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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0845)

[*English*]

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

There's one little thing before we get started and hear from the witnesses.

It has been suggested that I'm a little slack at timing the questions and the answers, that I let people go a little long. I'm going to tighten that up a little bit, so for the seven-minute questions I'm going to ask you to limit it to seven minutes questions and answers, and then five minutes. We won't cut anybody right off, but we ask your co-operation to keep it a little tighter. I tend to let people go on, on both sides, because if we have a good line of questioning going, we all want to hear the questions and we all want to hear the answers.

Yes, Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Mr. Chairman, I served notice of motion with 48 hours, as per our Standing Orders, and I would like to move my motion:

> That, pursuant to Standing Order 108(2), the Committee undertake an emergency study of the opioid crisis in Canada.

If I may speak extremely briefly, we know there is a crisis. All committee members are well aware of that. I know we're in the middle of a study on pharmacare. I would say that we would need four meetings for this. I would not be calling for a report but rather, perhaps, a series of recommendations to the minister.

Perhaps after we finish hearing the witnesses today we could take 10 minutes at the end of the meeting to discuss how the committee would like to schedule these. I think it's an emergency and while I don't think we have to do it immediately, as in the next meeting, I think we should get at this as quickly as we can while respecting the pharmacare study we're undertaking.

The Chair: I simply want to check that the motion is in order, and the time.

The motion is in order.

It's somewhat like Mr. Webber's.

Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): I welcome the intent of this motion, of course, for the NDP, but in fact, I raised a similar motion asking for unanimous consent to have this motion passed because of the urgency of the issue. I would simply like to know what the process is for putting a motion in to the clerk. It has to be translated, does it not? Also, does the individual have to have the floor in order to table a motion?

The Chair: We have it in English and French. Is that what you mean?

Mr. Len Webber: Yes. I'm referring to the timing here, because when I presented my motion I had the floor and was talking about my intent to want to get this motion on the table. Of course, I had the floor and I presented you with my motion. I want to know where we are with respect to who brought the motion in.

The Chair: I understand.

I'm advised that it is in order. Both came in by email, his first, and both within the 48 hours. Certainly, the chair acknowledges that it's almost the same motion as yours and I think you brought the issue up.

Mr. Len Webber: I was just questioning it.

● (0850)

The Chair: I think the issue will be addressed within the time designated for committee votes.

Mr. Len Webber: I hope it does get addressed.

The Chair: Is there any other debate on the motion?

Mr. Len Webber: I would like to make some amendments to that motion, Mr. Chair. I think it is a rather weak motion. It doesn't have a study with purpose.

I would like to get a copy of that motion, if you don't mind, from the honourable member of the NDP, Don. Thank you.

I see his motion here. I feel that it just doesn't have an action plan. My motion does. I can read out my motion. I'll read out the honourable member Don Davies's motion first.

It says here:

> That, pursuant to Standing Order 108(2), the Committee undertake an emergency study of the opioid crisis in Canada.

The motion that I had tabled, or tried to table, with unanimous consent on Monday reads, “That pursuant to Standing Order 108(2), the Committee undertake an immediate study of the fentanyl and opioid crisis in Canada, in light of the alarming and growing number of deaths caused by these substances, to determine what action can be taken by the federal government.”

I would like to make an amendment to Mr. Davies's motion to make it more specific, give it a study with a purpose and with an action plan.

The Chair: Do you have the wording?

Mr. Len Webber: I have the wording here, and translated, yes. That was the one I had submitted to you on the day that I had the floor, on Monday, when I tried to get unanimous support for this motion.

The Chair: Is this actually your original motion?

Mr. Len Webber: Yes.

The Chair: You're proposing you would replace—

Mr. Len Webber: To insert....

The Chair: —Mr. Davies's with yours, or to insert what words?

Mr. Len Webber: Well, no. Yes, to insert....

The Clerk of the Committee (Mr. David Gagnon): He would replace "emergency" with "immediate study of the fentanyl..."—

Mr. Len Webber: That's right, and then the action plan at the end.

The Clerk: —"in light of the alarming and growing number of deaths caused by these substances to determine what action can be taken by the federal government."

The Chair: You know exactly what we're talking about here. The members have to know exactly what you want to say.

Mr. Len Webber: Okay, all right.

The Chair: Can you put that in writing for us so that everybody can see it?

Mr. Len Webber: It has been tabled, and I understand that you're going to make a ruling on it, a vote, on whether or not this motion is going to pass. I'm introducing an amendment to that motion.

The Chair: We have your original amendment. I'm not trying to give you a hard time; we just need to know exactly what we're voting on.

Mr. Len Webber: The committee would undertake an "immediate study" rather than "an emergency study".

The Chair: It's just to change "immediate study" to "emergency study".

Mr. Len Webber: That would be one item.

The Chair: Actually, it would be changing "emergency" to "immediate".

Mr. Len Webber: That's right, yes.

I guess then insert "fentanyl and opioid crisis in Canada, in light of the alarming and growing number of deaths caused by these substances to determine what action can be taken by the federal government."

It's more specific. It has an action plan. It hopefully requires it to be an immediate study because of the urgency.

The Chair: Mr. Davies.

Mr. Don Davies: I think Mr. Webber's amendments amount to a difference without a distinction. Changing my word "emergency" to "immediate" is of no consequence whatsoever. In fact, I would argue that "emergency" probably has more impact than "immediate".

Second, as to adding fentanyl, fentanyl is an opioid, so when you say "opioid crisis", that includes fentanyl. When he adds the words "in light of the crisis in Canada", that's already understood. It's just an elaboration on the opioid crisis.

Finally, to determine what action would be taken, my motion is to undertake an emergency study of the opioid crisis in Canada. I believe it is obvious, clear, implicit and understood from the motion itself to be a study to determine what action should be taken. That's understood.

I don't think any of the amendments add anything to the motion as it stands. With great respect, it appears to me that pride of authorship is trying to take priority over getting to the actual substance of it, which is to get this committee to recognize the opioid crisis and to start studying it as soon as possible.

The reason that I don't think "immediate" is appropriate is that "immediate" suggests a certain time for action. An immediate study would mean we start studying right now. Do we suspend the pharmacare study right this moment and get at it? I didn't think that was fair to the committee. Although we, on all sides of this table, recognize the importance of this issue, we also recognize that we'll have to do a little bit of planning. We have to get witnesses before this committee that will be able to give us good advice on opioids. That's going to take a little bit of time, so I don't think we can start this study immediately. My motion recognizes that it's an emergency. It gives us the flexibility to take the next three or four days to suggest witnesses and to allow the analysts to plan the meetings. We have witnesses lined up for pharmacare for next Monday and Wednesday.

I think my motion does everything Mr. Webber wants it to do. If we're really interested in this, let's get at it, vote on the motion, pass it, and then we can get at the pharmacare study.

● (0855)

The Chair: Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): I would concur with Mr. Davies. I understand your intent, Mr. Webber. However, if we say "immediate", we might find ourselves obligated by the meaning of the word "immediate" to suspend all other business. That would mean sending home all the witnesses that we'll be having for the next three meetings, which I don't think we can do. Also, the amended motion has specifics we don't need. Fentanyl is only one of the opioids that we're dealing with in a crisis. There are several opioids.

Again, I understand the intent of your amendment, but I don't think there's any advantage to it. I think Mr. Davies's motion says it all. It gives us the flexibility to continue with the next three meetings we have on pharmacare, and then get going on this. If there's a motion on the floor, I'll second it.

The Chair: Ms. Harder.

Ms. Rachael Harder (Lethbridge, CPC): In 2014 this committee conducted a study on opioids in Canada. The interesting thing about what we face today is that we're not just looking at opioids in general. Rather, we are looking at the distinct nature of fentanyl, and that is where the emergency takes place in 2016. In order to draw a distinct line between the 2014 study which was already conducted and what we might spend our time wisely doing now, I think fentanyl is a key point in this study.

The Chair: Dr. Eyolfson.

Mr. Doug Eyolfson: I hate to split hairs on this. I agree that fentanyl is part of it, but there are also some novel opioids that have just come on the scene in the last month that are different from fentanyl and even more dangerous. I agree with you that fentanyl is part of it, but there are others as well that are even newer that are part of the same crisis.

Again, I don't see the advantages of specifying fentanyl. Carfentanil is one that's come up. It's a different compound. I read about it years ago and I didn't think we'd ever see it on the streets.

I don't think we need that distinction. It's all opioids, it's all a crisis, and I think what we have covers it in the generality. People are still dying of the older opioids. There's still the old OxyContin out there, and there's still heroin. It's part and parcel of the same problem, and I think this motion gives us the flexibility to study that.

The Chair: It's coincidental that there was a news program last night about this very subject, about how to raise the profile of it, and how important it is.

Mr. Webber.

Mr. Len Webber: Mr. Chair and committee, this is an emergency. This is something that has to be done immediately. I respect your comments, honourable member, but we have to get this done now. If it means our having to postpone a few presentations on pharmacare, then I would say so be it. We heard the panel the other day, and the crisis situation that we're in with this fentanyl issue, and I believe we have to do an immediate study. Of course it is an emergency, but what does that mean? Immediate study indicates the fact that it has to get done right away.

With respect to the other wording, we need to give it some teeth. We need to have an action plan and a purpose. I think this action plan could be an immediate report that can be written up once we have this study undertaken. I can't stress enough the emergency that we're going through right now. The requirement of an immediate study is that it has to be done now.

● (0900)

The Chair: Just by the sound of things, and looking at the schedule going forward, if this passed, then we would probably be starting it a week from Tuesday. I think that's pretty quick. We have to have a work plan, and we also have to have witnesses. If we had two more meetings on pharmacare, which are already scheduled and with the witnesses already scheduled, if it passes, that would allow us the time to get witnesses, and the proper ones whom we all want to hear from. It would allow us to ensure that the witnesses on the other meeting finish, and it would give the researchers a chance to give us some information on it.

Ms. Harder, you're next.

We're talking about a week from Tuesday, if it passes.

Ms. Rachael Harder: I understand what's being said with regard to splitting hairs, and I'm certainly not wanting to belabour this point. With everything that's taking place in the news, and the fact that this is drawing such careful attention, or prominent attention, in Canada right now, I think a focus on fentanyl deserves our attention, given the national scope of this issue.

We heard the witnesses the other day, and their focus was on fentanyl. With all due respect, it wasn't on other opioids; it was largely on fentanyl. It is what's making it into the news day in and day out across this country. It is what is causing us concern in provinces like B.C. where we're seeing alarming death rates. I think it deserves careful study.

The Chair: Mr. Kang.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Mr. Webber, we perfectly understand your concern. Everybody is passionate to get something done about this. If you're suggesting fentanyl is the issue, maybe we could say, "study of the opioids, such as fentanyl, crisis in Canada". That's just a suggestion. If we put "fentanyl" in the motion, would that satisfy you?

Mr. Len Webber: Thank you, Mr. Kang. I don't want to—

The Chair: No, we need Dr. Eyolfson.

Mr. Doug Eyolfson: At this point if there's a motion on the floor, I'd like to call the question.

The Chair: Yes.

We have two more speakers and they have to speak.

Mr. Davies.

Mr. Don Davies: In response to Ms. Harder's comments, again it's my understanding that fentanyl is included in opioids, so when I said "opioid crisis", absolutely fentanyl is one of the main opioids that are getting attention, but there are others. There's OxyContin and there are other issues as well. I want to be clear that my intention, when I say "opioid crisis", is to include the full scope of opioids, including fentanyl.

The Chair: I don't want to pretend I know a lot about this, but just from the TV program last night, I saw they also mentioned another opioid that is even more dangerous than fentanyl. Carfentanil is what I think it was.

Mr. Webber, you're up. Then we'll call the vote on the amendment.

Mr. Len Webber: Again, I want to just reiterate the emergency here and the immediate action that we have to take on this. I guess I would suggest this then. Can we put in the amendment both "immediate" and "emergency"? Can I do that on a second motion, or can I include it on the original one that I'm suggesting? Or are we discussing my original amendment?

● (0905)

The Chair: Can he amend the amendment?

A voice: No.

The Chair: We have to vote on the first amendment, first.

Mr. Len Webber: Then I can always submit a second amendment.

The Chair: Either way, we can't do it any sooner than Tuesday.

Mr. Len Webber: Okay, I'm not going to belabour this either.

Mr. Chair, I have the floor here, do I not?

The Chair: I'm sorry. I thought you had finished.

Mr. Len Webber: Again, I want to say that the presentations yesterday indicated to us that on average, there's one person dying every 14 hours, and Tuesday is a significantly long time when we're in a situation like this.

I would like to get this committee and the clerk and the preparation going so that.... An immediate study means next meeting. There have been 488 deaths to date in B.C. In nine months there have been 488 deaths due to fentanyl. I see this as an immediate emergency. I know all of you do as well. I just can't reiterate enough how important this is. To even focus right now on the pharmacare study, to me, is difficult.

In any event, let's vote on this, and I suspect we'll just move forward.

The Chair: The amended wording is that, pursuant to Standing Order 108(2), the committee undertake an immediate—rather than emergency—study of the fentanyl and opioid crisis in Canada, in light of the alarming and growing number of deaths caused by this substance, to determine what action can be taken by the federal government.

(Amendment negatived)

The Chair: Now we're going to vote on the main motion. That is:

> That, pursuant to Standing Order 108(2), the Committee undertake an emergency study of the opioid crisis in Canada.

(Motion agreed to)

The Chair: Perfect, that is settled. Thanks very much.

Mr. Webber, I mean, we all know you raised this issue in the beginning, so....

Mr. Len Webber: It's not my issue at all.

The Chair: We'll get to it. I don't see how we can get to it any quicker than a week from Tuesday anyway with the work plan and the scheduling of witnesses.

Hon. Pierre Poilievre (Carleton, CPC): Mr. Chair, I gave notice of a motion in the spring. It has been submitted in both official languages and is in order. It reads, "That, pursuant to Standing Order 108(2), the Committee immediately undertake a study into the government's rejection of an expert-panel's decision to locate the future Ottawa Hospital Civic Campus on federal land across the street from the existing Hospital; and that the Committee call the Ministers of Environment, Heritage, and Agriculture and Dr. Mark Kristmanson, CEO of the National Capital Commission (NCC), to discuss the matter."

I'm here today to introduce this motion. I thank the chair for giving me the floor. As I said, the motion is in order as notice was given in June. I had intended to move it then. However, the schedule did not permit, so I am moving it today. Today is a particularly important day in the matter because the National Capital Commission is holding two meetings, one for so-called VIPs in the Ottawa area and another for the public at large, to discuss 12 locations it has identified for the possible location of the Ottawa Civic Hospital.

To give background to members of the committee, normally we wouldn't be talking about the location of any particular hospital in a federal Commons committee as health care is a provincial jurisdiction. This is a very unique circumstance, however, because the previous government had allocated approximately 50 acres of land on the federal experimental farm, which is immediately across the street from the existing hospital campus.

Upon taking office, the Minister of Environment, Catherine McKenna, slammed the brakes on this decision and asked the hospital to go back to the drawing board and find a different location. The hospital then came up with four possibilities for situating its new campus. The minister was still not satisfied, so she has asked the heritage minister to task the NCC, the National Capital Commission, with finding a location that is suitable.

The NCC has since identified 12 possible sites where this hospital could be located. Most of the sites—

● (0910)

The Chair: I have to interrupt. I welcome you to the committee and it's nice to see you here, but I have to rule your motion out of order. This is not our jurisdiction at all whatsoever in any way. I know how strongly you feel about this, as I feel about my hospital in Amherst and everybody here feels about their own hospitals, but this is not something for us to deal with. My hospital can't be dealt with here. Your hospital can't be dealt with here.

It's simply out of order. I appreciate your—

Hon. Pierre Poilievre: I have a point of order, Mr. Chair.

The reality is that the committee is the master of its own domain and it can study whatever it chooses. As the committee's mandate on its website says, "The Standing Committee on Health may also study matters the Committee itself chooses to examine." If the committee decides that it's going to study this hospital or any hospital, it becomes in order.

I'd normally not bring a matter related to a particular hospital to a federal Commons committee. This is not a normal circumstance. We now have multiple federal ministers involved in the matter. We have a federal agency, the National Capital Commission, which is exclusively the mandate of the federal government, involved in identifying possible locations for this site. One of the locations proposed is Tunney's Pasture, which is, as you know, a hub for federal public servants. It's entirely federally owned land.

In other words, all of these matters are in the federal sphere. I wish they weren't, quite frankly. I think a lot of times local Ottawa residents wish that the federal government weren't so involved in localized decisions of this nature, and if that were the case, then I wouldn't be here today.

Mr. Chair, I can assure you, you being a very assertive representative for your area, if the federal government were involved in locating a hospital in your community, you would be at this table pounding your fist very aggressively and you would insist that it was in order. Fortunately, for most communities, the federal government is not involved in selecting a site location for a hospital. In my case, unfortunately, it is involved and, I would argue, far too involved. Because of that, it is appropriate that we, as a committee, study that question.

Why the health committee? Very simply, the facility in question is a hospital which is by definition a health care issue. I ask that we have a vote on the matter and if members agree with you that this hospital should not be studied in the health committee, then they can cast their vote accordingly, and if they agree with me that we ought to consider it, then we can work with your clerk to schedule times for hearings.

I'm not here to waste time. I'm not going to run out the clock; I know you have witnesses. All I'm asking for is a vote on my motion.

Thank you.

The Chair: I've made a ruling and I need to know whether the committee supports my ruling or not, so we're going to have a vote on my ruling.

Mr. Davies.

Do you have a hospital?

Mr. Don Davies: I do.

Mr. Chairman, I want to speak briefly to this, because from a matter of structure, I think Mr. Poilievre is correct that on this committee, we can study whatever we want. I think health care in Canada is a very complex issue, because, of course, it is split between the federal and provincial jurisdictions. I wouldn't want to support a ruling that would suggest this committee couldn't study something that may tie our hands in the future because it was within a local or provincial area.

I'm not going to be able to support your ruling. I'm not going to support his motion. As important as that issue may be to this local area, we have in front of us a study on pharmacare. We have passed motions on studying antimicrobial resistance, aboriginal health, community and home care, and now an opioid crisis, which we've just passed.

As important as Mr. Poilievre's issue may be about the location of a hospital in his area, those other issues have, in my respectful opinion, a far greater impact on Canadians. I just wanted to explain my reasoning. With great respect, I will be voting against the motion that we can't study it, but against the motion on the merits.

● (0915)

The Chair: Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Mr. Chair, for information purposes, and out of respect for the committee members and witnesses, I would like to know how the committee works.

I am wondering whether we are cheating the witnesses out of half an hour of their allotted time. We spend a great deal of time on finding good witnesses. However, we take time to pass or introduce resolutions. We could do that after the witnesses' question period, even if it means exceeding the normal duration of the meeting. That way we would not encroach on the witnesses' time.

I may be wrong. Perhaps a committee must work this way. However, if that's the case, I find it unfortunate.

I am currently speaking, but we should be speaking with the witnesses instead. The result is that we spend the first hour on resolutions that lead nowhere.

That's my comment. I would appreciate if you could inform me of the procedure.

[*English*]

The Chair: I couldn't agree with you more, but we have a process and rules, and we follow the process. Our plan was to hear from the witnesses first, then do our committee business after because we know some of the witnesses have already been bumped once. Out of respect, we wanted to do our witnesses first, but members have the right to raise issues and move motions.

I'm going to call a vote on my ruling.

(Ruling of the chair sustained)

The Chair: Sorry, Mr. Poilievre. We understand. I know you've been passionate about this for years, and I respect your bringing it forward.

Now we're going to hear from the witnesses.

Welcome to the committee. Some of you have been here before, so welcome back. To those who were bumped before, we're glad you're here to make a presentation to our committee on pharmacare.

We're going to hear from Mr. Keon from the Canadian Generic Pharmaceutical Association.

We're going to try to limit your remarks to five minutes so that we can have questions.

Mr. Jim Keon (President, Canadian Generic Pharmaceutical Association): Okay. I have a 10-minute presentation, but I'll cut it back.

The Chair: If you could tighten it up a little bit, we sure would appreciate it.

Mr. Jim Keon: I will do that, yes.

Thank you to the members of the committee for the opportunity to participate in the hearings today on the development of a national pharmacare program.

As was said, I am Jim Keon. I'm the president of the Canadian Generic Pharmaceutical Association.

[*Translation*]

CGPA is the national association that represents Canada's generic pharmaceutical industry. For more than 50 years, Canada's generic pharmaceutical industry has played a vital role in the country's healthcare system and its economy by providing safe, effective and proven alternatives to more expensive brand-name medicines.

Increasing access for patients and helping ensure the viability of drug plans—and, more generally, of the healthcare system—are key values of Canada's generic pharmaceutical industry.

To further gauge our contribution, some data provided by IMS Brogan is significant. In Canada, generic drugs are used to fill 69% of all prescriptions, but represent only 22% of the $26 billion spent each year on prescription drugs.

● (0920)

[*English*]

I will say a few words on national pharmacare. We believe that a national pharmacare program in Canada has the potential for improving prescription drug care in Canada for Canadians. CGPA would welcome the opportunity to play a key role in building a better prescription medicine coverage system for all Canadians. A national program could lead to better and more efficient decision-making regarding which drugs should be covered and how and when they should be prescribed.

There may also be savings by rationalizing the duplication caused by the varied formulary listing processes employed by each separate province and territory, which increase administrative costs for both drug plans and pharmaceutical manufacturers, and leads to uneven patient access and care across Canada.

I will add a few words on what we have been doing so far. I think it's important for the committee to know that in terms of sustainability and national coordination, CGPA and Canadian provincial governments, primarily, are already engaged in significant and direct actions that are yielding important results.

In 2010, Canada's provinces and territories established the pan-Canadian Pharmaceutical Alliance, or pCPA. All new brand drugs in Canada are now considered for national price negotiation through pCPA, and earlier this year on their website it was indicated that over 100 joint negotiations had been completed.

For the generic side, which I'm speaking to, participating jurisdictions, which now include the federal government and the federal government plans, and CGPA agreed to a national generic tiered pricing framework. As part of that pCPA-CGPA framework, beginning back in April 2013, 18 of the top-selling, high-volume generic prescription medicines had their prices reduced to 18% of the equivalent brand-name drugs. That saves the health care system more than $1.6 billion over the life of the agreement. These results are important given that the total annual or reimbursed generic prescription drug sales in Canada are only $5.5 billion out of the total spend of $26 billion.

I won't go through all of my comments.

A PMPRB-based study earlier this year indicated that the most effective way to save further would be to increase utilization of generic medicines. Not only has the pCPA-CGPA framework provided enormous savings to the Canadian health care system, it also has fostered greater pan-Canadian co-operation. Despite the strain on the generic pharmaceutical supply chain in Canada from the lower pricing, it has helped to bring much-needed stability and predictability for manufacturers attempting to bring cost-saving generics to the market.

Again, I will not go into detail, but I think some of the studies that we have seen on national pharmacare, in our view, provide unrealistic estimates of savings. As I said already, we have been negotiating with provinces on pricing, and now with the federal government drug plans, for several years, and unless you think that the provinces have done a very poor job, they're already getting prices that they've negotiated and feel are fair and just.

I will make a few closing remarks.

Due to the developments such as the pCPA-CGPA national generic tiered pricing framework, generic prescription medicines have never been of greater value. It's time for Canadians to fully capitalize on these lower prices by increasing utilization. As noted above, the PMPRB report, the “CompassRx” report, released last year confirmed that the most significant factor for controlling prescription drug costs in Canada would be to increase utilization. The use of generic medicines saved governments, employers, and patients nearly $15 billion last year. It is estimated that for every 1% increase in the use of generics, Canadians would save an extra $434 million. I said in my comments in French that the utilization in Canada now is at 69% of all prescriptions that are filled with generics. In the United States, it's 89%. We still have a long way to go to increase utilization and savings.

In closing, significant progress has been made through the pan-Canadian Pharmaceutical Alliance, specifically the pCPA-CGPA national generic tiered pricing framework. If a national pharmacare program is to be implemented, the generic pharmaceutical industry and generic prescription medicines will be key to its viability and sustainability. CGPA and its member companies remain committed to working cooperatively with all stakeholders to improve prescription drug coverage for Canadians.

Thank you for the opportunity to appear.

The Chair: Thank you very much for the presentation.

From BIOTECanada, we have Andrew Casey, president and chief executive officer, and no relation.

● (0925)

Mr. Andrew Casey (President and Chief Executive Officer, BIOTECanada): I'm glad you were able to clarify that, Mr. Chair.

The Chair: I bet.

[*Translation*]

Mr. Andrew Casey: Thank you Mr. Chair

On behalf of the BIOTECanada members, thank you to the committee for giving us the opportunity to speak today about these very important issues.

[*English*]

I'll briefly introduce our industry.

Biotechnology is a pretty broad envelope. It includes health biotechnology, but also for BIOTECanada we have members that are in the industrial, agricultural and environmental space. We'll focus uniquely on the health side today, but we do have members in the other parts of biotechnology.

On the health side, our members include many of the large multinational corporations that are brand names that everybody is familiar with across the country, but they are a very small percentage of our membership. The vast majority of our membership is comprised of small commercial companies that have a new innovation they're trying to commercialize. They're across the country in every province and are usually found in clusters that are centred around either hospitals or post-secondary university institutions. They are driving these innovations forward. They're driving the innovations forward for a world that's in a bit of trouble right now. Whether we're at 6.5 billion or 7 billion people, we're moving very quickly to 9 billion people. That's putting enormous pressure on the planet. It's changing our environment and we're dealing with a changed environment. We need to find solutions for those pressures that are being placed on the planet but, more importantly, for the pressures that are being placed on the people who reside on the planet. That's where biotechnology comes in. It's a solution to many of those challenges.

In the health space in particular, as we see with the emergence of new diseases across the world, we also see the growth of what we could consider traditional diseases, ones that we've been used to in the western world, that are emerging now in other countries. As their economies grow and they start to take on a more western-style diet, we're seeing similar diseases emerge there. Obesity, hypertension, diabetes, asthma, all of those we've been used to are starting to become prevalent in those countries as well. We have to find solutions for those.

We also have to take advantage of the fact that we can now map the human DNA. We know what the genome looks like and we have an ability to predict what sort of diseases are going to impact people, but also, we can come up with very specific cures for those challenges. That's an enormous opportunity. It's an enormous economic opportunity for Canada, because as a country we have a long-standing history of developing innovation in this space, from early days of vaccines, whether it's in the polio world, right through to developing solutions for other issues, including our contribution to the Ebola virus.

There's more to come. There's a great opportunity out there for this country, and we have, as I say, a long-standing history. We have a great set of institutions. We're developing great science and scientists who are moving these innovations forward.

I'll give you one example of an innovation. It comes out of New Brunswick. It is based on the saliva of the shrew, the lowly shrew that is a sort of little forest mouse. It has a paralytic quality in that saliva, and the paralytic quality is peptide. There's a professor out of UNB who has discovered there's an application there for a rare form of ovarian cancer. That's a remarkable development from something that seems so innocuous as a shrew out of the woods. But he has to get financing and partnership to move that forward and create a Canadian company, and that's the sort of membership we represent.

There's thousands of those out there across the world. Canada's not the only one developing these. We know there's more coming. There are great solutions. We're seeing solutions to what were once death sentences, whether it be in the world of AIDS or other afflictions, that are no longer death sentences. These are cures for many of these diseases, or at least prolonging life and turning them into simply chronic illnesses rather than a death sentence.

That's enormous innovation, but they do come with a cost. We're aware of that. We know the pressures that the provincial governments and the other payers are under. We think it's an important and timely opportunity to have this sort of study to figure out what those solutions can be to address it. At the end of the day, what we want to make sure of is that the solutions get to the patients. It's about health care. The industry absolutely stands ready to address those challenges with all the stakeholders, as Mr. Keon said. We do want to sit down. We think we can be an important part of the solution, driving this forward on behalf of all patients.

I'll leave it at that. Thank you very much, and I look forward to questions.

The Chair: Thank you very much.

Next we have Jessica Harris, vice-president of the Canadian Federation of Medical Students.

Were you here before, or were you bumped?

Ms. Jessica Harris (Vice-President, Government Affairs, Canadian Federation of Medical Students): I was bumped.

The Chair: I thought so. Welcome back.

Ms. Jessica Harris: Thank you.

Good morning, and thank you, Mr. Chair and committee members, for inviting me to speak with you as you explore the development of a national pharmacare program.

I'm a fourth year medical student at the University of Saskatchewan's College of Medicine, and I'm currently serving as the vice-president of government affairs for the Canadian Federation of Medical Students.

The CFMS represents over 8,000 medical students from 15 medical schools in Canada. In total there are 17, and the *Fédération médicale étudiante du Québec* represents the rest of those students. As the national voice of Canadian medical students, our mission at the CFMS is to connect, support, and represent our membership as we learn to serve patients and society.

The CFMS is grateful to be here to present our medical student perspective on the issue of pharmacare. It is our hope that in conjunction with other stakeholders we will be able to inform the body's final recommendations to Parliament.

Let it be known that the CFMS strongly recommends public universal single payer pharmaceutical insurance that will help our future patients to access the medications they need through an evidence-based and cost-effective system.

To highlight some of the problems with the current system, we've focused on the fragmented coverage and the exorbitant costs. Canada is the only nation in the Organization for Economic Cooperation and Development, OECD, with a universal health care system and no corresponding universal pharmaceutical coverage.

Outpatient pharmaceutical costs are covered by a combination of public, private, and out-of-pocket sources, and vary widely between regions and individuals. This fragmented system is financially untenable. Our annual rise in prescription drug expenditures is increasing faster than any other country in the OECD, and our medication prices are among the highest in the world, approximately 30% above the OECD average. Due to the relatively low proportion of public funding of pharmaceutical expenses, these costs come out of the pockets of your constituents and our future patients. Under the current state of affairs, one in 10 Canadians cannot afford their prescribed medications, with an even higher rate for low-income households.

As outpatient pharmaceutical therapy in many cases presents, replaces, or has come to complement the in-hospital treatment that our publicly funded system was created to cover, it's clear that a move toward covering outpatient pharmaceutical therapy is needed to keep our health care responsive to patient needs. Quality patient care does not stop at the hospital door, but ensures continuing care in the community.

For benefits that we see for pharmacare's access to medicines, the 2013 C.D. Howe Institute's report examined medication compliance in jurisdictions with different out-of-pocket costs and showed that a lower cost leads to a greater adherence to medication. By far the greatest compliance is in the U.K. and in the Netherlands where coverage is universal and copays are very low.

There is also safe and evidence-based prescribing that will come with pharmacare. Creating a national formulary of insured medications would help standardize practices and ensure that Canadians are being prescribed safe, effective, and evidence-based therapies from coast to coast to coast. It should be noted that best evidence prescription guidelines have cost-effectiveness as a key component in their creation. As such, covering necessary medications does not mean covering new and expensive drugs in most cases. Having a national pharmacare program would inform research aimed at improving prescription practices and ultimately would save costs.

On lower costs to the system, administrative costs of private health insurance amount to 15% of the total cost in Canada compared to 3.2% for publicly administered health care. Moving to a single payer system in Canada would save up to $1.3 billion, by some studies, abolishing the need for advertising in the private insurance market.

Another analysis showed that the government could expect the most likely base cost increase—and I know you've heard from Dr. Martin and Dr. Morgan—of about $1 billion, which the authors did not view as prohibitive to justifying a single payer pharmaceutical model. Employers and other providers of private medication coverage would save up to $8.2 billion according to the same recent analysis. In total, the net savings on prescription medication would decrease by $7.3 billion with that plan in the study from Morgan et al.

To highlight the medical learner perspective, and where the medical students are coming on this issue, we find that it's a cognitive dissonance that we have to reconcile the true state of access to medicines in this country with what we're taught in medical school. We're taught that in Canada all persons should have access to the care they need, that every life is equally precious, and that it's our role to treat patients in accordance with the most up-to-date principles of science and evidence.

● (0930)

However, as we move out of the classroom into the wards and into practice, we witness our professors and mentors spending hours fighting for patients, advocating for their access to needed medications. We also see that our future practice will in many cases be defined by something we are not really trained to do, which is trying to work around the system in order to ensure access for our patients.

What is worse is that the outcomes of these advocacy efforts are neither consistent nor sustainable. For every patient we are able to help, we know there are many we will not. This generates an added level of professional stress, which is not conducive to physician or system wellness and will ultimately impair our ability to deliver the quality care all patients deserve. A national pharmacare program would help mitigate these problems and allow us to focus on what is most important: treating our patients.

Personally, I recently had a disheartening experience. A patient I was seeing in clinic had not been in to see his physician for over two years, which is totally normal for a 40-year-old male. However, this patient is a type 2 diabetic and needs routine screening. I asked what was keeping him away for so long. The last time he had been in, he was going through a divorce. He had since lost his job and ultimately could not afford his medications. He was now back, two years later, with a job that covered his health expenses through the company's health insurance plan. As you can imagine, he had many negative consequences from two years of non-compliance with diabetes medication: weight gain, high cholesterol, vision problems, and the list goes on. The implications of that to the health care system in the future are something I haven't calculated, but I know it would be quite high.

Unfortunately, medical students hear stories like mine all too often, when we are on the wards, in our discussions with preceptors, and in conversations with our peers. It is difficult to reconcile the treatment protocol we learn in class, as learners, with what we are asked to practice in the community. We learn which medications have the best evidence for treatment, yet when we practice in the community, we must learn a new set of prescribing skills, which includes looking for the cheapest cost and the drugs that our patients can actually afford.

Our organization's position is that students across the country are passionate about the issue. For the past few years, our organization has chosen pharmacare to be the focus of our advocacy efforts. As many of you are aware, or I hope you are, we hold an annual lobby day on the Hill. Both in November 2014 and February 2016 we came to discuss pharmacare with the members.

Furthermore, we have launched a campaign called “Humans of Pharmacare,” where we are gathering ideas and stories from physicians, pharmacists, medical students, allied health professionals, and patients about how our current system is negatively impacting the quality of health care delivery.

In the spring of 2015, our organization passed a motion entitled “Pharmacare: Promoting Equitable Access to Medications”, which can be viewed in its entirety on our website. The four key recommendations from that paper are as follows:

Number one, the Government of Canada should establish an evidence-based national formulary of safe, efficacious, and cost-effective medications.

Number two, the Government of Canada or a pan-Canadian agency should support bulk purchasing for all medically necessary medications. Since that publication, the federal government has joined the pCPA. Although there is sure to be an increase in savings on top of the $490 million, with the federal government being a part of it, the pCPA is far from a perfect solution. Public insurance plans cover only 42% of national medication costs, and coordination between provinces is a complicated process. The pCPA has significant natural and logistical limitations as well. With the consolidation of a fragmented system of coverage into a single purchaser for the country, we can expect increased purchasing power to drive down prescription costs.

Number three, the Government of Canada should support the development of a public, universal, single-payer pharmaceutical insurance, as I highlighted at the beginning.

Number four is that we want to see collaboration between medical education stakeholders in Canada to ensure that the implementation of pharmacare is accompanied by renewed educational efforts for evidence-based prescribing, which is an important piece of this.

Our membership has spoken loud and clear. Pharmacare is important to the future physicians of this country, those of us who will be taking on writing prescriptions and treating patients in the years to come. Public, universal, single-payer pharmaceutical insurance is needed in Canada, and any other manifestation of the same would be a disservice to our patients and society. Pharmacare truly is the missing piece to Canada's universal health care system.

Thank you very much. We look forward to your recommendations.

● (0935)

The Chair: Thank you for making it back a second time.

Next, we have Jan Hux from the Canadian Diabetes Association. Fire away.

Dr. Jan Hux (Chief Science Officer, Canadian Diabetes Association): Thank you for the opportunity to speak with you today about a matter that touches us all, access to medicines for all Canadians.

I'm the chief science officer at the Canadian Diabetes Association, and I speak to you in that capacity, because having access to medicines is essential for more than three million Canadians who've been diagnosed with diabetes.

People with diabetes rely on medications to manage their disease and to achieve better health outcomes and quality of life. Unfortunately, not all of these patients have access to prescribed medication because of cost. This is problematic for the individual, their family, the health system that has to manage the health impact of poorly managed diabetes, and also to our society. We've become a country where access to essential medicines is determined by the place you live and how much money you have.

A survey in 2014 shows that 32% of people with diabetes took three to four drugs, 40% took five to nine drugs, and 12% took 10 or more medications. As you know, public coverage varies widely, depending on an individual's age, the amount and type of medication required, and their income. With private insurance such as employer insurance plans, drug access also varies considerably.

Hefty out-of-pocket costs can force people to have to choose between paying for food and rent or buying medication and supplies. People with low incomes but above the threshold for social assistance, those who work part-time, and those who are self-employed are the ones most impacted by out-of-pocket costs. We hear stories about people who have to make tough choices to pay for medication and the resulting impact that has on their physical and mental health and on their families. There are parents with type 2 diabetes who forgo their medication because their children need things like clothes and school supplies.

Drug costs are particularly difficult for chronic disease patients and those earning a low income. One study showed that 23% of people with chronic disease skipped medication due to cost compared to 10% in the overall population. In the diabetes population, our 2015 survey showed that 25% of people with diabetes reported that their adherence to prescribed therapies was impacted by cost. In another study, people with diabetes who lacked insurance were five times more likely to skip medication compared to those with insurance. Some individuals cut their dose in half just to make the medication last longer. The risk for medication non-adherence is greater for an asymptomatic condition like diabetes because, if the person skips the medicine today, they may not feel any different; however, over the long term, medication non-adherence increases the risk of the complications of diabetes such as blindness, amputation, and heart disease.

More and better treatments for diabetes have become available, and they are leading to better health outcomes for those who take them. Over the last two decades the rates of major complications of diabetes, such as heart attack, amputation, and stroke, have been cut in half, and that improvement is attributed almost entirely to the use of evidence-based therapies. Unfortunately, not all Canadians stand to benefit from these advances because they can't afford them.

There have been studies that have shown that a national pharmacare program or drug plan, one that replaces the current mix of public and private plans, could reduce public and private spending on prescription drugs. I'm not here today to advocate for a specific model, because there are benefits and costs to each of the different approaches, and these have not been clearly laid out for Canadians to understand. It is clear that getting people the medicines they need by removing cost barriers is something that resonates with Canadians.

This brings me to our first two recommendations: first, that the Government of Canada study the benefits and costs of various approaches to national pharmacare that would offer universal access to Canadians and publicly report on the results; and second, that the Government of Canada should adopt an approach to national pharmacare with a goal to reduce out-of-pocket costs for people with diabetes, to eliminate costs as a barrier to optimal drug therapy and better health outcomes.

It's critical that people with diabetes be active participants in the design, development, and implementation of a system that will ultimately be serving their medical needs. Patients must be at the centre of changes to the system. Our next recommendation is that people with diabetes be included as active participants in the development and implementation of the government's approach to national pharmacare.

● (0940)

As a clinician, I know that getting patients the right medication for their condition is partly the responsibility of the health care provider, so a national approach to pharmacare that is about improving access to needed medications should include supporting optimal clinical practice. One of the most effective ways to promote appropriate prescribing behaviour is with the assistance of proven technologies such as the electronic medical record.

Decision support tools encourage evidence-based prescribing by health care practitioners to help ensure individual patients receive the most clinically appropriate, safe, and cost-effective treatment for their disease. Providing health care practitioners with best practice information at the point of care to support their decision-making has been shown to improve outcomes, specifically for patients with diabetes. This support is an important component of leading the charge to ensure the right patients get the right drugs. So our final recommendation is that the Government of Canada take a leadership role in implementing support tools for diabetes management by incorporating electronic medical records into health systems within their jurisdiction and encouraging the provinces to do the same.

Again, thank you for your interest in this vitally important topic and for the invitation to speak with you. I look forward to our conversation.

● (0945)

The Chair: Thank you very much, to all of you. We appreciate your coming and spending some time with us.

Now we're going to go to questions. We're going to start with Mr. Oliver, for seven minutes.

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

I have to say that I quite regret that we weren't able to hear your full 10-minute presentations because of timing on the committee, but if you would consider submitting your remarks, I can absolutely assure you that I and my colleagues will read them quite faithfully to make sure we've heard your full comments. So thank you for that and thank you for what you represent.

My first question is for Mr. Casey. It's dealing with the affordability of immunotherapy and biologics associated with immunotherapy. There's a really good example, I think, that we've read about. Paul Henderson, our very famous hockey player, was diagnosed with a form of leukemia and the treatment was Imbruvica. I'm probably mispronouncing that. It was very successful, but the cost of that is about $100,000 per year, and that could continue for the rest of a person's life, depending upon the response to it.

The median individual income in Canada is around $27,600. Even for the highest one per cent of Canadians, the average income is $381,000. So we come to the amazing new treatments and drugs that will absolutely lead to return to health and ongoing life, and how we afford them. We've also heard that the employer-based private sector plans, because of some of the burden of these new drugs, are either cutting back the percentage that they'll cover or simply cutting pharma significantly out of their benefit plans for their employees.

It strikes me that either we embrace the new technologies and through a national pharmacare program look to how we share the costs of these treatments collectively, or we end up with a very small percentage of Canadians who can afford a private insurance plan that would provide coverage.

Do you have any reaction, any thoughts, on how we make these drugs affordable, and any reaction to my comments about pharmacare versus private plans?

Mr. Andrew Casey: Certainly you've touched on an important part of this, which is that these are new, are ground-breaking, are game-changers, and they're lifesavers. They're also expensive; there's no question. When you're in the biologics space, you're into a very different game. You require some fairly significant infrastructure to create the therapy, so there is an expense there. That's one part of the equation.

The other part, which I think we struggle with, is that this is presented in a very binary way, which is that it costs $100,000 a year for a patient, with no recognition of the cost if the patient didn't have the therapy available. It's not like you stop all health care treatment for patients if they're not able to get the therapy, so there is a cost. If a patient has leukemia or arthritis or diabetes, you look at long-term treatment costs to that patient and to the system as well, and without necessarily better outcomes, but there still is an expense. We have to take that into account as well.

That's not to say this is not going to put pressure on the system. There's no question it is putting pressure on the system. There have to be solutions. I think pharmacare presents some options. I have yet to see a distinct definition of what pharmacare actually is, so it's hard for me to provide you with exact comments as to what it would be and what it would entail. That's why the industry would like to be part of developing the solution process, because obviously, we're a big part of what needs to be addressed in terms of patient care.

Certainly, we would like to be at the table of whatever design that is, to make sure that we're doing it in the proper way, that we can contribute our expertise to it as well, and that also payers understand what's coming. There are more of these coming; there's no question. They're remarkable advancements.

Mr. John Oliver: Mr. Keon, where are generics in the biologics? In the recombinant DNA therapies and treatments, are the generics able to step into this space, or is this really not the generic companies' purview?

● (0950)

Mr. Jim Keon: That's an excellent question.

The follow-on biologic products are referred to as “biosimilars” or, currently in the Health Canada legislation, “subsequent-entry biologics”. They are entering the marketplace in Canada. We now have five products approved in Canada. There are generics for some of the most expensive treatments. For rheumatoid arthritis, there's now a generic, Remicade. Traditional generic companies are moving into that space. We have approvals from companies like Sandoz and Apotex, which are the large generic companies in Canada.

In that space as well we also have traditional brand-name originator companies like Merck, Pfizer, and Eli Lilly that are also developing biosimilars. That is a new area. It's very exciting.

To your comment earlier about the enormous costs of biologic drugs and complex medicines, they are tremendous medicines. I think everyone would like to see more competition in that sphere. One of the main ways to do it is through promoting biosimilars and certainly our sector is doing that.

Separately, we have formed a new organization called the Biosimilars Board, whose sole purpose is to increase the utilization and acceptance of biosimilars in Canada.

Mr. John Oliver: From other witnesses, one of the concerns we'd heard with a national pharmacare program is that the private plans tend to be more encompassing and the public plans tend to limit these kinds of new drugs, new technologies, new therapies. With biosimilars coming on in the generic industry, do you find that to be true, or do you think the national plans can accommodate these kinds of new technologies and new treatment modalities?

Mr. Jim Keon: This summer we went across Canada and met with all the large private payers, large insurance companies. One of the interesting things right now is that all the payers, whether public or private, are very anxious to see biosimilars in the marketplace. They're looking for them. They want to generate the competition, etc. But one of the things we found is a great deal of resistance right now from patient groups, prescriber groups. I think some of it, frankly, is fomented by some of the originator companies that have been selling these products for more than 20 years. They have created some concern about the biosimilars, but these are products approved by Health Canada as being similar and having no significant therapeutic differences between them and the originator products.

I think in terms of sales, biologics are now closing in on $6 billion a year spent in Canada. Biosimilars now have about $7 million, a tiny fraction. We're just at the beginning of the wave of biosimilar products coming into Canada.

The Chair: Ms. Harder, you have seven minutes.

Ms. Rachael Harder: Thank you so much for taking the time to be with us today and for being patient with us at the beginning of this meeting.

Jim, of the patients who use generic drugs, for what percentage is it successful?

Mr. Jim Keon: The success rate for generic drugs is identical to the success rate for the originator products. These products are approved by Health Canada as being equivalent.

When we do our testing, we have to demonstrate on patients that the product is absorbed at the same rate, at the same speed, and that the results are comparable, equivalent. The products have the same medicinal ingredients as the originator products. The only difference is that on some occasions the fillers and the non-medicinal ingredients can be different in the final medication, but there is absolutely strong, good, scientific clinical evidence that the generic products work exactly the same as the brand-name products.

Ms. Rachael Harder: I recently had a constituent whose daughter was taking a drug for epilepsy. It went off the market, and so she was prescribed a generic. The generic didn't even touch her daughter's condition. There are cases like that where generic drugs don't do the trick. I'm wondering, in what percentage of cases do generics not work effectively?

● (0955)

Mr. Jim Keon: One hundred per cent of the time they do work effectively. Health Canada would not approve them if they were not equivalent—

Ms. Rachael Harder: Okay, but this case study tells me otherwise. It did not touch this person's epilepsy.

Mr. Jim Keon: I can't comment on that case. All I can do is reassure you that Health Canada approved these drugs. Provincial drug programs—

Ms. Rachael Harder: I'm not saying whether or not they're approved, whether or not they work—

Mr. Jim Keon: —provincial drug programs review them, put them on the formulary, and pay for them because they work and are effective. Seven out of 10 prescriptions—

Ms. Rachael Harder: So 100% of patients are positively affected by generic drugs? They work for 100% of patients to take away the symptoms of their health concerns?

Mr. Jim Keon: Generic drugs are equivalent to the originator products.

Ms. Rachael Harder: You're not answering my question. You're skirting it.

Mr. Jim Keon: I cannot comment on this specific case.

Ms. Rachael Harder: Thank you.

Mr. Jim Keon: But they are equivalent. They are approved by the federal government and provincial governments, and all payers.

Ms. Rachael Harder: I understand that.

Mr. Jim Keon: Medical doctors and pharmacists trust them every day in Canada.

Ms. Rachael Harder: If we, as a country, were to go entirely to generic pharmaceuticals, would the condition of every single patient across this country be adequately cared for?

Mr. Jim Keon: That's not realistic. New medicines are very important, as Mr. Casey said. They are protected by patents for 20 years. During that time, generics cannot be sold. After patents expire, after companies have had an opportunity to recoup their investment and invest in new medicines, generics come on the market. They are approved by Health Canada. At that time, that's when I say generics should be used to the maximum possible.

The Chair: I think Mr. Casey has a comment.

Mr. Andrew Casey: Thank you, Mr. Chair. Thank you for the question, Ms. Harder.

I think your question points out something really important: it's not necessarily the therapy; it's the people. People are very complex. They react differently to different molecules, to different treatments.

Mr. Keon's point is correct. Health Canada regulates for safety and efficacy. In all cases, generic drugs are safe and efficacious. However, sometimes you put different therapies into different people and they react differently. That raises a very important point, one of subsequent entry biologics or the biosimilars. While, yes, they are all deemed safe and efficacious by Health Canada, they are very complex molecules and they will behave differently in different people. That's why the physician-patient dialogue is an extremely important one.

I cannot comment on the specifics of the case you mentioned, but I think that it would be one where you have to better understand what the physician is also seeing.

Ms. Rachael Harder: If we were to move toward a pharmacare program, I think the point I wish to make here is that oftentimes with a pharmacare program we end up using generic drugs because they tend to be cheaper. That's where governments tend to invest their money.

However, I think the point needs to be noted that often they're not as effective as other drugs. This means we are putting patients in a scenario where, yes, some of their drugs are going to be covered by a public plan, but they are still going to have to pay out-of-pocket when those generics are not effectively useful for them.

I'm not looking for a comment on that; I'm actually looking to let my statement stand.

My next question here would be with regard to BIOTECanada. I'd like you to comment on whether or not a pharmacare program would, in fact, advance innovation with regard to your industry.

Mr. Andrew Casey: It absolutely could; it depends on how it's designed. The complexity of our industry is one where you have small innovators that have a great idea and they're trying to move it forward, but they need partners. They need investors. A lot of those partners and investors come in the large multinational companies that are doing business here.

It's very easy to look at a drug and the cost of a drug and say you're going to cut it by *x*% because you know exactly, when you look at the ledger, what you're going to get in savings. In so doing, though, you also miss out on some of the other parts that are impacted by the industry.

As Mr. Keon points out, you cannot have a generic industry without the innovator industry. That's the key sort of relationship that needs to take place. You need those innovators to be healthy and contributing to the ecosystem that we have not only in Canada but around the world, because that is what will drive innovation forward.

The industry has fundamentally changed over the past decade. They used to try to do it all themselves. If you look at some of the companies, they used to do all the research, development—everything was in-house. They've now changed their model. They're going across the globe looking for those new innovations to fill the pipeline. They're finding it in the small companies that are in Canada, but also elsewhere.

That very interconnected relationship is very important to keep in mind when you're looking at something like a pharmacare program, because there will be consequences. As Ms. Hux pointed out, you have to weigh all of that to better understand what the impact is going to be.

Ms. Rachael Harder: In your estimation, then, Mr. Casey, how would we go about protecting those originator organizations in order to make sure that we do, in fact, have innovation taking place?

Mr. Andrew Casey: The system is in place to do that already. It's working in a very healthy way. On the small molecule side, you have the patent protection that allows the generics to come in. We're moving to the same sort of system for the complex biologics. That's already there.

In a pharmacare system, I think the challenge is going to be—and you were pointing this out in your remarks—that if you move uniquely to one type, whether it's a generic or you limit access to a number of different innovative medicines, you're creating a marketplace that's not competitive with other marketplaces. We're talking about a global marketplace. It's nice to think of Canada as a nice, comfortable place to be, but we're actually in a global marketplace.

Similarly, you can't go to Fort McMurray and get gas for 10¢ a litre. The reason for that is you buy gas in the global marketplace. This is not dissimilar. It's even more complex because we're not a commodity. We're an innovative product.

If you look at the therapy as a commodity and treat it as such, you will have negative implications for the innovative side writ large.

● (1000)

The Chair: Time's up.

Mr. Davies.

Mr. Don Davies: Thank you all for being with us here today.

Mr. Casey, I think you asked a profound question. You asked what we're talking about when we talk about pharmacare. I'm going to ask a general question, then. I'd like each of you to answer yes or no, and then I'll dig into it.

The evidence this committee has heard is that approximately 20% of Canadians don't have access to medicine they need when they're ill; about 10% have no coverage whatsoever, and another 10% of Canadians have such sporadic coverage as to effectively not have any at all. That's 7.5 million Canadians walking around our country today who cannot afford to buy the medicine they need to get well, even if it were prescribed by a doctor.

Do you support developing a system whereby every Canadian can get access to the medicine they need, regardless of their ability to pay?

Ms. Harris

Ms. Jessica Harris: Yes.

Mr. Andrew Casey: Absolutely.

Mr. Jim Keon: Yes.

Dr. Jan Hux: Yes.

Mr. Don Davies: Thank you.

Ms. Hux, in a statement released by the Canadian Diabetes Association in September 2015, you're quoted as saying:

> Over the last decade, complication rates from diabetes for major complications such as heart attack, amputation, and kidney failure have been cut in half. That improvement is almost entirely attributable to evidence-based medicines. Unfortunately, not all Canadians benefit from these advances.

I think you've elaborated on that today. In your view, what impact would a universal pharmacare program have on complication rates from diabetes?

Dr. Jan Hux: I'm not able to put a number to that, but certainly we know that the advances we've seen—66% reduction in heart attacks, 50% reduction in stroke and amputation—are due to the application of evidence-based therapies. We also know that people with diabetes won't take those medications if they can't afford them.

As I mentioned, many of the things we treat in diabetes are asymptomatic risk factors, like high cholesterol. A person in this condition feels no different if they skip their medication. If they're forced to choose between feeding their family and buying their statins, they will feed their family. The long-term consequences are the personal cost of amputation, blindness, heart attack, and the system cost of caring for those complications.

Mr. Don Davies: So it would be fair to say, without having numbers on it, just intuitively, that if we could expand coverage to make sure that all of those patients had access to the medication they needed, then logically, the number of complications these people experienced would be reduced.

Dr. Jan Hux: It would reduce the number of complications, yes.

Mr. Don Davies: Thank you.

Ms. Harris, in the CFMS briefing notes submitted to this committee, you described the contradiction between learning which medications have the best evidence for treatment and having to make prescribing decisions based on the patient's ability to pay. In your view, how frequently are doctors compelled to choose a suboptimal treatment because of their patient's inadequate prescription drug coverage?

Ms. Jessica Harris: I don't have a number on how often that happens, but it's very frequent. In Saskatchewan, in my personal experience, there's a drug coverage booklet, let's say, that gives the cost of each medication. You're often going back and looking to see which medication to choose. While they're all approved by Health Canada and all are evidence-based, not every one is the gold standard treatment for that medical condition. There's often a time when you're having to find a cheaper option.

A couple of weeks ago, I had a patient who had a gout attack. He was in quite a lot of pain, but he didn't have any coverage. He and his wife were both working, but his wife's drug plan was $300 a month and they couldn't afford it. When he had this gout attack and we prescribed the medication he needed, he was only able to take an ibuprofen that he had at home. He just didn't have any extra money between paycheques to go and buy the medication, even though it was $20 or $25 for the prescription.

You're working with patients on a daily basis to see what they can afford. I don't have a number for you, but it's very often.

● (1005)

Mr. Don Davies: It does happen. It's a real phenomenon.

Ms. Jessica Harris: Absolutely. It's a real phenomenon.

Mr. Don Davies: Thank you.

Mr. Keon, you've noted that, based on IMS Brogan data, only 59% of prescriptions dispensed and reimbursed by private drug coverage plans are generic drugs, compared with 74% in public drug plans. You've testified today, I think very logically, that it's desirable to increase the use of generic drugs. I think that would have good cost implications for our system.

What, in your view, accounts for the difference between public and private plans in the way they reimburse generic drugs?

Mr. Jim Keon: You're right that the utilization of generics in the private plans is lower. As you said, I think the benefit of generics is what we often refer to as headroom. If you save on the cost of older medications by using generics, you can then better afford the cost of some of the new medications. That's clearly what a lot of the programs do.

In Canada, we have a universal heath care system. Most employees are covered. If they're sick and they go to see a doctor, or if they have to go to the hospital, those costs are covered. If we compare that to the United States, those costs aren't covered. Often, the employee drug plans are part of a larger health care plan in the U. S. and much more expensive. I think, frankly, what we've seen is a more aggressive health management operation in the United States in the private plans. In Canada, some of the plans are not generic-only plans. In the public plan in Ontario, if a doctor writes “Lipitor”, and Lipitor is a genericized product, in all likelihood, the patient will get the generic atorvastatin at 18% of the cost, so they can fill five or six prescriptions. In many private plans, if Lipitor is prescribed, they pay for Lipitor, and simply don't require the generic. I think some of the private plans need to become more rigorous in enforcing generic-only plans.

Mr. Don Davies: Go ahead Mr. Casey.

The Chair: Your time is really tight.

Mr. Don Davies: Okay, I have a quick question.

Other countries in the world have universal pharmacare plans. Do you know how any of those countries that have universal prescription drug coverage deal with biologics and other sorts of innovative or expensive treatments?

Mr. Andrew Casey: You're entirely correct that other countries do have them. We've seen success in some, but some of them reduce their costs by just eliminating some of those therapies. They just say they're not going to pay for those therapies and take them right off, and the patients never get access to them. That's when I raise the issue that, however you define it or design it, the important part is how we design something that makes sure the patients are getting the treatments they need, but they're not limited to access.

You can limit access and save yourself a lot of money, just like I could say to you that I could save you a lot of money by telling you not to have any food in your fridge for a year. You'll save a lot of money, but there'll be consequences of not being able to eat for a year. It's the same thing when it comes to health care. If you are not getting access to certain therapies, there will be consequences to that, but you will save money though.

The Chair: Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you all for coming here, and sharing this valuable information.

As a diabetes educator, I know how untreated diabetes leads to other health problems, and it can cause a burden on the health care system.

My question is for Ms. Hux.

Can you talk more about costs associated with managing type 1 and type 2 diabetes? I heard a lot about the challenges of insulin and insulin pumps. In your view, how should it be designed to meet the needs of the general population?

Dr. Jan Hux: You're correct that the cost of managing type 1 diabetes is often very burdensome. Type 1 accounts for less than 10% of cases in Canada, and almost always onsets at a young age, and families are frequently burdened by these costs.

Not only is there that complication, but in a situation where an insulin pump is not publicly reimbursed, families are often forced to choose between an optimal therapy and a suboptimal therapy of frequent daily injections. Thanks in part to advocacy on our part, and insight on the part of government now, we do have pump programs in all provinces, but they have age restrictions in some provinces.

We see young people who have an opportunity to go for a great job internship in another province, but if they leave Ontario, they lose coverage for their pump and the crippling cost that would be involved may make it prohibitive. They're being asked to forgo a treatment that will give them excellent blood glucose coverage, and face the attendant threat of future loss of vision, kidney function, and amputation. It seems to us to be unfair to have that kind of patchwork system. The out-of-pocket costs can be very burdensome, especially for a new grad who's working in an internship or a poorly paid position. It can be thousands of dollars a year. Those costs in some cases can be shared by families, but when those individuals pass the limit for coverage on their parents' plan, that has to be borne differently, and it often leads to suboptimal choices.

I talked earlier about the fact that in type 2 diabetes, and particularly the management of risk factors for diabetes, patients are asymptomatic. In type 1 diabetes, insulin is a life-saving therapy. Skipping the medication will rapidly lead to potentially fatal consequences, and certainly a trip to the emergency department.

● (1010)

Ms. Sonia Sidhu: Thank you.

I want to echo Ms. Harris. I heard, especially in the diabetes population, that generic drugs are not working the same as brand-name drugs. I want to ask Ms. Harris about this, and after that, Ms. Hux.

Ms. Jessica Harris: Are you asking about my experience with generics?

Ms. Sonia Sidhu: Are generics working less well with the diabetes population?

Ms. Jessica Harris: As a medical student still, I'm not prescribing medications yet. We work with physicians and are involved in that management process. But as Mr. Keon mentioned, patients are using generics every day, Lipitor, atorvastatin. As evidence shows, generic medications are equivalent to brands. I haven't had the experience of a patient coming in and saying, “This generic medication isn't working for me”.

That's my experience. That hasn't happened.

Ms. Sonia Sidhu: Dr. Hux, just on the diabetes population and epilepsy patients.

Dr. Jan Hux: I would agree with Mr. Keon that, in order to be licensed, the drugs have to be proven to be equivalent. Why a patient's experience might differ, I cannot comment on an individual case.

For drugs to be licensed, we do randomized control trials in which hundreds of patients are randomly assigned to a treatment so we can know the changes that they experience are, in the end, due to the drug. If you only have one individual, you don't know what the trajectory of their illness would have been. Changes in their symptoms and experience may have occurred independent of the change of a drug. We rely on the research evidence that suggests these generic medications are equivalent. I'm certainly not aware of people having an inferior experience that can be directly attributed to the use of generic drugs.

Ms. Sonia Sidhu: I know there are other jurisdictions where insulin is declared a life-saving drug and anyone can access it. If a pharmacare program across Canada would do that, can you point to some other jurisdictions that have good insulin access?

Dr. Jan Hux: I am familiar with the notion of listing insulin as a life-saving drug and making it free, but I can't speak to the experience in specific jurisdictions that have done that.

Again, insulin is needed every day for someone with type 1 diabetes to avoid a fatal complication called diabetic ketoacidosis, as you know. Adequate doses of insulin are needed consistently to prevent long-term complications. So it's both short-term gets some, at least, and long-term gets adequate doses in order to forestall those long-term complications. Making access free would surely improve the appropriate and adequate utilization of insulin.

Ms. Sonia Sidhu: Thank you.

Can you describe the barriers people with diabetes face in accessing new drug treatment, cost being one, and are there any other barriers?

Dr. Jan Hux: In terms of accessing a new drug treatment, may I ask if you are meaning drugs that most recently come on the market?

Ms. Sonia Sidhu: Yes.

● (1015)

Dr. Jan Hux: Many of those drugs are not covered, and they're certainly not covered consistently. They'd be listed in some provinces and not in others. When they're not covered by the patient's individual insurance plan or a public plan, they'd need to pay out of pocket. These drugs are frequently expensive and that cost barrier would preclude those patients getting the benefit of those medications.

Ms. Sonia Sidhu: What costs associated with the management of type 1 and type 2 diabetes are covered by private health insurance plans?

Dr. Keon, can you enlighten us?

Mr. Jim Keon: This is probably a better question for someone else.

Dr. Jan Hux: Again, I think a recurring refrain from us is patchwork, that private plans also have inconsistent coverage, inconsistent levels of copayment. For instance, people are very vulnerable in making a job change if their current plan covers their devices, supplies, and medications. They may be reluctant to shift to a company that provides a better opportunity for them but doesn't offer the coverage they need.

The Chair: Thanks very much.

Now we're done the first round.

I want to ask a question of Mr. Keon. Mr. Keon, you said in your initial remarks that some of our testimony reflected unrealistic savings. Is that an observation, or do you have a study or anything that would help us?

Mr. Jim Keon: I think what I was referring to, and the witness from the medical students association also referred to it.... Already, as I said, over the past four years, on the generic side of the business, we have negotiated what's called a tiered pricing framework. When a product is more difficult to make and there's only one maker, the price may be higher. Where it comes down and there are many competitors, such as a popular drug like Lipitor for high cholesterol, the prices are very low. They're at 18% of the equivalent brand. You can fill five or six prescriptions.

The other thing about the tiered pricing framework is the private sector is not at the table, but they are covered by prices. Our prices are transparent. They're the same price for everybody. They are already getting the low prices. There is no difference in price between the public and private sectors.

I guess I would question how a national pharmacare program is going to reduce costs dramatically in the generic sector, for example, beyond what the provinces have already negotiated. There may be some further savings, and we're at the table discussing that.

On the brand-name side, there are confidential private listing agreements, which I don't think the researchers would have access to, which already provide further savings to payers. All I'm saying is these estimates appear to us to be wildly over-optimistic. Our view is if you're going to move forward with a national pharmacare plan, you do it because of patient access, because it's the right thing to do, and not because you think you're going to save billions of dollars. I do not think that is a realistic assumption going into this.

The Chair: Okay, but you just said it appears to you, so there's not a study or anything?

Mr. Jim Keon: Well, I'm telling you that we already negotiate.

The Chair: Okay.

Mr. Jim Keon: There is a study saying it was $7 billion. We criticized that study and do not accept the results of it.

The Chair: Okay.

On round two, we have Mr. Webber for five minutes.

Mr. Len Webber: Thank you, presenters, for your patience today. I apologize for belabouring some things, but I feel passionate about it. In any event, my question is for Mr. Casey.

I found your presentation very interesting, especially your comment on the new innovations, the saliva in the shrew. I find it fascinating that the saliva would be used for perhaps ovarian cancer treatment. My question for you, and perhaps for Mr. Keon as well is, do you think that experimental drugs should be part of a national pharmacare plan? If so, do you think there should be a limit on how much would be spent? How should that limit be set? Is that in your realm?

Mr. Andrew Casey: Perhaps you could define “experimental drugs”.

Mr. Len Webber: On experimental drugs, I go back to perhaps your example with regard to the saliva. It's going to advance and it's going to perhaps become a medication one day, hopefully, if it's positive. At that time, I guess it would be referred to as an experimental drug, as long as it passed Canadian health care requirements. Do you think an experimental drug should be part of a national pharmacare program if it's effective?

Mr. Andrew Casey: Sure, but just to be clear, by that time, and we're talking about probably in 10 to 15 years, it will have gone through a very rigorous testing process in labs where you use probably rats, but also then you have to go through clinical trials. There are three different phases of clinical trials in human beings to make sure these drugs are absolutely safe and efficacious for patients. Only then do you get approval from Health Canada. At that point in time, you then have a product that can actually be used for patients.

I wouldn't consider that to be experimental at that point, because by then you've done all the work on it, and you've made sure it's actually going to work and be safe for patients. Then you're talking about a novel therapy, in which case, yes, because it's addressing an unmet need. Obviously, it's addressing an affliction of a patient who is suffering. It could save a life, so, yes, any sort of pharmacare program should cover that therapy.

● (1020)

Mr. Len Webber: Technically, there really are no experimental drugs that would be....

Mr. Andrew Casey: The closest you come to experimental drugs is if you're enrolled in a clinical trial, in which you would be part of the process of discovering...but by the time it's being put into you, it's pretty much sure that it's going to be safe. The question is, what's the dosage and how much can the patient withstand?

Mr. Len Webber: Thank you.

Mr. Jim Keon: I endorse what Mr. Casey said, but there are circumstances in some cases where, for whatever reason, a company has not applied for approval of a drug in Canada, so it's not approved for sale in Canada, but it is approved elsewhere. Health Canada does have a program for exceptional circumstances where, if a physician is suggesting that this medication is needed, even if it's not approved in Canada, sometimes there can be opportunities to cover that medication.

Mr. Andrew Casey: If it has been approved. Usually the FDA or the European medical community has approved it as well. We're not talking eye of the newt type of stuff here.

Mr. Len Webber: Thank you.

I want to say to you, Ms. Hux, as well, that your presentation was interesting. I appreciate your coming up with recommendations for us. Your final comment was about how the federal government should take a leadership role with regard to a national electronic health records system.

Last spring we had a private member's bill regarding a national organ donor registry. It was defeated by the government. It didn't pass. The reason for it not passing was that they thought it would step into provincial jurisdiction. We've already heard here that a national pharmacare program would be a federal and provincial jurisdictional tug of war.

Do you anticipate any jurisdictional problems? Maybe I'll ask the entire panel here. The issue is jurisdiction between the federal government and the provinces, and such. Do you see a problem with a national pharmacare system being implemented and problems with the provinces?

Dr. Jan Hux: You began your question with respect to the electronic medical record. I may not have been complete in my remarks under the circumstances, but I suggested that an electronic medical record be implemented by the federal government for health care that is within its jurisdiction and that the provinces be urged to implement the same within their jurisdictions.

I think it is difficult to manage those jurisdictional issues. It's especially difficult when patients get caught in the crossfire of that and get suboptimal care because of jurisdictional issues. Nonetheless, we see tremendous promise in the electronic medical record for people with diabetes. The number of medications available for management of blood glucose alone in type 2 diabetes has quadrupled in the last 10 years, and it's difficult for physicians to always know which is the best treatment to offer for a specific patient in a specific circumstance.

Electronic medical record can queue that and can remind them that even though it looks like that might be the best medication, but because this patient has impaired kidney function, don't prescribe it. That improves the safety and effectiveness of drug treatment, and we feel that people with diabetes deserve to have that. Bolting it onto the pharmacare initiative would be an important way to support the implementation.

Mr. Len Webber: Thank you.

The Chair: Time's up.

Mr. Kang.

Mr. Darshan Singh Kang: I want to thank the panel for coming and appearing before the committee today.

My first question is for Mr. Jim Keon.

According to the Patented Medicine Prices Review Board, PMPRB, generic drug prices in Canada fell by 45% between 2010 and 2014. They continue to remain 19% higher than the international average. Why does Canada continue to have higher generic drug prices than other jurisdictions?

● (1025)

Mr. Jim Keon: Yes, the PMPRB report you refer to was from 2014. Since then, generic prices have continued to decline. You mentioned a 45% decline. The PMPRB reported that generic prices in Canada had declined more than in any other country.

I think if you take the current data, and include the fair comparison of the lower Canadian dollar than we had in 2014 with the further price reductions, then our prices now are competitive with prices across OECD countries. As I said, we are in ongoing dialogue with the provinces, and now the federal government plans as well, about what the fair price of medicines should be. We believe the prices are now equitable, and we will continue to sit down and negotiate what those prices should be in the future.

Mr. Darshan Singh Kang: My second question is about the effectiveness of generic drugs compared to brand-name drugs. Is it psychological? You said 100%, that generic drugs have 100% of the effect as the brand-name ones. I have come across...even my wife, she would rather go for the brand name, and me too. I have gone for the brand name. Patients have lots of concerns about using generic drugs compared to brand-name ones.

What role should there be for the generic manufacturers? Is it education? What could be done to...?

Mr. Jim Keon: There are, in all plans, even on the plans that specify they will only.... They're usually not called generic plans; they're called low-cost alternative plans. They will only pay for the low-cost alternative medicine. All of those plans have the ability for prescribers—doctors—to fill out and indicate adverse drug reactions. If their patient, for whatever reason, is not reacting well, they can indicate that. Most plans, if it's a recognized acceptable reason, will pay for a different medicine. That takes care of that.

In terms of the placebo effect, yes, that does occur sometimes. In the marketplace there are what are called “ultra-generics”, identical to the brand-name product, made from the same plant and sold as a generic, and the patient comes in and says it doesn't work as well. It's the same product; it's just stamped differently. If people believe it may not work as well, sometimes there's a concern.

As I said, I think that in terms of education we, the federal government, and Health Canada have a tremendous amount of material in terms of the way generics are approved. Again, 7 out of 10 prescriptions are filled with generics. Almost two million prescriptions a day are filled with generics in Canada. They do work well. Again, if there's a problem, then there is a system in place to allow a patient to switch to a different product.

Mr. Darshan Singh Kang: Has there been any study done on patients put on the same drug without their knowing who is taking the brand name and who is taking the generic?

Mr. Jim Keon: Yes, it happens all the time.

The way a generic is approved is called a double-blind study. Half of volunteers are given a brand medication and half of them are given the generic. Then the doctors and nurses study the reaction in the body to that. Then later, either that weekend or in the future, the same patients are given alternate drugs. They then, again, determine the reaction of the product. If they're determined to be equivalent, then they can be approved.

As I said, they are also subject to the same good clinical and manufacturing practices. These products are considered as safe and efficacious as their comparable originator products.

The Chair: Go ahead, Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): I want to thank all the witnesses for being here today. I want to throw out a few questions.

Mr. Keon, maybe you could start with the answers, because I do appreciate your institutional knowledge. I think you've been coming to this committee since I've been on it, on and off since 2004.

You made a comment that I think is really important. Why are we doing this, and how do we actually define the problem? We've heard from different people that some of the statistics we're relying on are from a Canadian standpoint and haven't even been really updated since the Romanow report.

A lot of assumptions are being made. I believe Mr. Davies repeated a couple of things we've heard over and over, that 20% of Canadians don't have adequate coverage. Yet we don't really know who defines adequate coverage. He mentioned seven million Canadians walking around without coverage; they can't afford the medicines they need. We do know there are a lot of Canadians out there who don't have coverage, but they don't seem to have a problem financially covering their medication, maybe because of different financial situations they find themselves in.

If you take a look at a long-term situation, and, as I said, some of these statistics have not been updated since the Romanow report, Canada has changed a lot. Employment benefit relationships have changed greatly. We have more people working part-time. We have pensions and pension benefits that have changed. We have more seniors, as a demographic moving into a situation where maybe they have coverage now because they're a little bit older.

I want your opinion and that of the rest of the panel. Do you think the federal government should update its statistics to ensure that we have an accurate picture of the current medical benefits situation in Canada?

Also, without recent statistical evidence, do you think our recommendations could be irrelevant, albeit well-intentioned? What are your thoughts on that?

● (1030)

Mr. Jim Keon: As an organization, as a sector, we actually support more harmonization across Canada. We think widely different programs for drug coverage are not good. If medications work well in one jurisdiction, they should be working just the same in others. We actually have recommended and supported moving toward more harmonized national formularies, what drugs are covered and what drugs aren't. As people have said, right now there's a real hodgepodge. We would support more harmonization there.

In terms of people not being covered, I mean there are, as you said, a variety of programs. There are private programs and public programs. If people are really desperate, there are often programs like the Trillium program in Ontario that can cover exceptionally high costs, etc.

Absolutely, I would agree with you that a really clear database and picture of who's covered and not and in what circumstances is necessary, but in general, we would support movement toward more comprehensive and harmonized coverage across Canada.

Mr. Colin Carrie: Does anybody else what to comment on statistical, like Mr. Casey and then Madam Hux?

Mr. Andrew Casey: You raised for our industry the most important question. Before we talk about what pharmacare is, we are designing something for a problem when we don't really know exactly what the problem is. Is it a coverage issue? Is it an access issue? Is it a combination of both? If somebody presents with the symptoms of a heart attack, you don't immediately cut them open and take a look at the heart. You try to figure out what really is going on in that person. We would do similarly. I think we should take a look and figure out what those numbers are.

The Romanow commission did a lot of great work, but that was almost 20 years ago. What do the statistics bear out? Where is the challenge? What is the opportunity here? Once we have a better handle as to what we are trying to address, then I think the solution will become a bit more evident.

Mr. Colin Carrie: Jan.

Dr. Jan Hux: Whether by research or by training, I'm never going to argue against the value of having better and more current information. However, I am confident that any study you would do would find that people living with diabetes face significant barriers to accessing their medication, just as Ms. Harris indicated. We did a study in 2015 asking people about their ability to access medication, and 23% of people living with diabetes said they couldn't take their medications as prescribed because they couldn't afford them. We know that diabetes is not an equal opportunity disease. It clusters in low-income communities, and so a disproportionate burden of this very expensive illness is borne by people who can't afford to manage it.

● (1035)

Mr. Colin Carrie: That's specifically for diabetes. I think what you said is absolutely true.

The Chair: Your time is up.

Mr. Colin Carrie: Darn. Okay.

The Chair: Dr. Eyolfson.

Mr. Doug Eyolfson: Thank you all for coming.

I have a very quick comment to Ms. Harris.

Thank you. I know how busy it is to be a medical student. I graduated in 1993, and for you to have the time to do this with your studies is a tremendous accomplishment.

Regarding the heartbreaking story that you told, I'll tell you that after 20 years of medical practice, you will see that on a weekly if not a daily basis depending on your practice, which is one of the reasons I am now in this new career.

In regard to diabetes, this is something I've been using in many of my examples, and again, from my practice. I practised emergency medicine in an inner-city hospital. There was a very poor population and a high number of aboriginal patients. We know the rate of diabetes in that population. I see the costs of non-compliance; they are acute. I know that people with severe DKA, diabetic ketoacidosis, will often end up in the intensive care unit, and we know how expensive that is. Then add in amputations, heart attacks, strokes, and dialysis.

I may be asking a question that has already come to you in a different way. Just in relation to this disease, if you look at what non-compliant patients, the ones who are non-compliant because they can't afford it, are costing the system in medical costs compared to what it would cost to make sure that everyone had their medication paid for by a universal system, would there be a balance? Would it still be costly to be supplying everyone with their insulin, or would that be more or less offset by these savings to the system?

Dr. Jan Hux: I don't have specific numbers to answer the question of whether paying for the drugs would be cheaper than paying for the complications, but we do have some really interesting evidence in regard to the benefit of universal access. Dr. Gillian Booth from St. Michael's Hospital in Toronto did a fascinating study where she looked at the benefit of turning 65 in Ontario. Generally, health outcomes are known to worsen after the age of 65, due to the impact of retirement and the change in lifestyle. However, what she looked at was the socio-economic gradient. For low-income people under the age of 65, many of whom can't afford their medication, there was a dramatically higher rate of complications, such as amputation, stroke, and heart attack. That gradient almost completely disappeared when people turned 65 and had access to universal coverage.

She has not completed it yet, but we have commissioned her to do an economic analysis to answer your question: would the cost savings from those adverse events outweigh the cost of paying for the medication? It is a great question.

Mr. Doug Eyolfson: Okay, thank you.

Mr. Keon, I appreciate what you are saying about whether we should be doing this because it is the right thing to do or because it would save money. I agree that we should be doing it because it is the right thing to do, to make sure that everyone can afford medication. As you say, if there is a case that we are not going to save a lot of money by the federal bulk buys versus the provincial bulk buys, the math may bear that out.

Do you think it is fair to say that we are looking at savings not because we are doing it to save money, but to show that the money we save in better outcomes might offset the costs of investing in that? Would it be a fair assumption that this would be one of the end points we should look for?

Mr. Jim Keon: As I said, we support the idea of all Canadians having access to the necessary medication. I think that is very important. As most people on the panel have said, it clearly does lead to savings elsewhere in the system. Again, our sector provides headroom for that so that new medications can be afforded.

I would make one comment on it, because there have been a few questions about quality and safety. The way drugs are approved in Canada is the same as the way they are approved in the United States by the Food and Drug Administration, and in Europe by the European Medicines Agency. Generic medicines are subject to the same standards. This is internationally accepted science.

After patents, our role is to provide protection for the new innovative medicines, which are often very expensive. Even the PMPRB has acknowledged that it hasn't always done a terrific job in controlling prices in Canada.

After the patents expire, you have good-quality medicines. The science is there. They should be used to help broaden access to medicines for all Canadians.

● (1040)

The Chair: Time is up.

Mr. Doug Eyolfson: I just want to reiterate that, from my medical experience and knowledge, I would not find a physician or a scientific publication that disagrees with you on that.

The Chair: Mr. Davies, you have three minutes.

Mr. Don Davies: Thank you.

The issue has come up about the very premise of this study, which is whether there are Canadians who do not have access to medicine. We have heard evidence of that impact.

Mr. Keon, I will start with you. You represent a major player in the pharmaceutical industry in Canada. Does your organization have any data or information to share with this committee on whether there are Canadians who can't afford their medicine?

Mr. Jim Keon: We have data on the utilization of medicines. Unfortunately, we do not have good data on people who don't take medicines and aren't covered. Our role in the system is to provide good, safe, quality medicines at good prices.

Mr. Don Davies: That is fair enough.

Mr. Casey, you are on the cutting edge of this. Are there people in Canada who can't get access, because of cost, to the kind of biologics and other innovative medicines that your industry is working on? Do you have any data to share with us on that? Is everybody getting the medicine they need?

Mr. Andrew Casey: I don't have any data. I would be hard pressed to come up with an answer to the question of whether everybody has access. I think that, for the most part, most do right now, but that is where the struggle is starting to happen. We start to see what is coming, and the payers recognize that they are barely managing the basket they have. How do they handle what is coming down the road? I think that is the challenge. I think that right now, generally, it feels like it's fine, but I think that what is coming is the bigger issue.

Mr. Don Davies: We have heard evidence that right now a lot of Canadians get whatever prescription coverage they have through their employers. Employer groups have testified here that many employers don't provide such coverage, or if they do provide such coverage, there are copayments and deductibles. In fact, a number of employers are struggling with the rising costs of these plans, and there is an increasing number of employers that are no longer providing prescription plans for their employees. There are spouses who are not working and live at home who may have only partial coverage through their spouse's coverage, and there are a lot of working Canadians who don't have any coverage at all. Does anybody dispute that?

Mr. Andrew Casey: I think it's a challenge. I'm an employer as well, obviously. We have people on staff and we go through a regular review with our insurance provider, and we see this challenge daily, even though we're only nine people, so I can only imagine what it's like for larger employers.

One point that I would mention as well is that there are some other drivers here. We've looked at it in a very narrow slice of treating somebody, keeping them out of the hospital, keeping the expense down, and saving the health care system. There is an important contribution to the employer as well. If you get individuals treated and get them back to work, the employer does benefit.

More importantly, what we do know about people is that if you are gainfully employed and contributing as an active employee, you're a healthier person generally. You feel like you're contributing to society and also, as a father, as a spouse, you're a better person at home. So there are a whole bunch of other parts to this that are very important to consider. I certainly know that employers and life and health insurance companies factor that into their decision-making; governments less so, for obvious reasons.

Mr. Don Davies: I have one quick question. The question of how we save money was raised. What's been identified at this committee so far is bulk buying, exclusive supply contracts, the savings from cost-related non-adherence, having a broad, independent national formulary, evidence-based prescribing, and streamlined administration. These are all features of national universal pharmacare plans that contribute to savings of money. In fact New Zealand—

The Chair: Make it a quick question, Mr. Davies.

Mr. Don Davies: Yes, I'll get to it.

The quote is:

> By tightly controlling the country's formulary, [New Zealand] has been able to keep costs flat while drug use has risen. One study found that New Zealand paid 51% less than British Columbia for four large, established classes of prescription drugs.

I would just put it to the witnesses that there are real-life examples in the world right now of universal national plans that are saving money because of those factors.

Mr. Andrew Casey: May I comment on that one? That's a great one. I would sound a note of caution when we're thinking about all of this and looking at other jurisdictions, because you're entirely correct, but one of the ways they've done that is limited access. Their formularies include fewer of the therapies.

● (1045)

Mr. Don Davies: Don't all formularies limit access to some degree?

Mr. Andrew Casey: Absolutely, but if you cut out 50% more than Canada does, you save. You just have to figure what that is. In your overarching comment, though, you did touch on the fact that it's an outcome. We need to look for better outcomes. There are a number of different ways to get there. We have to bring them all together so that the outcomes for the patients are better.

Mr. Don Davies: Thank you.

The Chair: The time's up.

Mr. Jim Keon: Mr. Chair, may I respond very quickly?

The Chair: Thank you very much to the panel. You certainly gave us a lot of good information to sort through, and again, if you have any other information you want to provide us, send it to us and we will digest it.

Thanks again. I hope you have a safe trip home.

Okay, crew, we need to have a little time for committee business. Next meeting we're going to set some time for committee business, because we have some to do.

We're going to restrict opening remarks for the guests to five minutes from now on. Is that okay with everybody?

That's it.

Everybody, we need proposed witnesses for the opioid study.

Mr. Webber, Ms. Harder, we need witnesses for the opioid study, so please submit them as soon as you can.

Ms. Rachael Harder: Would you like to put a deadline in place for that?

The Chair: How about Friday?

Ms. Rachael Harder: Okay.

The Chair: That's tomorrow.

The meeting is adjourned.