that applies equally across the country, and we already have a good understanding of the institutional requirements for this to work in Canada.

Finally, cost-effectiveness analysis is an important element of building a national formulary. It's an area where Canada has a good deal of capacity. This country has been an international leader in the area of cost-effectiveness research. Other countries, like Australia, provide examples of how Canada might integrate this analysis more fully into formulary decisions and price negotiations.

These are my take-home messages. In the remaining time I'd like to tell you about the reasoning and evidence behind each of these points.

First we have historical perceptions about cost containment in Canada versus the comparative evidence. My research has found that past proposals for broader public pharmaceutical insurance in Canada have tended to falter because of the perception that cost containment is difficult or impossible or that a universal pharmacare program is equivalent to a blank cheque. Although this perception is persistent, it's not based on evidence.

Expanding pharmaceutical coverage in Canada has been proposed at least five times since 1949. None of these proposals has received much serious political consideration because the initial response from national decision-makers in each case was that it was too expensive, too risky, and too difficult to control costs. However, during this time, similar countries, like the U.K. and Australia, were adopting and consolidating their comprehensive pharmaceutical benefits programs. 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. When it comes to combined public and private spending on pharmaceuticals, as I think you've heard, Canada pays more per capita than all OECD countries, aside from the U.S., and we pay more while providing less access.

Australia and the U.K. use different tools to contain costs. They use either a positive formulary, which is a list of drugs eligible for subsidy, or a negative formulary, which is a list of drugs ineligible for subsidy. There's broad use of electronic health records along with financial incentives to prescribers to aid in appropriate prescribing. In both countries, they can leverage the purchasing power of government to get significantly lower drug prices than Canada. This means there's not a single method for achieving an efficient, affordable system, but rather a variety of tools that can be adopted and adapted to fit the Canadian context.

My second message is about the role of a national formulary. A single nationwide formulary ensures that governments only pay for drugs that have undergone a rigorous evaluation process regarding their value to patients and to society. It means that access is the same for Canadians no matter where they live, which is not currently the case, and it means that governments have the bargaining power they need to get fair prices for drugs.

Here I'd like to emphasize the distinction between national and nationwide. It's not necessary for the federal government to have ownership of a formulary in order for it to be effective. In fact, provinces are already quite successful at co-operating on the process of formulary decision-making through mechanisms such as the common drug review and the pan-Canadian Pharmaceutical Alliance, pCPA.

What they need is an incentive to commit to shared outcomes. Currently, the recommendations of the CDR, common drug review, and the joint price negotiations undertaken by the pCPA are not binding on the provincial drug plans, which is understandable given that each province has sole financial responsibility for its own plan.

This means there is an opportunity for the federal government to act as a crucial partner by contributing financially and requiring consistency, similar to the way it sets national standards for public hospital and medical insurance through the provisions of the Canada Health Act.

My final message is about the cost-effectiveness analysis of pharmaceuticals. This is one part of formulary decision-making, along with other factors, such as budget impact, the burden of disease, and consideration of social values.

There's a significant concentration of expertise in these methods in Canada. We already have the capacity necessary to create an evidence-based national or nationwide formulary.

Currently, cost-effectiveness analysis is applied on a pan-Canadian basis through the common drug review, but as I mentioned, the CDR's role is advisory only.

Australia provides one example of a way to integrate cost-effectiveness analysis into formulary decision-making.

Australia has an expert body whose official mandate is to recommend new drugs for listing on the national formulary, taking into account clinical effectiveness, safety, and cost effectiveness compared with other treatments. The committee is also empowered to make recommendations regarding price.

If the Australian committee makes a positive recommendation, the drug goes to a pricing authority to discuss a final listing price. If the committee's recommendation is negative, the manufacturer may choose to resubmit the drug after gathering new clinical evidence, or propose a lower price.

Australian policy experts often refer to this as a system of “no means no, and yes means maybe”. Drugs can only be listed on the national formulary with expert approval, but final listing is dependent on reaching a satisfactory price agreement.

The final point I'd like to make is that cost-effectiveness analysis is a tool for ensuring value for money, not for containing overall costs. A drug that offers significant new therapeutic benefits may be cost effective even if it is relatively expensive.

Cost containment can come from other tools, such as a nationwide formulary with a transparent budget, fair drug prices, and appropriate prescribing.

Understanding what cost-effectiveness analysis does means we can put it to its best use along with other tools to ensure a national pharmacare plan is equitable, evidence based, and affordable.

Thank you.

● (1545)

The Chair: Thank you very much.

I appreciate your comments. We value your input.

Mr. Kang, do you think we have time for another witness?

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): I think we have, maybe, seven minutes.

The Chair: Ms. Holbrook, would you like to proceed?

Dr. Anne Holbrook (Physician/Clinical Pharmacologist, Professor and Director, Division of Clinical Pharmacology & Toxicology, McMaster University, As an Individual): Sure. I'm delighted to be here.

My name is Anne Holbrook. I am here in my role as a physician in a very small specialty in Canada called clinical pharmacology.

What you're discussing is actually core to my career. I want to take you a bit more—perhaps more than Katherine has from the policy side of it, though keeping that in mind—to what actually happens at our formulary committees that is problematic and back to the bedside, because we're looking after patients. There's not really a lot of disconnect between those roles, believe it or not.

I have this lovely power point presentation, which of course you can't see. My talk would have been more visual perhaps than discussion, which would have been better for you folks.

I was also charged to chat a little about evidence. I want you to know there is expertise required for all of these roles, of course, but the role of evidence comes from the pharmaceutical world and is probably at its zenith in the pharmaceutical world.

Everything you're discussing around health care has devolved from the drug world. The types of trials we need are very well established: knowing whether one drug is more effective than another drug. The type of economic evidence we need is very well established.

I'll give you some examples later of where we're trying to decide about a drug for rheumatoid arthritis, as well as lipid-lowering drugs and drugs for cancer. You have to have a common paradigm to look at those that's extremely well developed. This is not to say that it's not controversial and can't be played with in a certain way, but it is very well established. That's very important for us to continue and, as Katherine said, Canada has been among the leaders in the world.

What's problematic in our system now with regard to evidence is that drugs are coming to the formulary as fast as they can. As you can imagine, the manufacturers want to get a drug to market as quickly as possible. They've invested a lot of money. It's not usually as much as they say they have, but it's a lot.

It's often our role to deal with what is incomplete evidence. It's very common. The last drug I discussed has potential to cost the country $250 million a year. We do not know if it actually prevents cardiovascular events. We know it lowers lipids, but we don't know that it prevents cardiovascular events. Trying to decide if a drug is actually going to play out in the clinical world the way it has been advertised by the pharmaceutical industry is routine.

There are many other ways, which I think we'll just include in my brief.

In addition to the quality of evidence considerations, there are many other ways whereby evidence can be misleading. This misleading evidence, as you can imagine, often makes its way into the social media and the briefs that come to us. I'll leave that perhaps for the question period. I'm also happy to discuss anything further.

I'm sure that when you're all in your family doctor's office, somebody is scribbling on a pad or typing away, and it looks like a very simple act. One of my unique roles that I want to warn you about is that prescribing, which sounds very simple, is extremely complex and requires a lot of knowledge and skill.

At this point in time in Canada, there are over 13,000 drugs on the market. There are only nine to fifty hours in medical school devoted to prescribing. Prescribing now is not just about whether a drug will work for our society in general. It is much more about: for this particular person, with this set of diagnoses, comorbidities, socio-economics, values, and these other medications—forget the genetic profile for now; that's really not of much importance—is this drug going to be more beneficial than harmful for that patient?

These are very, very complex discussions. Therefore, one of my arguments in a public forum is always that we need a lot more clinical pharmacologists and specialization in this area of expertise. Since we're not training our physicians and prescribers as well as we should, some people have advocated that pharmacy be more involved. There's no doubt that pharmacists should be more involved in the vetting of prescriptions.

We can chat about this more. I do not believe that pharmacists should take over prescribing.

● (1550)

The Chair: Excuse me, Dr. Holbrook. I'm afraid that we have to go vote.

We want to hear what you have to say. It's very important to us. We are very determined in what we're doing here. We're very serious, and we want to hear what everybody has to say, but we have to go vote.

I think we'd better go right now, but we'll be back.

● (1550)

(Pause)

● (1620)

The Chair: Let's get under way. We have 51 minutes and 43 seconds. It's like a marathon here.

Dr. Holbrook, please continue.

Dr. Anne Holbrook: I'll finish quickly.

I was just making a point on appropriateness in prescribing. That is key. You've heard from others about this. That is a key element of a high-quality program where we're after value for money.

I want to make a couple of comments about formularies as they operate now. In a previous session, you heard from Brian O'Rourke, the president of CADTH, on the common drug review. That has been a great innovation in Canada. It got the provinces, the actual payers, together at a table to discuss drugs. I don't sit on that committee anymore, but I did for many years, and I can tell you that the premise used is quite good. I understand that you've committed to something on a formulary, but the problem for you folks trying to move ahead with a national process is that, although the review is excellent, it doesn't have much in the way of teeth. Occasionally, it deals with wrong information, without the actual comparators, without the actual prices that the provinces are paying. In Ontario we have routinely needed sober second thought on what this really means for the province. We have often been confronted with different results, which has led to some controversy in the media.

Before I make some general recommendations, I want to describe the typical formulary meeting. We do this regularly in clinical venues, in conference venues, just to have the audience pretend that they are part of the formulary. I have four drugs that we need to discuss.

One is a new immunotherapy for malignant melanoma. Metastatic malignant melanoma has previously been a virtual death sentence. There's now a class of drugs enabling a small number of patients to live considerably longer. We're actually talking about a cure. We have a new drug that costs $110,000 a year. The cost for quality-adjusted life, and we don't have time to get into that here, is essentially our metric for comparing one drug with other drugs that we use. The cost for QALY, quality adjusted life for a year, is $157,000. We typically have a threshold of around $50,000. Should we fund that drug? We know that it could save some lives, yet there will be a small number of patients for whom it is not cost effective.

We're also dealing with Kalydeco, or ivacaftor, which is a drug for a small genetic subset of cystic fibrosis patients. Probably 57 people in Canada could be helped by this drug, but the benefits are in a surrogate outcome, an outcome that doesn't actually describe the clinical benefit. It talks about lung function, which has only a small change, but there is some improvement in quality of life. The cost for QALY is almost $5 million, but it's children we're talking about.

Then we have a diabetes drug that affects three million people in Canada. There are many diabetes drugs. The cost is not very high, but our comparators are much cheaper, and we're talking about three million people. So the budget impact is tremendous.

Finally, we have the example of a cholesterol-lowering drug, a drug that's in the thousands of dollars per year compared with a well-known and very effective statin at $154. We are considering the potential for 11 million people with high cholesterol to eventually take this drug.

All of these have been key problems. We have our paradigm for considering the evidence, but the choices, even after you've made those important evidence considerations, are not all that clear-cut. If we were doing a strictly societal view where we have choices of physicians at the bedside, nurses at the bedside, we would probably make recommendations that are more negative.

I want to finish with what would be my wish list. I think we have to develop something nationally, based on principles of equity, efficiency, and affordability. We need essential drugs, all-people coverage of some sort, whether you call it pharmacare or something else. We have to negotiate much more aggressively on cost. We are probably entering an era in which we need funding priorities. Each clinical specialty will have to start developing its own priorities. This is happening in cancer now. We can't pay for everything. If people do not want to pay more taxes, we can't fund everything.

We need a national formulary. This is going to take a great deal of expertise beyond what we currently have. It should be transparent. We have an intelligent public and a good clinical workforce, but at present, our actual deliberations and the reasons we make our decisions are kept hidden. I think that's wrong.

● (1625)

In my own line of work around dealing with my colleagues every day, physicians and pharmacists, we do need much better education. We need some enforcement around the formulary decisions, and that's not there.

Thank you very much for this opportunity.

The Chair: Thank you very much.

You mentioned malignant melanoma. I think you referred to it as a death sentence. I'm a malignant melanoma survivor. I was fortunate to have early diagnosis right here on the Hill. I had no idea there was anything wrong, but I went to a screening that was sponsored here by a volunteer dermatologist. They discovered I had malignant melanoma, and I was in the hospital the next day. That was nine years ago. So far so good. You kind of rang a bell with me.

Dr. Dhalla.

Dr. Irfan Dhalla (Vice President, Evidence and Development Standards, Health Quality Ontario): Thank you for the invitation to be here today.

By way of background, I'm an internal medicine physician with a master's degree in health policy, planning, and financing. I spend most of my time working for Health Quality Ontario, a government agency in Ontario with the responsibility to be the primary adviser on the quality of health care in the province. I continue to practise general internal medicine at St. Michael's Hospital in Toronto. Prior to joining Health Quality Ontario in 2013, I was also a researcher with an interest in pharmaceutical policy, among other topics. For three or four years, I served on the committee to evaluate drugs, where Anne continues to serve. That's the committee in Ontario that makes recommendations to the provincial government about which drugs should be publicly funded and which drugs should not.

Last year, the minister of health in Ontario, the Honourable Dr. Eric Hoskins, hosted a round table where he invited I think all of the ministers. Eight ministers, including Minister Hoskins, participated. I attended the round table, and my colleagues at Health Quality Ontario and I wrote a report summarizing the key points made during the day, the areas of broad consensus, and also the areas of disagreement. The summary report is the main component of the brief I submitted, and I think most of you, or all of you, should have that in front of you. I was going to take the opportunity to highlight many of the points in that document, but I think in the interest of time, I'll probably truncate my remarks to some degree.

One key point I would like to make is on page 8 of the report, and that is that the growth in spending on prescription drugs in Canada over the last decade has been much greater than in all of the countries that we would generally compare ourselves to. I suspect you probably heard this finding from other witnesses who have presented here.

One point I would make though that's not in the report is that during the same period, there was no growth whatsoever in per capita prescription drug costs in the veterans affairs system in the United States. You might ask how it is the veterans affairs system is able to keep drug costs essentially flat, while in Canada drug costs have increased or probably doubled over the last decade on a per capita basis. Basically, the reasons are simple.

First of all, the veterans affairs system has a defined formulary. Second, they engage in aggressive price negotiation. Third, and this echoes one of the points Anne made toward the end of her presentation, the veterans affairs system supports intensive efforts to ensure high-quality prescribing by reaching out to physicians, and by putting in place a variety of mechanisms to help physicians prescribe in an evidence-based way.

A second point I would like to make is on page 10 of the report. It's that public subsidization of private insurance as it is done in Canada is inherently inequitable because people with higher incomes receive a larger subsidy than people with lower incomes. In effect, it's a regressive subsidy that goes against the general principle that government-financed programs are generally either universal or preferentially support those with lower incomes.

The third and final point I would like to make from the report starts on page 10. It's a bit of a longer point so I'd ask members of the committee to bear with me for a couple of minutes.

According to the experts who attended the round table, private health insurance plans in Canada have been somewhat overly expansive in their coverage and also overly permissive in their approach to guiding and monitoring prescribing practice. I'm sure Anne sees this in her practice. I see this routinely in my own practice. I'll give you an example. It's not unusual to see a patient with type 2 diabetes who has private insurance to be prescribed a new drug that costs $3 a day, when an older drug that costs pennies a day would be equally effective. In fact, the Canadian Diabetes Association, which produces clinical practice guidelines for type 2 diabetes, recommends the cheaper drug metformin be prescribed first for the vast majority of patients, not because it's cheaper, but rather because we know it works.

● (1630)

Quoting from the guidelines, the guidelines say:

> The recommendation to use metformin as the initial agent in most patients is based on its effectiveness in lowering BG, its relatively mild side effect profile, its long-term safety track record, its negligible risk of hypoglycemia and its lack of causing weight gain.

If you're unlucky enough to have type 2 diabetes, this is probably the drug you want, at least as first-line treatment, not the expensive one. You might ask if it really matters that patients with private insurance are getting the drug that costs $3 a day when they would be equally well served, maybe even better served, by a drug that costs pennies a day. You might say to that question, “Well, the answer is no. Private insurance is a private issue. It doesn't really matter.” But there are several reasons why private insurance is not just a private matter. One I've alluded to already, which is that private insurance in Canada is often publicly subsidized.

I want to focus here on another reason, which is that virtually every physician or nurse practitioner in Canada who prescribes medicines, both prescribes to patients who hold private insurance and prescribes to patients who have public coverage. The prescribing decisions for patients with private insurance may influence prescribing decisions for those with public coverage. That sounds like a hypothesis, but we actually have evidence that this happens.

Going back to the diabetes examples I just cited in Ontario, for patients with public coverage, the formulary committee that Anne continues to serve on and that I previously served on provides advice to physicians that they should use the cheaper diabetes drug first and only add the more expensive drug as second-line or third-line treatment. Of course, that makes sense from a value-for-money perspective.

Nephrologist Ainslie Hildebrand and I did some research along with our colleagues to see whether physicians follow this guidance. We published our findings in a journal called *Healthcare Policy* which is publicly available. When a patient had been prescribed the expensive drug, we looked back to see whether they had previously received the cheap drug, which all of them, or virtually all of them, should have received, and about half the time there's no record of the patient ever having been prescribed the cheaper drug.

In the public plan where you would hope that physicians are routinely prescribing the cheaper drug first, it seems to only happen about half the time. We don't know whether that's because doctors don't know about the guidance the government provides or whether they know about it but just aren't following it. Because this is in the public plan, clearly the costs of what we might call low-value prescribing are borne by all of us.

The report that I've enclosed with my brief lists several areas where there was broad consensus at the minister's round table as well as several issues where there wasn't consensus and what we have labelled as issues that need to be resolved. I'll refer committee members to the brief rather than go through each of those points, but I would like to make a couple of additional remarks that might build on some of Anne's comments.

There's no doubt that new prescription drugs have dramatically improved the health of millions of Canadians with a variety of diseases: cancer, heart disease, HIV, hepatitis C, literally dozens of different diseases. The problem, of course, with new prescription drugs is that they cost a lot of money, hundreds of thousands of dollars sometimes, as Anne described in her presentation.

Using cost-effectiveness research to help decide what drugs to put on a formulary is basically a technical way of saying that what we want to do is get the biggest bang for our buck. If we spend $100,000 on a drug that provides only a small benefit—let's say it extends the life of someone with advanced cancer by two months—that's $100,000 less that we have to spend on home care, mental health care, or something else that is a priority.

Anne described what happens at a typical committee meeting. Of course, committee members don't just look at value for money. They also think about other things like the type of disease that is being discussed, the availability of other treatment options, the size of the affected patient population, and equity issues. All of these issues are relevant, but value for money has to be a key consideration in every public drug plan. I think most of us, probably all of us today, would say that it has to be a key consideration in the development of a national formulary or a national pharmacare program.

● (1635)

In closing, I just want to say thanks again to the committee for studying this issue. It's such an important issue that matters to so many people across our country, particularly those who can't afford medications or who don't have private insurance. Thanks for the opportunity to be here today. During the question period, I'd be happy to answer any questions.

The Chair: Thanks very much.

Several presenters have referred to the U.S. Department of Veterans Affairs' successes as a good example, or a good model. How big is their budget? Is that equivalent to Ontario?

Dr. Irfan Dhalla: I think the size of the veterans affairs drug budget is approximately the same size, maybe give or take a billion dollars, to the size of the budget in the Province of Ontario for prescription drugs. I want to say $5 billion; I'm not sure. The fellow who chairs their equivalent of that formulary committee which Anne continues to serve on is a guy named Bernie Good. He's a physician. I don't know whether you have the opportunity to call witnesses from the United States, but he is very knowledgeable about this, and could take you through all of the details of how they've managed to hold drug costs down, and provide access, actually, to medications that we don't provide access to in Canada.

The Chair: Thank you.

Dr. Henry.

Dr. David Henry (Professor, Dalla Lana School of Public Health, University of Toronto, As an Individual): Good afternoon, and thank you very much for the invitation to present.

I'll provide a brief background. I'm Australian. I am a physician and trained as a gastroenterologist a long time ago. My relevant work was that for 10 years I was a member of the national committee in Australia called the Pharmaceutical Benefits Advisory Committee. It has been referred to by a couple of my colleagues today. For about eight years I chaired the economics subcommittee of the pharmaceutical benefits advisory committee in Australia, and it's based on that experience that I'm going to make some comments to the committee today.

By way of background, Australia has a national medicinal drug policy. It's foundational, and it has four arms.

The first, and really the one we're talking about today, is timely access to the priority medicines that Australians need at a cost that individuals and the community can afford. That's really the drug benefit program. It operates off the schedule of pharmaceutical benefits, which is the Australian national formulary. The committee that I was privileged to be a member of, and the committee I chaired, had responsibility for overseeing the maintenance of that. I'm going to call it a schedule, if you don't mind, but it's equivalent I think to a formulary.

The other three arms of the national medicinal drug policy are important, however, because I don't think that a national formulary exists in isolation.

Importantly, and this has been addressed before, this policy around quality use of medicines is the term that's used. It's sometimes called rational drug use, but that could be interpreted different ways.

Quality use of medicines is the responsibility of a national prescribing service. Not only is there a national formulary, a national drug benefit program, but there's also a national pharmaceutical prescribing service which provides educators who work in particular but not exclusively with family practices and large groups of family practitioners called divisions of general practice in Australia. They also work with specialists.

The third arm is the arm that most countries nearly all possess, and that is some assessment of efficacy, safety, and quality of medicines. That's the role of Health Canada in Canada. It was the Therapeutic Goods Administration in Australia.

The fourth arm, and I think an important one, is at the same time trying to balance the need to maintain a responsible and viable medicines industry. I'm not here to advocate for the industry, but just to make the point that a balanced national medicinal policy really does to some degree have to have some representation of these four functions in it.

Within that comprehensive policy—a very serious policy that was introduced by a Labour government, but it continued under different Conservative governments—the pharmaceutical benefits scheme sits.

I thought I would talk a little bit about that scheme. Why talk about the Australian scheme? Is it the best in the world? No, I actually don't think it is, but I do know it well so I can speak from that experience. I think it is an archetypal example of a scheme.

Also, I have worked for some time in both countries, and there are similarities between Australia and Canada in terms of social structures and values, a national single-payer health care system, albeit that Australia has also private health care, not just pharmaceutical coverage, but more broadly. The similarities in the system are really quite striking except for the lack of a national pharmaceutical benefits scheme in Canada. It's for that reason it probably does represent something of a comparator and maybe some useful lessons.

The schedule, if I can call it that, the formulary really provides medicines to meet the priority health needs of the population. It's complete population coverage. Everybody who's eligible gets the drugs. There are no exceptions to it. There's no postal code prescribing. In Australia, if you live in the Northern Territory or New South Wales, you get the same coverage.

● (1640)

I mentioned it sits within the national medicinal drug policy, but it's also supported by very strong legislation. It comes under section 85 of the National Health Act in Australia. The legislative effect of the legislation is important. The committee is named in the legislation, and the committee makes a recommendation to the federal health minister about which drugs should be declared on the national schedule. The point, however, is that the minister cannot declare a drug on the schedule without a positive recommendation from the committee. That helps keep the evidence-based process alive, but it also to some extent protects the minister in a political sense because the minister can always say, “Well, I haven't received a positive recommendation. That's why we're not subsidizing this drug.” Many ministers, while I was there, and there were quite a few, certainly used the committee, I think appropriately, as a shield at a time when they were under pressure for certain drugs not being listed.

It's an evidence-based evaluation rather similar to what happens in Canada. I'm not going to talk at length about that; you've heard about that. It had responsibility not only for looking at cost effectiveness and comparative effectiveness and making a recommendation to the minister, but it also had responsibility for looking at the total cost to the community and the total health impact. These are really important. What was the public health impact of this new drug being listed? What was the total cost going to be, and where were the savings going to be experienced, if there were going to be savings?

Two more components I think are relevant. The final price of the drug was negotiated by a separate pricing authority that wouldn't go to work until a positive recommendation came from the expert committee. That pricing authority would work across the table from industry and negotiate that final price. Now, there was nowhere the industry could go. If they couldn't get a negotiated priced, they couldn't get the drug subsidized in the country for what was then 22 million people. In other words, there was a considerable bargaining power across that table. I know that from the experience of working with it, because I chaired the economic committee that provided the pricing authority with the information that it needed.

The final thing to note is that when a price had been negotiated and there was clearly a positive recommendation to declare the drug on the schedule, it was finally a cabinet decision. The minister would take it to cabinet if the total cost implication was more than $10 million a year, really quite a low threshold. To be honest, I'm not sure if that's been adjusted upward, but the point was that finally cabinet would make the decision to spend the money.

Sometimes they said no when the committee had said, “Yes, this is value for money.” I'll give you an example. The committee recommended anti-smoking therapy, nicotine replacement therapies. The pricing authority negotiated what was a reasonable price. The total cost was reasonable, it seemed, but cabinet decided—and I'm not saying rightly or wrongly, just describing—that they did not support that. They felt the smokers were paying for the cigarettes so they should be able to pay for the nicotine replacement therapy. You can see there's a sort of logic there. I didn't support it, but that was the argument.

This has been in operation for a long time. Let me say right up front that Australia introduced this in the 1950s, ahead of comprehensive medicare that was really only introduced about 1982-83, really quite long after Canada. It's had a pharmaceutical benefit scheme since the 1950s, so it was there. It was foundational. I quite accept that it's harder to introduce a program when you already have a patchwork—and I don't mean that in a demeaning way—of systems in Canada, and it is different from starting from a clean sheet. Going from the Canadian system to an Australian system is tougher than starting with nothing and getting to where Australia is now.

I have some final concluding comments and examples, I think, of the power of a national system.

The average per capita spend in 2011 dollars, purchase parity corrected, in Australia was $588, that's OECD, as against $771 in Canada, so almost $200 less per person. You can see how that translates into quite a large sum. That's the average across the population.

● (1645)

That's my spiel about how that works. I don't think it's the best. I just know it, and I think there's some relevance.

I am just going to give two very brief examples of diseases that I think illustrate the advantage of a national program.

One is hepatitis C. Australia has announced that it's going to eradicate hepatitis C through the pharmaceutical benefits scheme. These drugs are expensive. Anne has mentioned them already. They do work.

We know from the experience of HIV that treating people stops them from infecting other people, as well as helping them. That seems to be the case for the new drugs for hepatitis C. By treating everybody, you also cut the chances of somebody becoming reinfected by someone else, but it depends on drugs, not vaccines. It's hard to do that without a national program. Imagine negotiating that in Canada through the provinces' and territories' non-insured health benefits. It's a hard thing to do.

My final example is diabetes. My wife is chief of endocrinology at Sunnybrook Health Sciences Centre. She was chief of endocrinology in an Australian teaching hospital, and moved from one position to the other. She treats diabetes, as well as everything else, in the same way. In Canada, in Toronto, she has a fridge for insulin. She had the same fridge in Australia to start people off and give them their first ever dose of insulin. She keeps the fridge in Toronto for the people who cannot afford their insulin. She sees five or six people per month in her practice alone who cannot afford insulin, a life-saving drug that was discovered by Banting and Best in Toronto, not very far from where she practises.

This is an extraordinary situation. She has to hand out free insulin to patients.

● (1650)

The Chair: That's a good message.

I have to ask you to end there.

Dr. David Henry: I'm ending.

The Chair: Thanks. We could listen to you all day long, but we have 27 minutes before the vote.

Ordinarily, we have seven-minute rounds. Should we move it to five minutes so more people can ask questions?

Are there no thoughts? Well, we'll stay at seven then.

Dr. Eyolfson, you're first.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you very much.

It was a pleasure listening to all of you. As I've said to a number of other witnesses, this is reinforcing some assumptions I've had.

My background is in clinical medicine. I've been an emergency physician for 20 years. I see the effects on those who cannot afford their medications, because the poorest people appear to use emergency departments for their primary care. We often have to resort to creative workarounds, such as writing an order on the chart for one month's worth of insulin and giving it to them, these sorts of things.

I can put this question to anyone on the panel who practises clinically.

What documented evidence do we have that our current pharmacare system is actually impacting the ability of physicians to provide care?

Dr. Anne Holbrook: We're just finishing a systematic review of Canadian data around cost-related non-adherence. This is a mouthful for saying that because of cost, as far as we can tell, patients aren't taking their medications appropriately. The best estimate we have for that is 15%. There are lots of issues around medication adherence. In high-quality studies, providing free medications hasn't yet been shown to make a big difference in clinical outcomes, but I think that if you asked any physician, within a few minutes they could give you multiple examples of where patients not taking medication properly had landed them in the emergency room with heart attacks, with strokes, with ongoing cancer, and so on. I think it's quite likely —and this is why cost effectiveness is such an important paradigm— that in many situations the benefit is worth the money, but there are other situations where it's very borderline, if worth it at all.

Mr. Doug Eyolfson: I couldn't agree more. The example I always throw out is that if I have one admission for diabetic ketoacidosis that ends up in the intensive care unit, I could probably pay for that patient's lifetime of insulin for the cost of that one visit. That doesn't even take into account the people with poorly controlled diabetes who have heart attacks after 20 years, end up on dialysis, require amputations, and these sorts of things. It's nice that we're starting to get some data to prove these assumptions that clinical practitioners have always had.

This is a bit of an open question. Where would you say the provinces are getting their best possible evidence to make decisions on pharmacare? What will we need to make sure we have the best evidence? How do we collect all this evidence beyond what you're describing here? What kind of national surveillance of outcomes and cost effectiveness would we need?

● (1655)

Dr. Irfan Dhalla: I'm happy to try to answer that question, at least as a starting point.

We have in Canada a pan-Canadian health technology assessment agency called CADTH, Canadian Agency for Drugs and Technologies in Health. I think their CEO has either already testified or will soon be testifying.

They rely on well-established scientific methods to review the clinical evidence and to conduct what we call cost-effectiveness analyses or value-for-money analyses. Obviously, these kinds of analyses take a lot of resources and take time. They can be conducted in ways that are better, and in ways that are quick and dirty, if you will.

Supporting the kinds of agencies that do this work is important. Katherine mentioned that we have significant capacity in Canada to do this work, and I would agree with her assessment. We've probably been leaders in economic evaluation for several decades, along with the British and the Australians and those in a few other countries.

Arguably, organizations like CADTH would need more resources to do this work if there were to be a national formulary or a national pharmacare plan.

Dr. Anne Holbrook: I would add to that something we're not doing so well. Because of the limitations of the evidence that comes to us when we're trying to decide about approving a drug, probably about 60% or 70% of the time now we're saying that we need to follow this up.

Where we lack evidence is in real practice. Has that benefit that has been suggested by the evidence actually played out in practice? There are worries that in some cases, either because it's utilized beyond what we initially proposed or for other reasons, the benefit may not have played out so well.

I think in any ongoing forward system, it's really important that we have some post-marketing follow-up on what is actually happening in terms of use and cost.

Mr. Doug Eyolfson: Thank you.

Further to that, and I'll be the first to agree, we see plenty of very cheap, effective medications and we see very expensive ones with questionable benefit at best.

Steven Morgan spoke to us in an earlier meeting. He suggested starting with a limited formulary and then evaluating that and stepping forward in an incremental approach. Others might advocate putting together a master formulary and starting with a more robust system.

If you had to pick between a completed system that you put in or putting it in incrementally, which would be the model you'd recommend?

Dr. David Henry: I would go for the big bang. I really would. Otherwise, you're going to be left with an iterative process of change, with the provinces still having a role in coverage, and it's going to be complicated.

When the Swedes changed from driving on the left to driving on the right, they couldn't do it incrementally. Sorry, that's a cheap shot.

We already know what those drugs are. We can put it together. We can put that formulary together, essentially at today's price. Then as the new drugs come on, the extra buying power and leverage of that national program, as well as reviewing prices....

We haven't talked at length about that. We've had a lot of experience of adjusting down drug prices that were already on the schedule in Australia, based on the actual cost of treatment as it played out in the community. Through some product listing agreements that can be introduced—difficult to do retrospectively—that risk of the drug actually being more expensive than was thought because of efficacy or their needing higher doses can be shared with the company. That can be written into the agreement. There are different ways that you can manage costs prospectively.

To get to your point, I would go for the full monty.

The Chair: The time is up.

Ms. Harder, you're going to split your time: three and a half minutes and three and a half minutes.

The time flies when you split, so I'm just going to hold this up when the three and a half minutes is up. I won't shut you down.

Ms. Rachael Harder (Lethbridge, CPC): That sounds very good, Mr. Chair. Thank you very much.

First, thank you so much for coming. We certainly apologize for all of the interruptions today. We know that this isn't ideal. We wish it wasn't the way it is.

My first question will be for you, Dr. Henry.

In our formulary, we obviously cover off certain conditions but not others. At the end of the day, I'm wondering what effect this is going to have on some of the smaller populations. Then as we add new medications to the formulary, the other thing I see would happen is that new medicines that have greater effects on public health would have urgency; meanwhile, the less prevalent conditions would not.

I'm looking for you to comment on how we could put together a formulary that is equitable. This is a key phrase that I'm hearing over and over again. At the end of the day, unless we're going to cover absolutely everything, we're actually only creating another tiered system. I need some understanding in terms of how it is actually possible to make this system equitable and affordable, because it has to be both.

● (1700)

Dr. David Henry: The critical issue is not only equitable access to some program, but it's the drugs that are in that program and whether they are equitably meeting the health needs.

The issue is, would it be better or worse with a national program than the current patchwork—I use patchwork in the descriptive sense, not as a value judgment—of that territorial and provincial system that exists in Canada?

I would have thought that an argument could be sustained that people with, say, fairly rare and expensive-to-treat diseases might be better served under a national program, because of the large buying power that would have. The power of a program representing the interests of 35 million people has considerable influence. While you're right that the public health impact is really important, my experience of working in a national program is that a lot of the agonizing has been to make sure that people with rare diseases—there might be 100 or less in the country—were looked after.

I didn't mention it in my talk, and again just for the record, there is an act of grace arrangement that exists around the national pharmaceutical benefits scheme in Australia, whereby individuals who believe they're seriously disadvantaged by non-coverage of a particularly expensive drug can apply directly to the minister, who can perform an act of grace payment to cover it. Therefore, I think there are other mechanisms that can sit under the umbrella of a national program.

Ms. Rachael Harder: Dr. Henry, perhaps you could comment. I think this is somewhat similar to the Australian model. Here in Canada the provinces obviously have jurisdiction over health care in the way that it's realized. When it comes to putting forward a national pharmacare program, I'm looking for some feedback in terms of how willing you feel provinces are going to be in terms of delegating their authority, or relinquishing their authority on this matter. How would you propose to go forward with that?

Dr. David Henry: The point is very valid and I've spoken to lots of people in the provinces. It's too strong to say they're perverse in centres, because they're trying to do good, but they're working and establishing their careers and their whole process is invested in a provincial program. Suddenly taking that away and replacing it with a single national payer who pays all the pharmacists in their province directly from a national payment commission or insurance commission for this purpose is really a very big challenge because they're invested in it.

There is no easy answer to that. There is little doubt that the public good is going to be served by it, that their provincial electorates are going to benefit from it, but the negotiation that takes place around it is going to be difficult.

As I've said, I think it's almost like a big infrastructure undertaking. We're going to build something really big, and one day it's going to be open and that will be the day that it starts and everybody has to be committed to that day, that it really is going to happen and we're really going to make it work. It's a very big idea to take on. There's no easy answer.

● (1705)

The Chair: Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Chair.

Dr. Boothe, in your presentation you mentioned the pan-Canadian Pharmaceutical Alliance. I want to talk a bit about that.

Currently, the Canadian provinces, and I assume the territories as well, through the pan-Canadian Pharmaceutical Alliance, are signing confidential deals with pharmaceutical manufacturers that give them the off-invoice rebates from the drug manufacturers.

Advocates of this approach say this is simply a matter of governments using their purchasing power to get a better deal for government, but there is a lot of secrecy around these deals. Some could argue it is unethical for governments and their drug plans to get that preferred pricing, when 60% of the pharmaceutical purchases in Canada are paid for by the private sector at list prices that are inflated as a result of the deals that the governments put together with the pharmaceutical manufacturers. Basically, the out-of-pocket and the corporate personal plans are left paying the inflated price.

Do you think we should have in Canada some principles, rules around how these price agreements are designed and used? I'd like to get your thoughts on that, or the panel's thoughts.

Dr. Katherine Boothe: Sure, thank you for the question.

I think there are two points. First of all, I don't think it is realistic to say that Canadians should not take advantage of confidential prices the way every other drug plan in the world does. It's become a fact of life in the pharmaceutical market. Without passing judgment on whether it's a good thing, I'm of the opinion that it's inevitable. The question is how we get the most people to benefit from this practice. The answer is to have universal coverage. It increases the purchasing power of government, as you heard from Dr. Henry.

If the drug plan is sitting across the table from manufacturers and saying, "It's our price, or you won't be subsidized for Canadians across the country", that's a strong bargaining position. I think you can have rules around the way these negotiations are conducted that would make them acceptable, but if you're going to have them, you should make sure all Canadians are benefiting from them.

Dr. Anne Holbrook: I have two quick points.

A bad deal is a secret price deal for which nobody knows whether it's good. It's the poor 25%, the most vulnerable of our population that have no insurance at all, who are losing. That is a tragedy. A good deal, and a good example I can think of, is a reduced price on a drug that may have a benefit for dementia. If the patient does not benefit from the drug, the company is paying the whole shot and is rebating. I think this notion of advancing our thinking is to look at what value we want out of these price deals clinically, as well as with cost reduction.

The Chair: There we go. Thanks very much. Madame Sansoucy.

[*Translation*]

Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP): My thanks to the witnesses for their presentations.

My question is for Dr. Dhalla.

You have reached a consensus at the Health Quality Ontario roundtable and through your work there, and I would like to know what the findings are. You have access to scientific data and research results. In your view, does all that information show that the Canadian health care system would benefit from a national pharmacare system with a national formulary?

[*English*]

Dr. Irfan Dhalla: In my view, the scientific evidence does point to the fact that we would save money collectively if we had a national formulary and some sort of a program whereby the provinces were asked to maintain consistent standards, or there was a national standard.

Going back to the points that Katherine made a few moments ago, one way of putting it is that if some Canadians get a good deal by being in the public system, don't we want every Canadian to get a good deal by being in the public system?

I would argue that we do and we know in Canada that people who are not insured at all get the worst deal. We also know that we can put in place a set of principles to make sure that we are making the best possible decisions about which drugs get onto publicly funded formularies and which drugs don't. Those principles should be transparent. They should be vetted with decision-makers and, most importantly, vetted with the public and with patients so that we're not disadvantaging people with rare diseases, or disadvantaging people who have certain conditions versus other conditions.

I share Katherine's view, and I think the view of the member who asked the question, that there are pros and cons to these confidential pricing arrangements, that in the current environment the pros likely outweigh the cons, but it is also possible for governments to put in place arrangements to make sure that those deals are being appropriately scrutinized to ensure that Canadians are getting value for money.

● (1710)

The Chair: I'm showing seven minutes until we vote, so we have maybe two minutes and then we'll have to run.

[*Translation*]

Ms. Brigitte Sansoucy: So the question I have for Dr. Holbrook will be short.

Witnesses have told the committee that hospitals are using formularies with a set budget to manage their drug costs.

To your knowledge, are those hospitals paying less per unit?

[*English*]

The Chair: I'm sorry, but I've just been corrected, and we have four minutes until we vote, so we have to wind up. We have to go.

We don't know what's going to happen next, so we should adjourn now, because we don't know if you'll be sitting here for two hours, or one hour, or what.

I just want to thank you on behalf of the entire committee. You obviously have a lot of information that's very helpful to us, and we're very grateful for your information and will probably be calling you back for more information. Thanks very much.

The meeting is adjourned.