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Chair

Mr. Bill Casey

Standing Committee on Health

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● (0850)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Welcome to our presenters this morning. Welcome to our members. We're going to continue our study of a national pharmacare program.

This morning we have the Citizens' Reference Panel on Pharmacare. Peter MacLeod is the chair, and Jean-Pierre St-Onge is a member. We have, from the Heart and Stroke Foundation of Canada, Lesley James, senior manager of health policy. Here as an individual, we have Dr. Larry Lynd, professor of pharmaceutical sciences at the University of British Columbia.

We start with a 10-minute opening. Most presenters find that they go over that. If I'm waving at you, you'll know that you've hit your 10 minutes and that we would like you to wind it up.

We'll start with the Citizens' Reference Panel on Pharmacare and Mr. MacLeod.

Mr. Peter MacLeod (Chair, Citizens' Reference Panel on Pharmacare): Thank you, Mr. Chair, and good morning.

I'm delighted for the opportunity to appear before the committee to share with you a very special report, which is, in fact, being released today.

As the committee is well aware, expanding comprehensive prescription drug coverage to all Canadians has long been considered the unfinished business of our medicare system. Our patchwork approach, with one in five Canadians having either inadequate coverage or no coverage at all, makes Canada an outlier among OECD countries with comparable comprehensive universal health systems. While policy experts, clinicians, and pharmacare advocates have, for some time, encouraged government action, the voices and preferences of Canadians themselves have been difficult to hear.

The report I am presenting to you today provides unprecedented guidance from Canadians, and is directed to health ministers and policy-makers across Canada. I would like, in my remarks, to first review our process and recommendations, and then invite a member of the Citizens' Reference Panel, Monsieur Jean-Pierre St-Onge, from Dieppe, New Brunswick, to describe his experience as a participant.

The Citizens' Reference Panel on Pharmacare in Canada, which I chaired, was a substantive effort to provide Canadians with the information and context they would need to reach their own conclusions on the appropriate drug coverage model for Canada. Working under the supervision of an 11-member advisory and oversight committee that included some of the most respected clinicians and health policy leaders in the country, and with a research grant from the Canadian Institutes of Health Research, the Mindset Social Innovation Foundation, the Michael Smith Foundation for Health Research, and the Universities of Toronto and of British Columbia, we set out to convene 36 Canadians, giving them a very special opportunity to help shape health policy in Canada.

As with the many reference panels that have helped to influence public policy in Canada, 10,000 letters were randomly distributed by Canada Post to households across the country, far more than for a focus group or a town hall meeting. Each letter invited the recipient to volunteer to spend five days here in Ottawa. I'm pleased to report that at a time when we routinely underestimate the public's appetite to play an engaged role in public affairs, almost 400 Canadians volunteered, coming from every conceivable corner of the country and walk of life.

From among the respondents, 36 individuals were randomly selected, with one member, regrettably, withdrawing due to illness immediately before the start of the process. The members of the reference panel themselves, as I've said, were randomly selected, but in such a way as to mirror the Canadian population and the prevalence of drug coverage and personal expenditure.

I would refer the committee to page 10 of the report to see a map indicating their place of residence as well as the short biographies we have included. In short, we brought together a cross-section of Canadians, and working out of the Canadian Museum of History, with a commanding view of Parliament and that other body of citizen representatives here at the House of Commons, we began our work.

From Wednesday until Sunday, the members met and held lengthy, bilingual sessions often running from nine in the morning until nine at night. My facilitation team had prepared a detailed curriculum, and during our first days together we heard from 20 different speakers. These included clinicians, policy-makers, pharmaceutical manufacturers, insurers, patient representatives, and economists. Each was intended to add a critical perspective to the discussion.

For the members, it was a remarkable immersion in a difficult and nuanced policy field. These 35 people put everything else on hold for five days, without remuneration, in order to serve their fellow Canadians and provide the government with their best advice.

The question of drug coverage affects each panellist differently, and although they did not always agree with one another, they found a way to tackle these differences with enthusiasm and grace. Working together, the panellists identified nine issues, or areas of concern, which they recorded in their report. Among these concerns, they cited the following areas.

First, there is a patchwork approach that leaves millions of Canadians without the coverage they need, leading to poor patient outcomes and increased overall health care costs.

Second, there is weak purchasing power, leading to higher than necessary drug costs.

Third, there are inadequate data systems for monitoring the use and cost of prescription medicines.

The fourth concern was predatory pricing and patent extensions that drive up costs, with little transparency on the true research and development costs of new medicines.

● (0855)

Fifth is limited public awareness of this issue, leaving many Canadians to cope with inadequate coverage alone.

In response to these concerns, the panel issued a series of principles that they believe should guide policy-makers, as well as a set of detailed recommendations. The panellists named five principles: that any action uphold the principle of universality, that it be patient centred, be accountable to the public, be evidence based, and be sustainable.

Following extensive deliberations, the panel reached consensus and calls on the government to work with the provinces and territories to implement universal public coverage of medicines listed on a new national formulary. They recommend that this formulary be extensive enough to accommodate the full range of individual patient needs, including rare diseases. They also recommend that all covered drugs undergo a rigorous evaluation process to ensure both the efficacy and value for money of funded treatments.

Importantly, and as a first step towards a comprehensive public drug plan, the panel also calls on the government to move immediately to implement public coverage for a short list of basic, frequently prescribed drugs. This short list would begin the shift towards a comprehensive universal pharmacare system and become the basis for this new national formulary.

The panel also endorses an ongoing and valuable role for private insurers in providing supplemental coverage. Under any new system, employers, unions, and individuals could continue to purchase private insurance for medications not on the public formulary as well as other paramedical services.

Finally, the panel is not averse to the government funding the program through modest income and corporate tax increases, which they believe is the most fair approach. They also urge further consideration of copayment models, provided they do not create unreasonable barriers for low-income individuals.

To conclude, much as the health system is rightly focused on patient-centred care, it's my belief that federal legislation can only benefit from a more citizen-centred approach to policy-making. I hope you will recognize the members of the Citizens' Reference Panel on Pharmacare in Canada for their singular contribution to this important debate and the service they have provided on behalf of Canadians.

Let me now turn to a member of the panel, Jean-Pierre St-Onge, so that he can comment on his experience.

[*Translation*]

Mr. Jean-Pierre St-Onge (Member, Citizens' Reference Panel on Pharmacare): Thank you, Mr. MacLeod.

Mr. Chair, I'm honoured to appear before this committee today.

The letter I received really caught my attention in three areas, namely, the special opportunity, the assistance with creation and the cost of prescription drugs.

I spent my life working in the insurance and financial services sector. I'm aware of the insurance problems experienced by people who have a pre-existing condition. When they learn that their drugs are excluded, most decide not to obtain the drugs.

When I received a call telling me that I would be participating in the reference panel after I responded to the invitation, I was therefore pleased to note that the knowledge I'd acquired throughout my life would be useful for something, especially in the government.

On October 19 and the following day, the 20 experts mentioned by Mr. MacLeod overloaded us with information. However, we also had the chance to ask them questions. After two days, we were up to speed on the issue and we went to work.

I noticed that the group of participants showed a desire to help others. When people realize that problems exist, they seem to launch into finding solutions. The participants all contributed. We were divided into sub-groups, and we all shared information.

I was very impressed with the process. The ratio of men to women was 50/50. There were people from all walks of life, including young people and older people. There were people from different ethnic groups and different cultures, along with new Canadians. The diversity was incredible, and I was impressed with everyone's participation. We were guided by an experienced team. I must admit that I was impressed with the entire process. It was well planned.

We based our recommendations on core values. Our system needs to be updated. When we always use the same working methods, we obtain the same results.

We spent five days trying to find solutions. Other methods exist. Obviously, if we want to accomplish something in this area, decisions must be made. The status quo is no longer an option, because millions of Canadians are affected each day.

We're confident that our recommendations will help you achieve your goal.

● (0900)

[*English*]

The Chair: Thank you very much.

Now we'll go to the Heart and Stroke Foundation and Lesley James.

Ms. Lesley James (Senior Manager, Health Policy, Heart and Stroke Foundation of Canada): Thank you.

Mr. Chair, committee members, on behalf of the Heart and Stroke Foundation, I'd like to thank you for the opportunity to appear before you and to share our perspectives on the development of a national pharmacare program in Canada. My name is Lesley James, and I'm the senior manager of health policy with the Heart and Stroke Foundation.

First and foremost, I want to express gratitude to Parliament for recognizing the importance of this subject area. Access to medicine remains a vital challenge in the provision of quality health care throughout Canada. The issue of inequitable access to medicines and the need for a national solution have been key priorities of not only the Heart and Stroke Foundation, but also of the Health Charities Coalition of Canada, which is a collaborative group of 30 health organizations that the Heart and Stroke Foundation is proud to work with. Access to medicines impacts every health issue faced in Canada, with some common barriers across all conditions and unique challenges for individual diseases.

We are here today to discuss an issue that represents an ongoing gap in our universal health care system. As Canadians, we are extremely proud of our world-class system of care and its defining principles, which ensure all Canadians are able to access health care, regardless of their ability to pay or geography. We value these principles because they represent fairness and equity. Unfortunately, they don't extend to pharmaceuticals outside of the hospital.

Access to medicines remains an area of inequity, fragmentation, and systems failure, with 10% of Canadians being left behind. Without better drug coverage systems, Canadians truly do not have universal health coverage. Heart and Stroke believes there is much opportunity for improvement. We'd like to underscore that the first step for Canada is to continue to strengthen behaviour and lifestyle modifications at the population level, as a means of both preventing disease and managing heart and brain health. We thank the government, and specifically members of this committee, for their commitment and leadership around disease prevention through healthy living strategies. We need more in order to make it easier for Canadians to access healthy food, lead active lives, and remain smoke free, which will reduce their risk of chronic disease.

At the same time, the foundation recognizes that prescription drugs represent a very important component of treatment for a wide range of cardio and similar vascular conditions. When prescription drugs are used appropriately, they help to prevent disease, save lives, and improve quality of life. They can shorten time spent in hospitals and reduce demand for physician services, leading to decreased costs for the health care system in the long term.

While innovation in pharmaceuticals has led to medical breakthroughs and improved health status for many Canadians, our reliance on medicines has become greater, and many fear that the rising costs will be unsustainable for our system. Prescription drugs have risen from 6.3% in 1975 to 13.4% in 2014 of overall health care spending in Canada.

Our reliance on prescription drugs is clear, and it is not forecasted to diminish. Roughly half of Canadian adults take at least one prescription medication, while 15% take four or more. This means that in this room, at least five of you are taking one medication daily. Approximately 98% of Canadians with chronic diseases take at least one prescription drug, and 54% of Canadians with chronic conditions take four or more.

In 2014, Canadian pharmacies dispensed roughly 87,000 prescriptions for medications to treat cardiovascular disease. That's up 2.5% over the previous year, and it represents the highest dispensed category of medications in Canada. Prescription drugs, especially taken over an extended period of time, can be very expensive. Overall, while a majority of Canadians have some level of drug coverage, access to medicines is neither universal nor equal. In some cases, people go without recommended medications because they cannot afford them, and in other cases, purchasing the required medications puts them in serious financial difficulty. The next time you pick up a prescription medication from the pharmacy, take note of the initial cost and the cost after insurance benefits have been applied. You'll likely be very surprised by this difference.

Between 60% and 75% of Canadians are covered by private insurance plans, and between 9% and 43% qualify for government insurance, depending on their area of residence. Unfortunately, 3.4 million Canadians are either under-insured or not insured at all for out-of-hospital prescription drugs. In a survey of Canadians with comorbidities, with heart disease being one, 14% report having no insurance for necessary medications.

● (0905)

Access is a major issue, with more than one in five Canadians reporting difficulty paying for prescription medications without insurance coverage and one in 10 reporting difficulty even with insurance coverage. In 2010, 12% of Canadians reported paying more than $1,000 out of pocket for medical cost and 10% said that they did not fill their prescription or skipped doses as a result of the cost of their medication. Both of these figures depict Canada as much worse off than comparator countries.

Non-adherence to prescription drugs is extremely problematic and has been associated with significant increases in mortality, hospitalizations, and health care costs. These issues need to be addressed to ensure sustainability of our health care system.

Why are 10% of Canadians under-insured or not insured? Many do not have insurance because they are self-employed or working on contract or on part-time work. One-third of Canadians employed full time and three-quarters of part-time employees have no insurance for prescription medications. In addition, many drug plans provided by employers have maximum coverage thresholds and a limited range of therapeutic options, so even when they are covered by private insurance sometimes they find the options they need unavailable to them.

With the number of Canadians working part time increasing and many employers reducing drug coverage in insurance plans, fewer Canadians are covered for their necessary medications through their jobs. We need to do better for these underserved Canadians who are forced by circumstance to choose between putting food on the table and taking their medications.

The Canadian drug system does not provide equitable coverage between geographic regions. Drug availability differs among provinces because the country lacks a common formulary. Coverage of necessary and cost-effective essential medicines needs to be universal without geographic barriers.

Finally, we need to address the cost of medicines in Canada. While there has been some great cost-savings as a result of patent expirations and shifts toward generic use, research shows that generic drugs in Canada are more expensive than in foreign comparative markets, with only Switzerland outpricing Canada.

Recognizing the importance of drug access, the World Health Organization has declared that all countries are obliged to ensure equitable access to necessary medicines through universal health coverage. Canada is uniquely the only developed country with a universal health care system that does not cover prescription drugs. In 2012, the United Nations unanimously endorsed a resolution advising governments to ensure universal health access to quality health care without financial hardship, yet Canadians continue to experience such financial hardship around access to medicines.

It's time for Canada to fill a gap in our health care system and truly provide universal health care for all. The Heart and Stroke Foundation believes in the values of universality, equity, and equality in our health care system. All people living in Canada should have equitable and timely access to necessary prescription medications based on the best possible health outcomes rather than their ability to pay. The solution needs to be made in Canada, addressing our specific context and needs, while learning from the success of pharmacare programs elsewhere in the world. Building a national pharmacare plan will ultimately improve drug adherence, reduce the burden on the health system, and create a healthier, more productive population.

We call on the Government of Canada to take a leadership role in addressing the aforementioned issues, and we have a number of recommendations that can help move us forward. In particular, we recommend that, first, the Government of Canada create an advisory panel that would inform the development of comprehensive, evidence-based, and pan-Canadian pharmacare standards, which include universal and equitable access to essential medicines.

Second, we recommend that the federal, provincial, and territorial governments come together for collective negotiations to reduce the costs to the health care system and increase access to needed medications. Third, we recommend that the Government of Canada take a leadership role and share the cost of implementing pharmacare standards with the provinces, and fourth, that the health charities and the Canadians they represent be invited to participate in federal, provincial, and territorial consultations to support the development of pharmacare standards that meet the needs of all Canadians.

In conclusion, we are confident that in working together across sectors and levels of government, with the inclusion of the patient voice, we can create a drug system for Canada that is truly universal, equitable, and leaves no Canadian behind. The Heart and Stroke Foundation will continue to advocate for progress on this issue, and we are ready, willing, and able to work with the federal government and other health charities to ensure that Canadians of all backgrounds have access to affordable and necessary prescription drugs.

I thank you for your time today.

● (0910)

The Chair: Thank you.

Dr. Lynd, please, you have 10 minutes.

Professor Larry Lynd (Professor, Pharmaceutical Sciences, University of British Columbia, As an Individual): Good morning, Mr. Chair. Thank you very much for the invitation to speak with you today. Just by way of disclosure, I'm the principal investigator in a CIHR team grant evaluating policy and reimbursement decisions around rare disease. I'm also a member of the B.C. Ministry of Health advisory committee for expensive drugs for rare diseases.

I'm going to talk to you today about my perspective and my experience specifically around orphan drugs and rare diseases.

In my discussions with provincial payers, particularly in B.C. as that's where my experience is, they have raised four key areas of concern, particularly around evidence, price, access, and communication and transparency of decisions in general, and specifically as these relate to reimbursement decisions for drugs for rare diseases.

We are in the midst of a paradigm shift and really a disruption in drug development, where we're moving from the blockbuster model and biologics to more niche products, targeted products around orphan drugs and rare diseases. This disruption has resulted in exorbitant costs of many of these drugs for rare diseases, in the order of millions of dollars per year per patient, for lifelong treatment. Now, with others in the pipeline, we're seeing prices in the order of $2 million to $3 million potentially, and the cost just seems to be continually pushed higher.

With new technology and incentives, the number of drugs in the pipeline with potential orphan indications continues to increase, which is a good thing, offering new treatments for our patients, but which will obviously bring further pressures on our system. Given the costs, it's obviously not feasible for any Canadian to be expected to pay out of pocket for these drugs if they are not insured benefits. Therefore, I think we also need a bold paradigm shift or disruption in our policy and reimbursement decision-making.

Now in Canada we know we have the common drug review, and more recently, the pan-Canadian pharmaceutical alliance. The common drug review was implemented with the specific objective of providing evidence of value, efficiency, and consistency of evidence evaluation across the provinces. The pan-Canadian pharmaceutical alliance was initiated with the objective of having a strategy for collective negotiation on drug prices by the provinces following CDR review. The theory is that this would result in greater cross-country equity. However, such is not always the case. Even in cases where pricing and product listing agreements haven't been reached with pharmaceutical manufacturers by the pCPA, some provinces have chosen to fund some drugs, resulting in inequity of access.

In a recent study of 2,600 Canadians, we asked Canadians what they felt were the most important considerations related to funding of new drug therapies. The top five considerations were the effect of the drug on quality of life, the effect on length of life, the safety of the drug, the ability of the drug to really work, and the severity of the disease that it's meant to treat. Those were the top five related specifically to the drug and the disease.

The next most important factor, however, was equity of access for minority populations, and in a more recent study, we found that equity across provinces was also very important. So despite the common drug review and the pCPA, we know Canadians do not have equal access to all treatments. However, for common diseases or even cancers, there are generally alternative therapies such that most patients are not necessarily left completely untreated, notwithstanding some of the comments we just heard this morning about the ability to pay and about the ability to get coverage. This is specifically speaking about equity.

For many rare diseases, however, there is generally only one therapy. Thus with different coverage decisions across provinces, there is truly differential access to treatment. I'm not suggesting that all treatments should be available to all patients across all provinces, whether they be for a rare disease or a common disease, but that the development of a national pharmacare program would prevent this from happening. All patients in Canada would either get access or no patients would get access, based on a transparent, consistent, evidence-based decision-making process, thus, evidence-based equity of access across all provinces.

We already have evidence of such a program having worked for a rare disease, specifically Fabry disease, with the Canadian Fabry disease initiative or CFDI. This initiative was conceived due to the inability of Nova Scotia to pay, given the high prevalence of Fabry disease in that province.

● (0915)

This is an initiative that, as I understand it, was initially funded as a partnership among provinces, the federal government, and the pharmaceutical industry, with two primary components: drug procurement for the entire country and data evaluation, data collection, and the development of a patient registry. As a result, we have an example of equal access. Only eligible patients receive treatment, based on guidelines and excellent data on the treatment effects and the natural history of Fabry disease, which contributes significantly to reducing the trepidation and uncertainty around treatment coverage decisions.

This initiative, I believe, could act as a model for other rare diseases as part of a national pharmaceutical strategy, given that this model provides a data collection platform to inform research, evaluation, and decision-making and supports evidence-based decision-making. It supported procurement and pricing negotiations. Also, in this environment, I think it could provide an opportunity for notice of compliance with conditions or reimbursement with evidence development, which we know lots of people are talking about but which we really haven't seen implemented in any situation yet.

This also speaks to what is included in the proposed Canadian orphan drug framework, specifically a post-marketing authorization plan, which I feel is imperative, given the limited evidence on the efficacy of these drugs when being reviewed for market authorization. Although I have been skeptical about how this could occur in the current regulatory and reimbursement environment, given the separation between federal and provincial responsibilities, a national strategy with an active post-marketing authorization pharmacovigilance plan would provide a framework that supports the growth of the evidence base. Economies of scale of a single system could be implemented across multiple rare diseases, resulting in system efficiencies. It could also provide a framework or a platform for international collaboration, and of course a national platform for price negotiation.

In closing, a national strategy for reimbursement, which could be the start of a national pharmacare strategy, would support equity of access or non-access, depending upon the evidence; system efficiencies on multiple levels; and potential earlier access to therapy for patients, given in an environment to support notice of compliance with conditions or reimbursement with evidence generation. It would support evidence-based, consistent reimbursement policy and decision-making, spending only where spending is warranted, and improved transparency and communication around systems and reimbursement decisions.

I would like to thank you, once again, for inviting me, and I hope I have provided you with some insightful comments for your deliberations.

● (0920)

The Chair: Thank you very much to all the presenters. I am sure we have a lot of questions for you.

We are going to start our first round of questions with Mr. Erskine-Smith, for seven minutes.

Mr. Nathaniel Erskine-Smith (Beaches—East York, Lib.): Thank you very much.

I have only a couple of questions, and then I'll split my time with Doug.

As we, hopefully, move towards a universal pharmacare plan, we talk about improved access to drugs but also actually saving on drug expenditures. If we can hit both of those goals, it seems like a good idea to me, but we are not going to get there tomorrow.

Can you lay out the first steps the government ought to take in moving forward with establishing a national pharmacare plan? I've read a lot about national formularies, for example. Can you lay out one or two key first steps for the government to take to move forward with this initiative?

Prof. Larry Lynd: Sure. I'll start.

This is the area I am most familiar with. I propose this as—for want of a better term—an area of low-hanging fruit, where we have a model, which wasn't perfect, in the CFDI. I think that does provide a really good starting point for a model to be built specifically around orphan drugs for rare diseases and maybe to start to target the groups that are most at risk and have the highest impact, and then continue to incrementally build from there.

I think there are some other good recommendations in other reports, as well, to go more global about starting with a smaller common formulary. I think we are all cognizant of the difficulties of going large initially. This is what I would perceive as some initial, early quick wins, to see if it might work.

Mr. Nathaniel Erskine-Smith: Are there any other comments?

Mr. Peter MacLeod: It was certainly a matter of concern for the panel. Frequently, members would ask what the timeline would be for potential reforms and how long it might take. They would urge the government to act as quickly as possible. That's really the rationale for their immediate action or urgent first step concerning this smaller, basic list of medicines. I think that would be a significant down payment towards a comprehensive system.

Ms. Lesley James: I think it needs to be a phased approach. We're not going to solve this in a short time frame. Creating a vision with defining principles that we're striving to work towards is important. The consultation piece is very important too, so that's getting the patient voice and learning what Canadians want, because our context is very different.

We also need to learn from other countries that have gone this route and figure out what might work in Canada and what might not. I see this as a short-, medium-, and long-term approach that ultimately gets towards those defining principles that we've all commonly addressed.

Mr. Nathaniel Erskine-Smith: You read about the billions of dollars that can be saved on the consumer side, if such a program were implemented. It's unclear to me exactly how much this would cost the government up front. If there are savings on the consumer side that overwhelm the upfront costs on the government side.... One study out of UBC said you could save up to $8 billion, I think, on the consumer side.

When other countries have gone down this road or when we look at Canada going down this road, to ensure that we don't have red on our balance sheet for a long time, given the upfront savings for consumers, is there a way that other countries have actually captured some of those consumer savings and shared the savings between government and the consumer, to make sure we stay in the black but that overall there are savings?

Prof. Larry Lynd: I do not know the answer to that or what other countries have done. I know there's evidence on both sides. We know Steve's paper says there will be $8 million in savings, and we've seen other evidence saying that it's maybe not quite so much.

I know there's a debate about what those savings will truly be. I absolutely appreciate the implementation costs and the development. That's why I think this incremental development and implementation is going to be really key because I don't know that there's an answer, in terms of the absolute savings and the outcomes.

Mr. Nathaniel Erskine-Smith: I don't know if any of you have any other comments about how government can perhaps share in some of the savings at the end of the day.

Mr. Peter MacLeod: I might just add briefly that, of course, the committee appreciates that there is ultimately only one payer, and I think it was most persuasive to the panel that a public approach would mean greater economic efficiency in our ability to purchase and provide these medicines.

Mr. Nathaniel Erskine-Smith: Doug, I'll pass it over to you.

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

Thank you all for coming.

My first question is for Mr. St-Onge. You were talking about private drug plans and you made mention of pre-existing conditions. Are you aware of the prevalence of people on employee-sponsored drug plans being denied coverage due to pre-existing conditions?

● (0925)

Mr. Jean-Pierre St-Onge: That's the beauty of a group. They don't select by individual. My statement was that it's individual people that won't.... A group will cover everyone. Does that answer your question?

Mr. Doug Eyolfson: I was thinking more about whether you knew about trends. In your discussions—maybe, Mr. MacLeod, you might know the answer to this—was there discussion about that among the group of people?

Mr. Jean-Pierre St-Onge: No. That was my background that I was bringing to the table.

Mr. Doug Eyolfson: Sure. Yes.

Mr. Jean-Pierre St-Onge: I thought that awareness raised the—

Mr. Doug Eyolfson: Sure. Okay.

Mr. Peter MacLeod: For members of the panel, I think the greater concern, as reported to them by members of the insurance industry, was the consequences, especially with small businesses that have small group plans and one employee who then develops a rare disease. Very quickly, the cost of providing those medicines swamp that business's ability to sustain that private insurance.

That is definitely a major concern and I think it's one echoed widely across the small business community and among insurers.

Mr. Doug Eyolfson: Thank you.

Ms. James, you mentioned that, particularly with cardiovascular medications, there are costs due to non-compliance. A person's morbidity and mortality are higher when they are not taking their meds. Through the Heart and Stroke Foundation of Canada, are you aware of any overall societal costs, like costs to the medical system, or how much a year it is costing our system for people who are not taking their medications?

Ms. Lesley James: I don't know that figure but there have been studies in Canada and elsewhere in the world, showing that issues with cost quite often lead to non-adherence, which then increases the risk for patients presenting with heart attacks in emergency departments.

We are seeing that, over the long term, the cost of treating cardiovascular disease in the health care system is more costly than it would be to get them on hypertension medication or whatever it needs to be.

Mr. Doug Eyolfson: Thank you.

The Chair: Your time is up.

Ms. Harder.

Ms. Rachael Harder (Lethbridge, CPC): Thank you very much.

My first question goes to Mr. MacLeod. Mr. MacLeod, you said that this group of individuals who sat on this panel was randomly selected. They seem to be a pretty knowledgeable group if they were able to come up with these recommendations. Can you please explain to me how the random selection was done?

Mr. Peter MacLeod: Absolutely. It's a process called a civic lottery and it's been used to select members for almost 30 panels across the country at the municipal, regional, and national level. More than 1,000 Canadians, at this point, have been selected, and one in 60 households in Canada received similar invitations to participate: serving on panels, examining health issues like supervised injection sites, but also on municipal planning issues concerning mass transit.

In this case, there were I believe 378 volunteers. They were then entered into a database and it was done in such a way that effectively we were blind to the outcomes of it. We know what the demographics of the Canadian population are, so effectively a computer algorithm sorts through all of those applicants and then randomly selects the series of attributes—the gender, the age, the geography—and in this case we were also looking for what their annual out-of-pocket expenditure was on medicines, and we were also looking at whether or not they had drug coverage.

From that composite of attributes, we would then blindly identify a series of candidates who fit that profile, and from among those candidates, again blindly, one name would be selected. Then they would be contacted and invited to serve.

Ms. Rachael Harder: Okay, thank you.

I've been studying pharmacare on this committee for quite some time now. The terminology used within this report, I would say, is about my level and I'm about six to eight months into this study. Now, these folks were only together for five days, so tell me a little about how their discussion was driven in order to come up with the recommendations here. Were they presented with all sides of the argument? Were they presented with what it might look like to advance our private health care system as well as continuing forward with a public health care system, or was just one side of the coin presented to them?

● (0930)

Mr. Peter MacLeod: Certainly that was a concern for the conveners of this process. That's why we have an 11-member advisory committee. Their names are contained in the appendix of the report. We had lengthy discussions about how we could, to the best of our ability, create a balanced curriculum so that among those 20 invited guest speakers there would be a range of perspectives provided.

I'll leave it to my colleague, a member of the panel, to explain his sense of the fairness and balance of the process. But I would also suggest that, given five full days where you're really in the thick of it with people, with the benefit of all these materials in front of you, frankly, I think we underestimate the capacity of the public to play a more sophisticated and informed role in policy-making.

It's important to note that the report is really in two halves. We wrote the blue pages, but the white pages were exclusively the words of the panel members.

Ms. Rachael Harder: Thank you.

My next question, then, is going to the Heart and Stroke Foundation, to Ms. James.

You described the fact that prescription drug use, of course, has increased quite drastically over the years in Canada. Can you comment as to why we're seeing that increase in prescription drug use?

Ms. Lesley James: I think prescription drug use is increasing throughout the world and it is not unique to Canada. It's increasing in cost and it's an increasing proportion of our health care spending. That's the concern for the Heart and Stroke Foundation.

Ms. Rachael Harder: Thank you, but why?

Ms. Lesley James: I can't speak to that. I think that's a clinical question.

Ms. Rachael Harder: Okay.

In your estimation you said there are a number of other countries that you've looked at that are doing a national pharmacare program. Which country is doing it the best?

Ms. Lesley James: I don't want to say which one is doing it the best and which one is doing it the worst. I think what would work for Canada is looking at our needs and our context, considering the fact that we do have private insurance already.

I think the U.K. has an interesting model where there is coverage of prescription medication available to all people, as well as private insurance available as a top-up. Perhaps that's worth looking into in Canada because it's a quite similar context.

Ms. Rachael Harder: In your estimation then, should we also protect private insurers as well as public?

Ms. Lesley James: I think there needs to be a balance in Canada. Given that we've had this system in place for so long, there needs to be consultation to see what would work best going forward.

Ms. Rachael Harder: Okay.

Your reason for drawing attention to the U.K. is the fact that they've preserved their private system in addition, or as a "top-up", which were the words you used, to the public system. I'm hearing you say that's a positive thing.

Ms. Lesley James: I'm speaking as an individual. I studied part time in the U.K. I think it's quite wonderful that you access all medications without major service charges to individuals. There is an option to top-up with private insurance through employers.

Ms. Rachael Harder: Do you see any disadvantages to the U.K. system?

Ms. Lesley James: Not that I'm aware of, no.

Ms. Rachael Harder: Mr. Lynd, I'd be interested in asking you the same question.

If you were to look at the international context, other countries that have a universal pharmaceutical system, what would your observations be? What country is doing it well and we can learn from?

Prof. Larry Lynd: I'm going to speak about the orphan drug environment because that's where I've worked the most. We had a study done out of Ottawa that actually looked at orphan drug or rare disease drug decision-making internationally. What's interesting is that lots of countries have processes, but we haven't been able to.... They have at least frameworks in place to support decision-making, much as we have in British Columbia—

Ms. Rachael Harder: I'm sorry, Mr. Lynd. We are short on time. We have about 20 seconds.

Could you draw on a specific country, please?

Prof. Larry Lynd: No, I cannot. I'm afraid nobody has a really good process in place.

Ms. Rachael Harder: Okay, thank you.

The Chair: Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair.

Thank you to all the witnesses for being here today.

Mr. MacLeod, I want to quote from the preamble to your report. The report states:

> There is an urgency behind our recommendations, and action needs to be taken immediately. People are suffering and dying, as our current system does not meet their needs. Our population is aging, and new needs are emerging. We have to look out for all Canadians, young and old, regardless of socioeconomic status....
>
> We, as a panel, expect our federal, provincial, and territorial political representatives to listen to and review our advice.

Given that we have three years left in the current federal government's mandate, with the next election in 2019—it being 2016—would you recommend that this federal government, this Parliament, act on the recommendations?

● (0935)

Mr. Peter MacLeod: I certainly believe it was the intent of the members of the panel to signal to government that they expected action within this term of Parliament.

Mr. Don Davies: Thank you.

I'm going to move to the first step that is recommended by the panel. The panel calls on the government to move immediately to implement public coverage for a short list of basic, frequently prescribed drugs. I think you called it a down payment on the national comprehensive formulary that you ultimately recommend.

Can you expand a little on that for this committee? How many drugs are you contemplating, and what kinds of drugs do you think this government can act on immediately to provide national coverage for Canadians now?

Mr. Peter MacLeod: The idea of a basic list is an evolving concept. Typically, we're talking about between 100 and 200 medications that, to the best of my understanding, make up about 40% to 50% of prescriptions. These drugs are often used to treat chronic illness, and often they prove to be quite costly to those people without insurance. Those who are in precarious employment, those without coverage, those who are low income, perhaps, stand to benefit the most from a basic list. Of course, it would also begin to normalize the idea of public insurance for all Canadians.

In a sense, it's your biggest bang for the buck in terms of health equity and health outcomes.

Mr. Don Davies: Give us a couple of examples of what kinds of prescription medications you're talking about there.

Mr. Peter MacLeod: I have to be careful; obviously, I'm not a physician nor a pharmacist.

However, these would be to treat normal chronic conditions, which might include hypertension or gastrointestinal issues. These are commonplace medicines that physicians, and certainly patients, would be very familiar with.

Mr. Don Davies: To be clear, the only prescription I'm asking for here is the policy one.

Mr. Peter MacLeod: Thank you.

Mr. Don Davies: Your panel recommended ultimately broadening the system to a universal public coverage of medicines listed on a new national formulary. You recommended that this formulary be extensive enough to accommodate the full range of individual patient needs, including rare diseases.

I also note that the principles identified by the panel either are the same principles or a mirror or are compatible with the principles under the Canada Health Act.

I am curious about your views on whether the panel would like to see the creation of a national public insurance system as a standalone system, with a national formulary administered on its own, or whether it sees an expansion of insured services under the Canada Health Act, under the present system of delivery. Or is there any big difference between the two?

Mr. Peter MacLeod: I'm not sure if there's a significant difference between the two. I know it was the intention of the panel to see that any new regime would be operated at some arm's length from political pressure so that it could be an evidence-based system that was directly accountable to Canadians both as patients and as taxpayers.

I think it's important, however, that any new public insurance plan reflects the intent and spirit of the Canada Health Act, and I think members of the panel were surprised to see that our existing patchwork approach is not consistent with those principles. Perhaps, besides universality, the key concern was the degree of variability that exists across the country. That's why, in working with the provinces and the territories, they call for national federal action.

Mr. Don Davies: Mr. MacLeod, I've already quoted language from your report, some pretty tough language that "People are suffering and dying" under the current system.

Ms. James, is it your organization's experience that under the current patchwork system where people are not necessarily covered, people are dying in Canada because of an inability to access prescription drugs?

● (0940)

Ms. Lesley James: I did mention examples of people unable to access necessary and basic prescriptions for cardiovascular disease who skipped doses or are not adherent and that results in increased rates of heart attack presentation in emergency rooms.

We've been able to reduce the risk of mortality associated with heart attacks, but many people don't make it unfortunately, and that could be prevented with better access for all Canadians to preventive prescription medications.

Mr. Don Davies: Is morbidity a consequence of this gap?

Ms. Lesley James: Yes. Both morbidity and mortality are.

Mr. Don Davies: Thank you.

Mr. MacLeod, researchers estimated before this committee and otherwise that overall savings in Canada could be achieved by a national universal pharmacare program in the nature of $4 billion to $11 billion annually, depending on the structure of the system and the parameters adopted.

According to your report, an expert panel I think urged a more conservative view of cost savings achieved through universal pharmacare. Was the reference panel still in favour of a national universal pharmacare program if it achieves universal coverage but results in no overall cost savings to government for pharmaceuticals? Should we proceed anyway?

Mr. Peter MacLeod: I want to be careful in not speaking beyond the text of their report. My understanding of their intentions was that improving health outcomes and addressing fiscal inequities for Canadians probably superseded other concerns.

The Chair: Your time's up.

Mr. Kang.

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

I want to thank the panel members for appearing before the committee today.

Mr. MacLeod, your recommendation is that:

> This national pharmacare system should be provided through public insurance. This will ensure all Canadians have the same access to pharmaceutical coverage. It will unify buying power.... A public insurance system should...be accountable to Canadians through an arm's-length agency free from any profit-motive.

In the next paragraph you say, "This system must also allow individuals and employers to continue to purchase optional private drug insurance."

When we have national pharmacare that is going to cover all Canadians, why do we need any private drug insurance? If national pharmacare is going to leave the door open for companies, what role do you see for private insurance?

Mr. Peter MacLeod: Thank you. That's an excellent question.

It was not the intent of the reference panel to see that all available drugs would be covered through a national formulary. Those that were evidence based and judged to offer the best course of treatment at a reasonable price are those that would be listed, as they are in other countries with national formularies. Nevertheless, it was important to members of the reference panel to preserve an avenue through which patients could still exercise some choice in the medicines they access. They see the private insurance market as an opportunity for supplemental coverage to provide access to those additional drugs.

Mr. Darshan Singh Kang: Here we're trying to bring in national pharmacare. You said one in five Canadians probably don't have insurance, or they don't have enough. That's going to be kind of like a two-tier system. How about the people who cannot afford to get private insurance? How would we cover them?

Mr. Peter MacLeod: I don't think the two concepts are in any way mutually exclusive. We can look to many other countries that have robust systems of publicly funded prescription medicines but that also have supplemental drug insurance, much as we have, still with a robust medicare system in this country, many individuals who, either individually or through their employers, hold private insurance, which, of course, gives them access to paramedical services.

● (0945)

Mr. Darshan Singh Kang: I'm not really satisfied with that answer because I know we have people who are probably on fixed incomes, and if they were to try to get private insurance, they probably couldn't afford it. They have a difficult time putting their bread and butter on the table as is. My concern is leaving the door open for those who are disadvantaged and not covered.

Mr. Peter MacLeod: It's important to be clear that we're not talking about preferential access, nor are we talking about any barrier to required or necessary medicines for those on public insurance. What we're talking about, as one example, is the difference between a generic and a national brand medicine. Some people may continue to prefer that recognized brand, but as most clinicians are aware, those medicines are effectively identical.

Mr. Darshan Singh Kang: Okay, my next question was on generics. Are there any studies on, for instance, how much money is being saved by generic drugs compared to brand name drugs? Do you have any numbers there?

Mr. Peter MacLeod: I would refer you to the generic manufacturers industry association, which I know has extensive studies that can answer your question more conclusively.

Mr. Darshan Singh Kang: Okay. Thank you, Mr. MacLeod.

My next question is to Dr. Lynd. During her appearance before the committee, an official from the PMPRB highlighted several challenges facing the organization, including controlling the high cost of drugs, especially drugs such as biologics, oncology drugs, and orphan drugs. In her testimony, the PMPRB official identified the need for the PMPRB's legal and regulatory framework to adapt to these changing circumstances and efforts to remain relevant and effective in protecting consumers from excessive pricing.

In your view, how does the PMPRB need to evolve in order to better control the high prices, especially for drugs such as biologics, oncology drugs, and orphan drugs?

Prof. Larry Lynd: Again, that's a question around international pricing control, which isn't my area of expertise. Looking at what's happening with the PMPRB and the challenges that they're having in court now, and looking at the ways they are trying to control prices —and they're having challenges with that—just speaks to my proposal of a disruption in our reimbursement and pricing process here in Canada. What the actual answer to that is, I don't know.

Mr. Darshan Singh Kang: Should a national pharmacare program be developed? Do you see an ongoing need for the PMPRB? Why or why not?

Prof. Larry Lynd: Yes, I do, because I think we need to control the prices. I think if we look at where the prices are going with pharmaceuticals, particularly given the paradigm shift in drug development, we're looking at more development of personalized and precision medicines with drugs that are going to be orphan priced. That's just going to increase the need for price control with prices continuing to be pushed to the limit, as I foresee it.

Mr. Darshan Singh Kang: Do you think the buying power of our national pharmacare will have some effect on getting the drugs cheaper, probably with the help of PMPRB?

Prof. Larry Lynd: That would be my opinion, yes. That's exactly the premise the pan-Canadian pharmaceutical alliance was developed under, to have a consortium to increase buying power. That would be my understanding and my belief.

Mr. Darshan Singh Kang: Thank you.

The Chair: Your time is up.

That completes our seven-minute rounds. We're going to five-minute rounds now.

We're going to start with Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Mr. Chair.

I thank the witnesses for being here today.

We've had a lot of witnesses who are really putting forth one type of model, a monopolistic type of model, moving forward in Canada. I have had some challenges with the study we're doing because I don't see a lot of contrarian views, but I see you have brought up a few interesting points I would like to investigate a little further.

My first question would be to Dr. Lynd. My colleague asked if there's a system out there that is an example we could look towards. In Canada, we're trying to define who are the Canadians who are really having problems with it.

If you look across the world, you see the U.K. has put in a system that looks like more of a monopoly, but if you look at the results, there are certain restrictions on certain medications that are available in other parts of Europe. The U.K. has a worse cancer survival rate than these other countries. New Zealand has a monopolistic system. You actually see people from New Zealand moving to Australia just so they can get the drugs they need.

You mentioned that if we do put in a system like that, it really is going to affect choice. In other words, everybody gets it, or no one gets it. As a Canadian, if I pay into a system for years, and it comes to a point where I need medication—you're the expert here on rare diseases—would you say it's even fair if some bureaucrat is making the decision that I can't get these drugs covered under a system I paid into my whole life?

● (0950)

Prof. Larry Lynd: I guess my point was, I'm not arguing that every drug should be covered. If I'm saying everybody doesn't have access, I'm merely suggesting the evidence doesn't suggest that the drug has a significant enough impact on quality or quantity of life, or that the cost is such that it doesn't warrant reimbursement. That decision is being made, and not necessarily by a bureaucrat. I think we have multiple contributors to that decision-making process. It means everybody has the same access whether it be access to the drug, or maybe no access to a drug that we shouldn't have access to.

Mr. Colin Carrie: If somebody's advocating for a monopolistic system, and as I say, to look at the fairness issue, all Canadians will be asked to pay for it, should Canadians then be able to buy private insurance? In other words, if there are these unique drugs, and somebody who is advocating for a monopolistic system is trying to really help out all Canadians, and there's a portion of Canadians who can't get certain drugs, are we just transferring one system that's not covering people to another system that may not be covering people if we don't allow access to private insurance?

Prof. Larry Lynd: I'm not arguing for no access to private insurance, but I also think we can look at the private insurance industry. I think there's a paradigm shift going on there, too, where historically they have covered everything, and that's changing. We've seen it in the news in the last four weeks where they have been discontinuing coverage on biologics because of the pressure from the employers.

I think both systems work together, and they are looking at their reimbursement policies and procedures at the same time.

Mr. Colin Carrie: That's something we have to look at as well.

Again, I like the contrarian viewpoint. I think, Ms. James, you are one of the few witnesses we've had here.... You talked about heart and stroke and the emphasis you have on behaviour and lifestyle interventions, I think you said, and healthy living strategies.

What I find problematic.... In one of the contrarian viewpoints in your appendices, Mr. MacLeod, one person said we should be having this as providing a health benefit not necessarily a drug benefit.

Ms. James, in a national pharmacare program we would cover statins for life. We would cover blood thinners. We would cover blood pressure medication. Has your organization ever done a study, where if you can get people to take preventative measures—exercise, diet—how much of a cost saving that would be? Because if we're trying to get together for healthier Canadians, I think we should take a more holistic viewpoint of it.

My background is that I'm a chiropractor. I think you should look at natural interventions first before people get into drugs, but if we have a system in place like this, the easy thing to do is to take a drug.

Has your organization ever done a study on cost-effectiveness, on not going the drug route and saying, let's pay for interventions that may change lifestyle, change a person's weight? Have you ever done something like that?

Ms. Lesley James: It's a fantastic question. We have done things of that nature. Eighty per cent of heart disease and stroke is preventable through lifestyle modification, so changing physical activity levels, remaining smoke free, and most importantly changing a person's nutrition. We need to make sure that access to healthy food and fresh and whole unprocessed food is affordable for all Canadians, and that's a major challenge we're facing right now.

That said, there is a role for pharmaceuticals in preventing and treating cardiovascular disease, but much of this is within our control. Personally, we need a system in place that makes it easier for Canadians to make a healthy choice.

● (0955)

The Chair: Mr. Oliver.

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

I want to begin by thanking the citizens' panel for the work that you've done. To come out of your homes and take on this study as volunteers is a wonderful accomplishment and the time and energy you've put into it is quite remarkable, so thank you very much for that.

The committee has been talking about this topic for some time now. I have been asking myself how to keep this as simple as we can. To me, the basic transaction is that a Canadian meets with a caregiver, doctor, nurse practitioner, then a prescription is written, and then they go into a pharmacy and receive the drug. There may be a small, flat dispensing fee, maybe a copayment to be determined, but they receive the drug, they go home, they take it, and—presto—25% of Canadians get what the other 75% have, that is, access to drugs.

For the pharmacists, there's a win. Instead of dealing with hundreds of private insurance plans, they have one organization they contact for reimbursement and for their fee. The first complexity, though, is what would be permitted and what prescriptions they could go in with. I heard slightly different views here from Larry and Peter.

The World Health Organization has already come out with a list of essential drugs. I think you recommended that the essential drugs are there. This is pretty simple; it's the Pareto principle. Eighty per cent of prescriptions are going to be coming from about 20 per cent of the available drug pool. Most of those are already in generics. Most of them are already under pretty aggressive pricing models. This should be a simple list to start with.

Then we add in the rare disease drugs and the other ones as we go forward and then we think about how to compensate it. The first thing is the establishment of that essential drug list. CADTH has said they think they could manage it. Did you have any thoughts on a new agency or letting CADTH take that on?

Ms. Lesley James: It's a great point. I think the World Health Organization's list of essential recommended medicines was compiled for a reason. They are cost-effective, they'll likely improve population health in the long term, and that's a first stepping stone for us as Canadians. I'm quite pleased that you brought that up.

I think whatever system we move forward with needs to be transparent. It needs to consider public administration and cost savings to Canadians. I can't speak to whether CADTH is the right agency for that, but there are options to look at elsewhere in the world. The U.K. has NICE. Other countries have different regulatory bodies to do that.

Mr. John Oliver: Thank you.

Ms. Lesley James: Perhaps we have that in place in Canada already, or perhaps there's something different.

Mr. Peter MacLeod: We didn't look at the exact agency, but I think the panel endorsed the idea of an arm's-length relationship. They really want this to be an evidence-based exercise, and they want to preserve a role for citizens only.

Mr. John Oliver: Exactly.

It has to be evidence-based. There has to be clinical....

For Canadians who might be watching our committee, this is already in place. If you're going into a private lab, or if your doctor has asked you to get a lab test done, or if you're going into a private diagnostic, there are already mechanisms in place in every province for that lab or that diagnostic centre to bill the province. As a Canadian, you don't pay when you go in for those services. We're broadening that out to include pharmacies, but the structures in the billing processes are already in place in every ministry. Some of those labs and tests are not insured, and then you pay for it yourself, but most are insured. There is a choice, then, that the consumer has: pay for something a bit different or to stay in the publicly-funded plan.

How do we pay, after we've decided what drugs are in the formulary? I saw you came up with some suggestions around potential income tax changes, corporate taxes. Forty per cent to fifty per cent of Canadians right now are insured by private plans through their employer. Would it make sense to you that those costs would be recovered through some kind of corporate tax? This way it wouldn't cost the employer any more, and we could use those funds to publicly administrate the plan.

Mr. Peter MacLeod: You've got it. Exactly.

Mr. John Oliver: Then on the specialty or the rare disease drugs, is there a panel capacity in place that would somehow.... I can see these are very complex. There's lots of diversity. We've heard from tons and tons of rare disease groups about their concerns about access to new and emerging treatments, and how we could quickly adopt those and bring them into a restricted formulary.

Do you have any advice on who should be doing that?

● (1000)

Prof. Larry Lynd: We do have experience. We do it in British Columbia. We do it in Ontario. Other countries are doing that. We know we evaluate them differently. Specific panels with specific expertise to evaluate orphan drugs have been developed. That's certainly doable.

The Chair: Your time is up.

Mr. Webber, you have five minutes.

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

I want to focus my questions to the citizens' panel, the members who are here. I read through this and found it quite interesting. I read the names of the people who are on the panel and their backgrounds and such, and of course your recommendations to have a universal, mandatory, public drug insurance system that provides the necessary coverage to all Canadians.

It sounds wonderful, doesn't it, to have a system here in a Canada where all the drugs are paid for and everybody has access to the necessary medicines that they require? But there is a price to that. Of course, you know that. You mentioned some equitable revenue tools in your paper here. Mr. Oliver brought that up, about the income tax, corporate taxes, and such.

In your panel discussions, when you brought in some experts, did you talk about the costs involved and what the costs may be to implement your recommendations? Are there any specific numbers? I would just like to know more about the actual cost of implementing what you're recommending.

Mr. Peter MacLeod: Sure. We looked at this largely in a comparative perspective, as to what it costs to receive comparable coverage in other countries with universal health care.

As you're well aware, there aren't any solid numbers in Canada because there hasn't been a determination as to what the right model is for Canada. The focus of our efforts was not to develop the fiscal model around this, but it was to at least gesture towards some revenue sources that the members of the panel felt would be productive.

Mr. Len Webber: Again, I would love to drive the nicest cars on the street, but there's a price for that. Likewise with the universal medicare system here, there is a cost. People have to be cognizant of that. I know they are, but it just seemed that your panel was all about covering everyone. I would love to see that as well, but there is a cost to it.

Mr. Peter MacLeod: Certainly, the panellists were very sensitive to these costs. To be clear, their intent was to cover everyone but not to cover everything. That's where the role of an evidence-based national formulary is essential, to identify those medicines that are deemed to be both effective in health terms but also cost-effective as well.

Nevertheless, I think it was striking to realize that Canada continues to spend more as a country per capita to meet the pharmaceutical needs of its population than any other OECD country, barring the U.S. and, as my colleague has pointed out, Switzerland.

Mr. Len Webber: Could you talk a bit about the patient paying a fee for medication, a portion of money that the patient would pay rather than collecting the revenue through corporate income tax or income tax? Maybe you could share a little on that.

Mr. Peter MacLeod: There's no question that many members of the panel thought that it would be advantageous to look at a system of copayments. That was really a values-based gesture, believing that everyone who can ought to contribute more directly to the cost of their care. Nevertheless, the panel hesitated to make that a clear recommendation because they were unsure of the potential consequences for low-income individuals and whether those copayments, even as low as a dollar or two, could constitute a barrier. Then you would have people not taking their medicines and being a greater cost to the system.

● (1005)

Mr. Len Webber: Ms. James, you talk about the behaviour of Canadians, active lives, no smoking, and healthy food choices. For the individuals who do this, should they be rewarded in some way, perhaps through tax breaks? Do you have any thoughts on that at all?

Ms. Lesley James: I think Canadians who do that are rewarded with good health already, and that in itself is the reward.

Heart and Stroke believes that there are culprits that lead to poor population health, such as tobacco, sugary drinks, and processed food. It may be worth increasing the price of those options to fund health care coverage and universal pharmacare. A good way to offset the difference would be to tax the culprit, as opposed to the individual.

The Chair: Your time is up. That was a good question.

Mr. Ayoub, you have the floor.

[*Translation*]

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

[*English*]

I'll be asking my question in French.

[*Translation*]

Obviously, we talk a great deal about costs and efficiency. In an ideal world, if we didn't need to talk about economic issues, the choices would be easy.

My question is for the group of volunteers. They deserve our congratulations for the time spent on the study.

The issues discussed were universal coverage, cost effectiveness, the choice of the list of drugs, and a combination of private and public coverage. This sums up the fact that we have a choice and that we can draw a line between what's acceptable for many Canadians and what is exceptional for others. Where do we draw this line? Are you ready to draw a line? You don't suggest one line in particular because the issue is quite broad. I want to quote a passage from your brief. You said the following:

> In order to be patient-centred, this list should be ample enough that it provides sufficient flexibility to take into account individual patient circumstances. This list will include the drugs proven to be most suitable for all conditions, including rare and catastrophic diseases.

You don't make a choice. That's also likely not your goal. However, what would be the government's role and what would be its ultimate responsibility in terms of economic and health costs?

Mr. MacLeod, you can answer first.

[*English*]

Mr. Peter MacLeod: I was actually going to invite Jean-Pierre to speak, if I could, and then I'll speak second.

Mr. Ramez Ayoub: Please go ahead.

[*Translation*]

Mr. Jean-Pierre St-Onge: That's a very good question.

During the five days, I noticed that there was no consistency from one province to another. I learned about the situation of low-income people and seniors who receive family assistance. This leads me to conclude that the most vulnerable people in the 55-to-65 age range are those who don't have group insurance or who lose their jobs.

For example, in my own area, it happened to three couples my age. I'm 63 years old, and I'm sad to see them liquidating all their savings to pay for their drugs because they don't have insurance. I'm an ordinary individual, and I can see the situation in my area. I know three couples in this situation.

It bothers me to think about the rest of Canada. It's sad to see people who have worked their whole lives reach retirement age thinking they'll be able to live better and then fall ill. These things can't be predicted. As Mr. James said, people can do things to help themselves, but I think we can do something to find a solution. If there's a will, we'll find a suitable way.

● (1010)

Mr. Ramez Ayoub: Do you want to expand the coverage for most chronic diseases, or for the most common ones? The coverage for more specific and less prevalent diseases is more expensive. The fewer the patients, the higher the cost of the research and drug. It's a matter of math. Canada has a population of 36 million. The United States has a population of over 300 million. When research is conducted, the market is completely different. How do you deal with this aspect? What's your solution?

What do you think, Mr. MacLeod?

[*English*]

Mr. Peter MacLeod: Thank you.

The two ends of the spectrum really were of central concern to the panel. We need to provide those necessary medicines through a basic list in the first instance, which would deal with many of those chronic and pervasive conditions and relieve the pressure on Canadians who lack sufficient coverage. They also think—and I think it's the reason why many provinces have moved to provide some degree of catastrophic coverage—there needs to be, as quickly as possible, action taken to absorb those costs and relieve Canadians of the burden that comes with a rare disease.

Mr. Ramez Ayoub: I think my time is up. Thank you very much.

The Chair: Your time is up.

That completes our five-minute round.

Now, Mr. Davies, you have three minutes.

Mr. Don Davies: Thank you, Mr. Chair.

Mr. MacLeod, I want to refer again to your report, where you say:

> A national pharmacare system should provide coverage for drugs on a comprehensive, evidence-based complete list. Medicines should be selected for this list based on medical and cost effectiveness. New drugs will be evaluated using the same criteria before they are added to the formulary. In order to be patient-centred, this list should be ample enough that it provides sufficient flexibility to take into account individual patient circumstances. This list will include the drugs proven to be most suitable for all conditions, including rare and catastrophic diseases.

You go on to say, “This national pharmacare system should be provided through public insurance.... However, all essential, medically necessary drugs will be covered for all Canadians under the public system.”

You have further said that there's room for some private coverage to purchase optional private drug insurance. I'm interested in finding out what kinds of drugs would be covered under the private system, given the results of the panel's report.

Mr. Peter MacLeod: There are, of course, many different pharmaceuticals available, depending on the condition. Sometimes it's the difference between a generic and a brand-name medicine. I think it's the intention of the panel to move the generic medicines into a public system, and perhaps not retain exclusivity but that you would offer a degree of patient choice around some of these brand names through private insurance.

Mr. Don Davies: Do I have it right that the basic thrust of the panel's report is that all medically necessary prescriptions that are evidence-based should be covered under the public system?

If someone wants to purchase a brand name over and above the generic, or some form of experimental medication, they are free do to so. The goal here is to make sure that every Canadian has access to medically necessary prescriptions under the public system. Do I have that right?

Mr. Peter MacLeod: That's exactly right.

Mr. Don Davies: You probably heard from my colleagues in the Conservative Party that there's a bit of a philosophical divide on this committee around expense, and what I'm hearing your panel suggest is very similar to the medicare system.

Sometimes I think I'm being transported back to 1962, where people are arguing, “It's too expensive to cover every Canadian for basic medical coverage. Sure, it would be nice to have everybody be able to go to a doctor or a hospital and get the coverage they want, but we just can't afford it.” I think right now medicare is one of the most cherished values of Canadians today, and not many Canadians would argue that we should dismantle our public health care system.

Am I right in seeing this as a natural extension? The next stage of pharmacare will gradually expand universal coverage to the medicines that Canadians needs?

Mr. Peter MacLeod: I believe so. The fact that Canada is an outlier in this area has to be of some significance. Other countries wouldn't have adopted universal public coverage if the health outcomes were lower and if the costs were higher. Canada, being a highly decentralized country with health responsibilities resting with the provinces, perhaps has made it more difficult and has diffused responsibility amongst governments for seizing the initiative on this file.

● (1015)

The Chair: Your time's up. Sorry, that was a short round.

That completes our opportunity to have your testimony. We want to thank you all for coming and providing a new perspective for us to consider. If you have anything you can leave with us, we would like to have it. We have Mr. MacLeod's report. If any of the other witnesses have things you could leave, then we would like to have them.

We want to thank you very much for coming and providing testimony.

We're going to take a five-minute break, and then we're going to go into committee business in camera.

[*Proceedings continue in camera*]