House of Commons
Chambre des communes
CANADA

Standing Committee on Health

HESA • NUMBER 074 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Thursday, October 19, 2017

Chair

Mr. Bill Casey

Standing Committee on Health

Thursday, October 19, 2017

● (1530)

[*English*]

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

This is meeting number 74 of the Standing Committee on Health.

I want to welcome everybody. Today we're going to have an open general round table discussion to see where we are after all of the meetings we've had and to get the opinions of our guests.

We will proceed with a regular questioning series and then we'll have a second round, by the looks of things, until we have to go to vote.

Just before we start, I want to acknowledge that Mr. Davies brought up an issue about the parliamentary budget officer last week, and you were right. I hate to say this, but you were right. We did ask the PBO to do a study based on the WHO. He acknowledged that, but it didn't get done.

However, we did ask, and he did acknowledge it. I just wanted to let you know that. Thank you for bringing it to our attention.

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

The Chair: Okay, with that little piece of business, I'd like to welcome our witnesses today.

We have Dr. Marc-André Gagnon, associate professor, school of public policy and administration, from Carleton University. Welcome. We have Professor Steven Morgan back. He is a professor in the school of population and public health at the University of British Columbia.

We also have, from Canadian Doctors for Medicare, Dr. Danyaal Raza, chair. Thanks for coming. From Canadian Life and Health Insurance Association, we have Stephen Frank, president and chief executive officer, and Karen Voin, vice-president, group benefits and anti-fraud.

We are going to ask you to make a 10-minute opening statement. I would ask you to limit it to 10 minutes. Then we'll go to a question period.

We'll start with Dr. Marc-André Gagnon.

[*Translation*]

Dr. Marc-André Gagnon (Associate Professor, School of Public Policy and Administration, Carleton University, As an Individual): Thank you very much, Mr. Chair.

My thanks to the committee for the opportunity to share my expertise on the issue.

I would like to discuss two issues with you today. I will start with a few comments on the report of the parliamentary budget officer (PBO). I will then proceed with an analysis of Quebec's prescription drug insurance program.

In terms of the PBO's report, I very much appreciated the quality of the work done by the analysts. The issue of pharmacare is extremely complex; it is very difficult to navigate the data, and it seems to me that the team has managed to get around the main pitfalls. I am fairly satisfied with the PBO's report.

However, I have some questions about certain aspects of the report.

I would first like to discuss the mandate of this report with respect to the concept of copayments. The report asks that $5 copayments be applied for brand name drugs, and it includes a list of exemptions for those who would not have to make the copayments.

First, why doesn't the list of exemptions include low-income people? I think that's a problem.

Second, I do not understand why a $5 copayment is imposed only on brand name drugs. If it is to encourage the use of generics, let me remind you that all public plans include a mandatory generic substitution as it is called. A financial incentive for the use of generic drugs is therefore not appropriate.

Furthermore, copayments are a very poor funding tool for a drug insurance plan, because they can prevent patients from getting the optimal treatment. This can result in higher costs for the rest of the health care system.

I published an article in the *Canadian Medical Association Journal* on the role of copayments. I would be pleased to submit the article to the committee if it wishes. In the article, I propose that copayments be used in the most effective way, following the Dutch model.

Copayments can be used to optimally guide the choice of prescription drugs. The Netherlands uses copayments as part of a reference price system. A reference price is a cap imposed on the reimbursement of drugs, in certain therapeutic categories, in order to cover the costs of optimal treatments. For all therapeutic categories, drugs are therefore fully covered up to the first dollar spent. However, to provide patients with more choice, patients have the opportunity to choose drugs that cost more without providing additional therapeutic value, even if there is no medical justification. At that point, it's up to the patient to pay the difference. The copayment is therefore used to pay for that difference.

Not only does this type of copayment based on reference prices provide better access to the necessary treatments, but it also makes it possible to use a reference price system that considerably reduces the costs of a pharmacare program, while providing patients with a greater choice of treatments.

A second aspect is problematic in the PBO report. It is the notion of the purchasing power of a single plan that will allow discounts of 25% on all drugs. In addition, this figure has sometimes been criticized because it is considered too optimistic.

I would like to remind you that Quebec is the only province that can have a bidding system for generic drugs for its entire market, both public plans and private plans. In July, Quebec threatened to use a bidding system. I have long argued for a competitive bidding system, as it reduces costs and could reduce drug shortages. As soon as Quebec threatened to resort to tenders for generics, manufacturers offered a 38% discount on average for all generic drugs. The 38% discount was not considered by the PBO because the report was already written when the agreement was made.

All that to say that a 25% discount on drugs is an extremely modest figure, given the purchasing power we could develop. We could go for a lot more.

Finally, a number of savings were excluded from the calculation. It is important to remember that the administrative costs of private plans are on average 10 times higher than those of public plans.

The report does not take into account the fact that 30% of the costs of private plans represent the private coverage of public sector employees. The government is spending that money. We are talking about $3 billion spent by the government on private drug coverage for public sector employees.

● (1535)

In addition, tax subsidies for private plans as well as tax credits for medical care amount to a $1.4-billion tax expenditure for the federal government. I would have liked to see those items in the report, but I understand that the decision was to focus on another, smaller model. If we take the model a step further, if we have a more macroeconomic vision, we strengthen the conclusions of the parliamentary budget officer's report.

This week, together with Professor Morgan, we published an analysis of Quebec's prescription drug insurance program. I would be happy to provide you with a copy of the analysis, in which we try to see the outcome of that model.

It is important to understand that, initially, when we looked at the issue of pharmacare reform in Quebec, all the recommendations were along the lines of creating a universal public plan. However, in the context of fiscal restraint, there has been a lot of pressure from private insurers, a lot of pressure from pharmacy chains and pharmaceutical companies, and we ended up compromising on a plan that follows the private sector logic. So we set up a system based on mandatory private insurance, and we also included private sector logic. Actually, instead of using institutional tools to better control costs, for example through active management of a drug formulary or a reference price system as recommended by the Gagnon report, we preferred to try to control costs by increasing the copayments and deductibles.

If we measure the results in terms of access to drugs in Quebec, we can in fact say that the Quebec plan has made it possible to extend coverage, since more people have access to drugs, but at the same time we still have significant financial barriers.

If we measure access to drugs using as an indicator the percentage of the adult population that has not had at least one prescription filled for financial reasons in the last 12 months in Quebec, this affects 8.8% of Quebeckers. It's a lot better than in the rest of Canada, where it's 10.7%. However, the average for countries with a universal public system is 3.7%. Compared to countries that have a universal public system, Quebec is therefore at the back of the pack in terms of access to drugs.

We also measured the issue of equity. We showed that the Quebec system is quite unfair in many ways. First of all, it's not a universal system, so not everyone has the same access to drugs in the same way. Second, the premiums for members of the public plan, calculated according to income, are relatively regressive. A household earning $40,000 per year must pay the maximum annual premium of $1,334, which is 3% of their income. A household earning $180,000 a year pays the same premium, but that's 0.8% of their income. In the case of private premiums, there is no relation to the income, so we end up with very big inequities.

The premium is mandatory, and the premium of a full-time worker is often equivalent to that of a part-time worker. For a part-time worker or a worker whose status is precarious, premiums can reach 10% to 15% of their income. In some cases, the pharmacare premium even reached 35% of the income.

In addition, following the private sector logic where people pool risks among workplaces, some workplaces will pay higher premiums if the people use more drugs. For example, a taxi drivers' association will end up paying higher premiums than those paid by a university professors' association.

For me, the analysis is very important when it comes to costs. In 2014, our high spending on drugs per capita placed Canada second among all OECD countries, after the United States, despite the fact that Canada has a very poor record in terms of access to drugs.

In Canada, $952 per capita is spent on drugs every year. Quebec is the province that, by far, spends the most on drugs per capita. Quebec spends $1,087 per capita, while the rest of Canada spends $912 per capita. The median of OECD countries with a universal public drug plan is $603 per capita, and these countries offer much better access to drugs. An amount of $603 per capita is 45% less than in Quebec.

● (1540)

Quebec's hybrid plan, which includes mandatory private insurance, was set up with the intention of reducing public spending on drugs. Compared to the rest of Canada, there has been no decline in public spending on drugs.

However, our analysis also shows that, in terms of household and employer spending, Quebec spends $205 more per capita on drugs.

[*English*]

The Chair: I have to ask you to conclude.

[*Translation*]

Dr. Marc-André Gagnon: Okay.

In short, there is a problem with controlling private plan spending.

In conclusion, the issue of costs aside, universal public insurance for drugs is a matter of principle. For too long, access to drugs has been thought of as a privilege provided by employers to employees. It now seems clear that all Canadians must be able to have access to this essential part of health care, regardless of their postal code or where they work.

Thank you very much.

● (1545)

[*English*]

The Chair: Thank you very much.

Now we'll go to Professor Morgan. Welcome back.

Professor Steven Morgan (Professor, School of Population and Public Health, University of British Columbia, As an Individual): Thank you very much for the invitation to speak before this committee again.

Rather than provide a full introduction, I'll simply mention that since I last spoke before this committee in April 2016, I've published a further 22 peer-reviewed research papers on issues concerning the accessibility, affordability, and appropriateness of prescription drugs used in Canada and comparable countries.

I'm very pleased to report that my economic analyses of universal pharmacare in Canada have won two article-of-the-year awards, one from the Canadian Institutes of Health Research and one from the *Canadian Medical Association Journal*.

I'll frame my remarks based on important research published since the last time I testified at this committee. The first publication I want to speak about is not mine, but rather that of the parliamentary budget officer.

I believe the estimate of the PBO provides this committee with a reasonably solid analysis of what I would call a worst-case scenario of a universal pharmacare program that nevertheless remains an attractive option from an ethical and economic point of view.

The PBO estimated that Canadians are currently forgoing approximately 50 million prescriptions for medicines that might be covered under a universal public pharmacare program because of the out-of-pocket costs they face, either because they're uninsured or because they face cost-sharing rules under the insurance plans they have. The PBO estimated that universal pharmacare could help Canadians to afford those prescriptions and the health benefits that would be associated with their use. Although Canadians would be filling 50 million more prescriptions under a universal pharmacare system, the PBO estimated that a universal public drug plan would save Canadians $4 billion per year.

To be perfectly clear, the PBO used a number of assumptions that likely overstated the public cost of a universal pharmacare plan for Canada. It may be good strategy from a government budgeting point of view to assume the worst-case scenario and then work to bring in the program well under budget, but it is a conservative estimate because of the assumptions embedded in the modelling they did.

Some of the assumptions, such as the idea that the program would underwrite the costs of all medicines on the Quebec formulary, were at the request of this committee. Other assumptions, such as the decision not to look abroad to find out what single-payer systems pay for medicines, were likely the result of time constraints by the analytic team. Overall, however, the PBO estimates are about the same as the worst-case scenario in my economic models published in 2015.

Given the alignment of the PBO modelling with independent academic modelling on this topic, the question can now be put to rest. Canada can afford a universal public pharmacare system because it will improve access to medicines while simultaneously saving us billions of dollars per year. Anyone who says otherwise is either misinformed or trying to misinform others.

Next I would like to share some findings from comparative policy research I have been doing with my colleagues at Harvard University. This work concerns how the structures of drug coverage and pricing policies affect access to medicines and overall costs to society.

The first thing we have shown in that work is that coverage matters. Countries that provide universal coverage of medicines at little or no direct cost to patients achieve better outcomes in terms of access to needed treatments. Using international survey data from 2015 and 2016, we have found that Canadians are between two times and five times more likely to report skipping prescriptions because of cost than citizens in nine comparable countries with universal drug coverage. This is because millions of Canadians are either uninsured or have insurance that causes them to face rather blunt cost-sharing terms, such as deductibles and co-insurance, which have been proven to reduce access to necessary medicines.

Despite the rhetoric of drug manufacturers and the think tanks they might hire, this committee should not be fooled by claims that there is a lack of access to innovative medicines in countries with universal pharmacare models. All comparable high-income countries with universal pharmacare provide access to medicines of proven safety, effectiveness, and value for money within their health care systems. What these countries do not do is provide drug manufacturers with access to markets at prices that cannot be justified by quality scientific data concerning comparative cost-effectiveness. That is why industry stakeholders do not like universal pharmacare systems that are well integrated into the broader system of health care financing.

Related to this, the second finding from our comparative policy research that I'd like to share is that the way medicines are financed profoundly affects cost controls. In a recent paper, we showed that single-payer systems for prescription drug financing achieve better outcomes in terms of cost control than multi-payer systems do. On average, the single-payer systems in Australia, New Zealand, Norway, Sweden, and the United Kingdom cost 20% less per capita than the multi-payer systems in Switzerland, Germany, France, and the Netherlands.

● (1550)

Unfortunately for Canadians, we found that Canada's fragmented system of financing results in the highest prices and the lowest incentive for cost-conscious coverage and prescribing decisions amongst all of these comparable countries.

If Canada were to integrate medicines into our single-payer medicare system in ways that are comparable to Australia, New Zealand, Norway, Sweden, or the United Kingdom, we could save at least $7 billion per year while dramatically improving access to medicines.

This brings me to the final relevant finding from our work on the structure of financing of medicines, which is that none of the comparable countries with single-payer systems for health care use a separate private system for financing prescription drugs. All comparable countries integrate their medicines within their broader insurance systems, and in doing so, they provide system managers both with the incentives and the moral authority to carefully consider the costs and benefits of medicines versus other forms of care for the populations they serve. This is one reason that other countries are able to effectively manage pharmaceutical costs while retaining public support for the tough but necessary decisions they must make concerning which medicines will be covered and which will not.

The last area of research I wish to highlight concerns our obligation to provide universal pharmacare and the importance of the federal role in doing so. Canada has ratified United Nations declarations that establish the right to health care, including the right to access essential medicines without financial barriers as a fundamental human right. Member states of the UN have an obligation to uphold fundamental rights for all of their citizens, which means the federal government has specific responsibility to do so in Canada.

Despite the complexities of our federation, Canada has successfully achieved national standards for universal public insurance for medical care and hospital services, doing so in the 1950s and 1960s. It did so through a system of cost-sharing that ensured that all provinces both could and would provide for their residents. Frankly, Canada must do the same for prescription drugs, or at the very least for essential medicines.

Just as in previous chapters of Canadian medicare, the federal government will need to help make this happen. Some provinces cannot go it alone on pharmacare because of resource constraints. Other provinces cannot go it alone because of the intense regional pressures that stakeholders place on governments that wish to bring pharmaceuticals into medicare and thereby rein in the excessive cost of medicines in our current system. Governments are stronger when they act together, and I think in the Canadian context this requires a federal partnership with the provinces and territories.

The question may then turn to where to start. Earlier this year, with Dr. Nav Persaud and other colleagues at the University of Toronto, I published a paper showing that the establishment of universal public coverage of a limited basket of essential medicines is one place to start as governments work towards more comprehensive universal pharmacare. In that analysis, we showed how covering a list of just over 100 medicines could fulfill about three-quarters of Canadians' pharmaceutical needs.

Though more comprehensive public coverage would remain the goal for a national pharmacare program, starting with the essential medicines means that we would not need to replace existing private and public drug plans at the outset. While the other plans are being phased out, the essential medicines program could establish the Canadian process for publicly covering however many drugs made sense, given its initial budget.

Rather than the historical approach of defining which Canadians would be covered for virtually every medicine, this approach would determine which medicines would be covered for every Canadian. This would help fulfill Canadians' right to health, since the obligation of a nation is not to provide any medicine for any purpose at any price; the obligation of a nation is to ensure universal access to medicines that safely and effectively meet legitimate health needs and to do so at a cost that can be justified and sustained, given the competing health needs of our population and the competing means of addressing those needs with available budgets.

If the federal government provided, for instance, $3 billion per year, it could fund as much as 50% of the cost of a reasonably comprehensive essential medicine list that could be provided to all Canadians within a year. Within that time frame, the list of medicines could be determined by an expert advisory committee, a tendering process could be established and implemented for the roughly 100 medicines that would make the cut, and provinces would certainly be brought along by the savings to their budgets and the benefits to their residents.

Despite being limited to a small number of drugs, such a program would likely save Canadian households and Canadian businesses approximately $6 billion, generating a net savings to Canada of $3 billion.

● (1555)

As the program grows, it could be expanded to one as comprehensive as the pharmacare model for which the PBO estimated the cost. If based on best procurement practices in the pharmaceutical sector, that program would certainly result in net savings that would exceed the PBO's estimate of $4 billion per year.

I'll conclude by noting that there are clear and compelling options for an equitable and sustainable system of universal pharmacare in Canada. I'm very grateful to be invited back again to provide evidence you require as you decide which of these options is best for Canadians.

Thank you.

The Chair: Thank you very much. We're glad you came.

Next we have Dr. Raza.

Dr. Danyaal Raza (Chair, Canadian Doctors for Medicare): Thank you, Mr. Chair.

Thank you to the members of the health committee for the invitation to speak today.

I'm here today not just in my role as chair of Canadian Doctors for Medicare, but also as a family doctor in Toronto, with an inner city downtown practice that runs the spectrum from those struggling to make ends meet on social assistance, to the working poor, to those solidly in the middle class, and yes, even a few bankers and consultants from Bay Street. My waiting room is always a lively space.

Founded in 2006, Canadian Doctors for Medicare provides a voice for doctors from coast to coast to coast, advocating for evidence-based and values-driven reforms to our public health care system.

As a background to my remarks today, I will submit copies of a brief report that was published by us, Canadian Doctors for Medicare, in partnership with the Canadian Centre for Policy Alternatives, in advance of the recent PBO report on the cost of pharmacare. In that document we provide an overview of current public and private spending on prescription medications and some of the potential savings that Canadians could expect to see with the introduction of a universal pharmacare program.

We have the benefit today of hearing from some well-known economic experts who have deep expertise on this issue, and while I'm happy to talk dollars and cents, I also want to focus my remarks on the positive health impacts that such a program would bring.

I've been very lucky to have been born, raised, and trained all through university in Canada. Now I'm very fortunate to practice as a family doctor in our universal public single-payer system. As Canadians, it's something that we are sincerely proud of, and rightly so. Unfortunately, as a family doctor who works within a very diverse practice and set of patients, I also see first-hand how that same public system doesn't go far enough. Every day that I'm in the clinic I see how gaps in coverage and gaps in medicare mean many Canadians are falling through the cracks in our incomplete system.

At Canadian Doctors for Medicare, we're of course proud of our system; it's why we work tirelessly, not only to defend the principles on which it was based and on which it was founded, but also to find ways to improve it. That of course means seeking innovations that will make it more efficient and more accessible, and ensure it achieves the best outcomes for Canadians. When we talk about pharmacare, we talk about it as one such program. We talk about it as the unfinished business of medicare.

When I'm with a patient, in my role as a physician there is nothing worse than being able to make a diagnosis, have a conversation with my patient, develop a treatment plan that makes sense for them and for me as their family doctor—which often includes prescription medications—only to realize that they're ineligible for a means- or age-tested public plan, they have no job-linked insurance, and that their ability to fill those prescriptions means having to dip into their savings account for medically necessary care.

In fact, this happens so often that I include questions about insurance status whenever I meet a new patient in my meet-and-greets. I ask these questions because I need to be cognizant of this situation, of how it serves as a barrier to treatment and how it influences the care I either can or can't deliver. When a patient's only option is to pay out of pocket, the cost of drugs also begins to influence other budget decisions, including rent, healthy food, hydro, and, of course, medically necessary prescriptions.

This is particularly true for the working poor and people who are precariously employed. It means that patients experience a phenomenon known as “cost-related non-adherence”, resulting in unnecessary hospitalization and a downstreaming of disease. It means that chronic medical conditions like hypertension or high cholesterol go untreated until acute complications develop, creating an unnecessary burden on patients themselves, their families, their loved ones, and our health care system as a whole.

It's estimated that between 5% and 6% of hospitalizations in Canada are a result of non-adherence to prescriptions, costing us approximately $1.6 billion per year. While we don't know the percentage of these cases that are due to the financial burden of filling prescriptions, we know it is frequently reported as a problem, not just by doctors, but by patients. For example, cost-related non-adherence was reported by 9.6% of respondents to the 2007 Canada community health survey who received a prescription. Financial barriers to accessing medically necessary prescriptions are felt especially acutely by low-income Canadians, with 20% of these respondents reporting issues with cost-related non-adherence.

● (1600)

Here in Ontario, where I practice, if you're old enough or poor enough, you're entitled to a comprehensive public drug plan. However, for Ontarians working in contract or precarious jobs who might have the very same diseases as their means-tested or age-tested peers, access to drug treatment depends entirely on their private insurance plans or the balance in their bank accounts.

For example, in 2015 the Wellesley Institute reported that if you were an Ontarian earning $100,000 or more a year in income, there was a greater than 90% chance that you'd have access to a job-linked drug program. However, if you were earning less than $10,000 a year, that fell to less than 20%. We know from the medical literature as well that health is tied to wealth and income, and of course the folks who are least likely to have a drug plan are also the folks who are most likely to need a drug plan.

If we instead look at disease not by employment income but by disease itself, another recent study estimated that the disparity in access to treatment among working-age Ontarians with diabetes resulted in 700 premature deaths a year. That's 700 premature deaths each year in one province for one disease due to a lack of access to treatment. That doesn't begin to capture the cost or social impact from complications of diabetes, such as chronic kidney disease, issues with vision, impaired wound healing, peripheral neuropathy, and an increased risk of heart attacks and strokes.

When I speak with my colleagues in other countries about why I am proud to be a doctor working in Canada, I cite the relief of knowing that cost is not a factor when patients access medically needed hospital or physician services. Medical bankruptcies such as those we hear of in the U.S. are thankfully rare here, but we cannot ignore the significant financial burden that comes with a diagnosis when we do not have access to medically necessary prescription drugs.

I was happy to see in the recent PBO report an acknowledgement of the potential savings that a national pharmacare program could bring to Canada, especially as I saw the $4 billion in estimated savings that were determined despite prudent, conservative estimates of administrative and drug price reduction savings.

You've heard from economists and experts in the PBO about the number of factors that go into determining potential costs of implementing a single-payer universal prescription drug program here in Canada. As well, of course, you have heard of the potential financial savings that would result from expanding access to everyone.

What I and my colleagues at Canadian Doctors for Medicare, as well as doctors across the country, can convey to you with a high degree of confidence is how such a program will have a tremendous and positive impact on the health of everyday Canadians, the patients we see in our offices every day. It will ensure that when any Canadian goes to the doctor, the care doesn't end when they go out the door, and that the medically necessary prescriptions they leave the clinic with are the most appropriate and best available medications based on need and not on ability to pay.

It's time to close this glaring gap in medicare.

Thank you.

The Chair: Thank you for your contribution. I appreciate it very much.

Mr. Frank, welcome back. I see you were here in May 2016 on this issue.

Mr. Stephen Frank (President and Chief Executive Officer, Canadian Life and Health Insurance Association): Thank you for inviting me again.

● (1605)

[*Translation*]

My name is Stephen Frank and I am the president and CEO of the Canadian Life and Health Insurance Association (CLHIA). Joining me today is Karen Voin, vice-president, Group Insurance and Anti-Fraud, also from CLHIA.

[*English*]

On behalf of the life and health insurance industry, thank you for giving us the opportunity to speak to you again as you finish your consultations on this very important matter of pharmacare.

[*Translation*]

Our association accounts for 99% of Canada's life and health insurance business. Across the country, 24 companies offer extended health coverage to more than 28 million people. Our industry includes not-for-profit organizations such as Blue Cross, benevolent associations and larger companies. We work with employers to provide Canadian workers with extended health coverage for a wide range of prescription drugs, paramedical services, such as psychologists, physiotherapists and chiropractors, as well as eye exams, lenses and glasses, and dental care, just to name a few of our coverages.

[*English*]

Canada's life and health insurers believe that all Canadians should be able to access affordable prescription drugs. Today, prescription drug costs are too high, and we know there are gaps in coverage. However, meaningful reductions in prices and improving access for all Canadians can be achieved today within our current system.

Canada's insurers are keen to help and believe we have much to offer. Several initiatives set out by both the federal and provincial governments will make a difference.

[*Translation*]

The proposed amendments to the regulations of the Patented Medicine Prices Review Board (PMPRB), are important because they will provide the PMPRB with the necessary tools to reduce costs. We fully support the direction the PMPRB has taken and will continue to work with the authorities to better assist them.

[*English*]

As well, through the pan-Canadian Pharmaceutical Alliance, or pCPA, this will also help bring down the costs for public plans. We believe the federal and provincial governments are on the right track, but they need to go further. The current approach only leverages half the buying power of the Canadian market in any negotiation, and it leaves those Canadians with private insurance or who are paying out of pocket to fend for themselves. This situation results in prices that are higher than they need to be, and it also entrenches unequal prices for the same drugs across Canada.

The good news is that there is an easy way to address both these shortcomings. Private plans need to be included in the pCPA. This would allow governments to negotiate the best prices possible, using the entire Canadian market volume, while ensuring that all Canadians are treated fairly and pay the same price for the same drug.

Ultimately, Canada's life and health insurers believe the best solution to ensuring sustainable prescription drug coverage is one that blends together the strengths of both the public and private systems. We work together with employers to offer access to a wide variety of prescription drugs through employer-sponsored benefit plans. Canadians value their benefit plans, which provide them with rapid access to over 12,000 prescription drugs. The Sanofi survey in 2016 points to the importance that employees place on their drug coverage: 94% of them indicate that drug plans are very important or somewhat important. One of the reasons employees value their drug plans so highly is that new drugs are approved more quickly than they are in private plans, providing Canadians with faster access to new and innovative medicines, generally with fewer restrictions.

However, there are gaps in the Canadian system, and understanding the gaps is crucial if we're to develop appropriate and targeted solutions. There are Canadians who do not have access to a public or private plan or perhaps do not have adequate coverage. We need to focus and coordinate our efforts to understand where these gaps are and to work on achievable and targetable solutions.

The report that the parliamentary budget office tabled with this committee a few weeks ago highlighted the costs of moving to a universal single-payer system, as well as the savings that could be garnered from bulk purchasing. Even with optimistic assumptions, the costs would be nearly $20 billion for the federal government. As for any estimated savings, the bulk of these are estimated to arise from negotiating better drug prices by using the full buying power of the Canadian market. As I outlined above and want to stress, there's nothing stopping us from moving in that direction now by including insurers in the scope of the pCPA.

The bottom line is that the projected savings to the overall drug spend can be achieved today with minimal disruption and without taking away access to the wide variety of prescription drug plans that are so highly valued by Canadian employees.

● (1610)

[*Translation*]

In closing, I would say that our industry is committed to working closely with governments to help improve Canada's health care system.

Thank you for your time today. I would be happy to answer any questions you may have.

[*English*]

The Chair: Thank you very much. You still have some time left. Madam Voin, do you want to make some comments, or are you good?

Ms. Karen Voin (Vice-President, Group Benefits and Anti-Fraud, Canadian Life and Health Insurance Association): No.

The Chair: We'll go right to questions, then, starting with Mr. Oliver for seven minutes.

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

Thank you again, some of you, for coming back to the committee.

Dr. Gagnon, Dr. Raza, and Professor Morgan, thank you for your leadership on this case. You've been at this for years and years, I think, some of you. Mr. Morgan, you said you've been at it for close to 20, so it's great leadership in bringing this to the point where we as a committee are able to draw on the work that you've done.

We're wrapping up. I think this is our last meeting with witnesses before we begin to give direction to the analysts to draft the committee's report. My questions are going to be focused on some areas I don't think we have addressed yet and had testimony on, so they won't be too general in nature. They primarily focus around the federal, provincial, and national aspects of how things get done.

With the challenges of developing a science-based and evidence-based formulary and achieving the best negotiating strategies that we can in terms of buying processes, it seems to me that a national formulary—done in collaboration, obviously, between the provinces, territories, and feds—would be the ideal place for the formulary to sit. Do you agree with that?

Dr. Marc-André Gagnon: The answer is yes. However, at the same time, you can have a different list of exemptions for the different provinces based on specific needs, but—

Mr. John Oliver: —but, in general, the place it begins is at a national—

Dr. Marc-André Gagnon: —a national formulary, yes.

Mr. John Oliver: Would you comment, Mr. Morgan?

Prof. Steven Morgan: It is fair to say that all the countries with effective systems for managing cost and access so that there's equity of access with cost control use some form of a national formulary.

Mr. John Oliver: Thank you.

Dr. Danyaal Raza: It's not only good for cost effectiveness. It will also ensure that we pay only for medications that actually work, and not just medications that are approved.

Mr. John Oliver: The next question, then, is who is to administer it. If we think about a single-payer model, is it federally administered, or is it provincially and territorially administered like the rest of our health plan?

The conclusion I have come to is that the provinces spent $13.1 billion on public plans in the last year to insure their insured populations, so they already have robust payment mechanisms to pharmacists and others to support that public system.

This is something I don't like in this report. It says the cost to the federal government would be $20.4 billion, but in reality $13.1 billion is already being spent at the provincial level. If we think about who pays and how we afford it, there are other levels of payment. Private insurance was around $9 billion, but of that almost one-quarter went to municipalities, universities, schools, hospitals, and governments, which again are under provincial control, and they're able to extract payment.

By my math, if I look at what's already in public plans and look at that one-quarter of the insured workplace, $15.8 billion is covered, and we're really left looking for about $3.5 billion or $3.7 billion at the federal level. That's assuming we let all the employers off, so that all their employees are now insured and they don't have to cover benefits for them.

Does that make sense to you? Is that how you would see those numbers rolling out?

Dr. Marc-André Gagnon: That makes sense to me, but, as I mentioned in my presentation, you're not counting the federal tax subsidy spent right now for private regimes. This is more or less $1.4 billion a year, so in fact the number would be lower for the federal government.

Mr. John Oliver: I also haven't mentioned the fees that are being paid to manage the 100-and-some private insurance plans. These fees of around 4% to 5% aren't built in here as savings.

Dr. Marc-André Gagnon: Absolutely.

Prof. Steven Morgan: To answer your question, the logic of the way Canadian medicare was supposed to work, the way our system was supposed to be built in stages, including prescription drugs and eventually things like home care and long-term care, was that it would be provincially and territorially administered with cost-sharing at the federal level.

The lump sum of money to bring the provinces along probably needs to come from the federal government, so some new revenue tool needs to be introduced, but there will be a lot of payers who will benefit significantly from that.

● (1615)

Mr. John Oliver: Why do you say new money is needed?

Prof. Steven Morgan: You have to find it. You can't necessarily immediately grab it, for instance, out of the extended health insurance from which public sector employees currently benefit. Eventually, that will become a savings both to those employees and their employers, but in the short run, to incentivize the program you need to find a revenue tool to bring money into the system.

One of the things you have heard from private sector employers at this committee is that they are willing to embrace a model of pharmacare. There have been surveys of employers in Canada in recent years that show a surprising number of Canadian employers would be willing to contribute in some way to a publicly run plan, because the public plan is better capable of managing the costs. One of those things means they won't pay for just anything at any price, because no rational country in the world does that. The only actors doing that, unfortunately, are Canada's private insurers, and it is costing us dearly as a result.

Dr. Danyaal Raza: The only other thing I'll add is that the provinces are already starting to act on this, because many provinces recognize this as a huge gap in the health care system. We've seen Ontario launch the OHIP+ program for those up to age 25 to expand publicly paid prescription drugs. That is rolling out in January. For my younger patients who are working in a gig economy and contract jobs, who can't find work and instead are driving Uber cars or delivering pizza, that is going to make a huge difference.

Mr. John Oliver: Thanks. Do I have time left?

The Chair: You do, but Mr. Frank wanted to make a point.

Mr. John Oliver: The logical direction then would be to go back to the Canada Health Act and add into the definition what provinces and territories are responsible for covering. It would be a statement around the coverage of medicines that are prescribed by—

Prof. Steven Morgan: I can quickly answer that. I'm not entirely sure about going into the Canada Health Act, which is what Roy Romanow recommended for prescription drugs as a long-term goal. There are certain principles of the Canada Health Act that might not be consistent with the way you manage a pharmacare program, such as having no user charges to patients for any of the eligible drugs covered. In fact, as Dr. Gagnon has pointed out, most systems do use some kind of patient cost-sharing as an incentive to get patients to at least use the cost-effective treatments first before moving on.

You might decide to move it into the Canada Health Act, but it would require some tweaking. You could create an analogous Canada pharmacare act, and it would have the same purpose and maybe have more specific language about how this would be run, what kind of national agency would manage the formulary, how they would be subject to some budget constraint. I think there's expert consensus, for instance, that we make sure this program is budgeted so that it's not a white elephant.

The Chair: Your time is up. Thank you very much.

Mr. Frank, you wanted to make a comment.

Mr. Stephen Frank: Yes, I wanted to address the concept of administrative cost savings, which I think an individual raised.

I want to remind everyone on the committee that we don't administer drug plans. We administer the business of supplemental benefits, which includes a wide range of things: dental coverage, paramedical, vision care, hospitals. You cannot assume that if prescription drugs were taken over by government, the cost to employers of providing those services would go away. I think you need to be careful when talking about billions of dollars of savings there.

The other thing I would point out is that generally when you move from a private to a public plan, you leave behind a lot of individuals who are covered for things today that will not be covered on the public plan.

In the PBO report there is reference to that. It's a throwaway line about the $3.9 billion that's spent. It is just assumed that this cost will continue to be picked up by employers. I think the committee needs to reflect on what $3.9 billion means. It means hundreds of thousands of people getting reimbursed for therapies today that this model assumes are not going to be covered in the future, and they will somehow have to find coverage.

Frankly, when we talk to employers—and we have lots of experience, particularly with public sector unions and anyone else who has collective agreements—that's the biggest reticence to making change. Insurers want to provide really robust and advanced drug management tools. It's the employers who are reticent to do that. In some cases it's the collective agreement and bargaining clients who are the most difficult to move, because they're acutely aware of what they'll be leaving on the table.

The committee needs to understand that moving from private to public has costs. People will get left behind, and it's not as easy as it is being portrayed by many of the people proposing it.

The Chair: Thank you very much.

Ms. Gladu, you have seven minutes.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Thank you, Chair.

Thank you to all the witnesses for coming back. I am new to the dance and I wasn't here when you were here the last time. I appreciate your testimony.

I really want to come up with an answer that will address the gap of the 12% that the parliamentary budget officer has indicated are people who today can't get prescription drugs, either because they have no coverage or they have an inability to pay. When we selected Quebec for the costing model, it was because that was thought to be the Cadillac.

I'm a bit disturbed to hear the testimony from Monsieur Gagnon that in Quebec 8.8% of adults are not able to fill their prescriptions due to finance, because when I compare that to the 12% who were without coverage. the gap that we were trying to fix, it means we're only fixing a third of the problem.

Do you have information about why they can't pay? Is it the copayment? Is it deductions? Is it a combination, or some other factor?

● (1620)

Dr. Marc-André Gagnon: Yes, absolutely.

We need to understand that when we implemented the regime in Quebec, it was in order to cover the low-income workers with no private coverage at all. We expanded coverage. In terms of the working population, you have much better access for the working population in Quebec.

Seniors, for example, have very large copays and deductibles they have to pay as well, and an annual maximum contribution of up to more than $1,000 a year now. The thing is, when you compare seniors in Quebec versus Ontario, for example, seniors in Ontario have much better access than seniors in Quebec.

We have better access for the working population, but the non-working population in Quebec is much more problematic. In fact, for a while they also imposed copays for people on social assistance in Quebec, but then the costs that it generated elsewhere in the health care system were so huge that they decided to repeal the copay for people on social assistance. That's the main reason.

Ms. Marilyn Gladu: Yes, I see that and I agree with that, because what we are seeing is that the 12% who can't afford to pay really can't afford to pay, whether it's five bucks for the copay or the deductible or any of those things.

Mr. Morgan, go ahead.

Prof. Steven Morgan: I think one of the flaws of the Quebec model was that it was based on an insurance industry's model of what prescription benefits are, rather than an integrated model of a health benefit that includes prescription drugs.

Systems around the world that integrate medicines into their equivalent of our medicare system make sure that preventative medicines are free of charge to as many people as possible, so that at least the stuff that keeps people out of hospitals is actually getting filled when prescribed appropriately.

We have to recognize that in Quebec, for the average beneficiary of any of the plans available, there are significant monthly deductibles and co-insurance charges that just don't make sense from the logic of managing this as a health benefit. If we move forward with pharmacare in Canada, I think there is expert consensus that we want to make sure that carefully chosen medicines are available to all without financial barriers. For other medicines, there may be copayments or co-insurance, but there would be what were referred to as tiers in the formulary or in the charges for patients.

Ms. Marilyn Gladu: Very good.

There is another thing I'd like to see. I don't have great confidence that the government, if we gave it the responsibility of administering national pharmacare, wouldn't return the same kind of service that we get today from CRA, immigration, and a number of other departments. I have been on the receiving end when I try to interact with those departments myself. I would like to see this plan implemented quickly.

I am very interested in the idea Mr. Frank was talking about. I don't quite understand how the provinces pay out their insurance. For people who are covered under social assistance and everything else, the province is covering that insurance. Are they covering it from one of the 24 companies that are in the pCPA? How is that covered today?

Mr. Stephen Frank: If it's a public drug program, they would be funding it out of general funds. A senior in Ontario on the senior ODB plan would present their OHIP card at the pharmacy. That would get adjudicated on the back end and paid out of Ontario government finances.

Ms. Marilyn Gladu: Okay, so it's not really from an insurance company there. It's the private companies that—

Mr. Stephen Frank: It has nothing to do with the insurer. An employee of the Province of Ontario would be sponsored through an insurer. It depends on which province you are talking about. In that instance, it would go through a different channel, the way that payment would be settled. Sometimes it goes through the insurer; sometimes they pay directly. It's complicated.

Ms. Marilyn Gladu: Is the cost different for province-provided insurance than it is for firms like Sun Life, Great-West Life, Blue Cross, etc.?

Mr. Stephen Frank: Yes. That's what I was referring to in my remarks.

What we have today is a scenario where governments have banded together. They negotiate lower prices on new drugs coming to Canada, but they do that only for the benefit of their own beneficiaries, their employees. Anyone else in the province who is on a private plan is basically left to fend for themselves.

I'll reiterate: when you look at the savings that everyone estimates are going to come from pharmacare, you see that the bulk of those come from doing a better job of pooling our resources together and negotiating lower prices using the whole volume of the Canadian market. There is a very simple way to do that: we just agree to start doing it. You invite everybody to the table with the pCPA, and we can start to realize those savings.

● (1625)

Ms. Marilyn Gladu: To address the 12% who are not covered today, would your recommendation be that we put them into the existing provincial plans immediately? We could just say, “Okay, we're going to cover everybody who doesn't currently have coverage in those provincial plans.” Would that be a start?

Mr. Stephen Frank: To be really frank, I don't know that we understand who those 12% are. I don't think we understand why they are not filling their prescriptions. Is there a certain class of drugs that is the problem? Is there a certain regional distribution that is the problem? We don't know enough for me to say that I can help you design a target solution.

In a normal environment, when 95% or 96% of people are getting everything they want and you have a gap that's 4% or 5%, you do try to find solutions to address the gap. You don't suggest we throw everything out and start from scratch.

In the short term, that's the way we would propose, the way it would logically make sense to move forward.

Ms. Marilyn Gladu: I have one quick question about out-of-hospital drugs.

For the Quebec formulary, it wasn't clear to me whether out-of-hospital drugs for cancer and palliative care were covered. With the huge aging population that we have, I think that's going to be a huge cost.

Do you have any information on that, Mr. Gagnon or Mr. Morgan?

Dr. Marc-André Gagnon: The problem we have right now with this fragmentation between the way we pay for drugs and the way we pay for other health care services in an establishment, in hospitals, is that we have a lot of cost-shifting. With the new wave of oral anti-cancer drugs, for example, we don't need to treat you in the hospital, but then you need to pay for your cancer drugs yourself.

Many of the cases we see.... Last week we had a study that showed that half of the new cancer drugs arriving in the market did not show any therapeutic benefit compared to what already exists. The thing is, if you have a new treatment that instead of requiring, let's say, 10 injections in a month, requires only four injections in a month, you can be sure that for the patient this is something more interesting, but if the price difference between four and 10 injections is $60,000 per month, then you need to ask whether we should be paying for that. Then you can say, “Well, this is fantastic. Private coverage does accept to pay for that.” In terms of cost-effectiveness, that might not be the best solution.

The Chair: Mr. Davies is next.

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

Thank you for being here.

We return from whence we began. Dr. Gagnon, Professor Morgan, we called you back to bookend this because you testified at the beginning of this study some 18 months ago. I'm going to be addressing my questions to you, if I can, as two of the world's pre-eminent researchers on pharmaceutical policy.

It seems to me now that every serious, non-biased, peer-reviewed study of universal pharmacare in Canada concludes as follows: one, that millions of Canadians can't afford the medicine prescribed by their doctors; two, that Canadians pay among the highest prices for pharmaceuticals in the world; three, that we can ensure that universal coverage could be brought to all Canadians through a public system; and four, that we will save billions of dollars collectively in doing so.

My first question is, Dr. Gagnon, Professor Morgan, do I have those points correct?

Dr. Marc-André Gagnon: Yes, absolutely.

Prof. Steven Morgan: Yes. I guess the PBO report is only the latest.

Mr. Don Davies: Professor Morgan, I just want to repeat this. It appears to me, in my review of the PBO report, that the PBO's conclusion that we would save $4.2 billion a year, every year for the next five years, was based on using the widest formulary in the country—that's Quebec's formulary—and making the most conservative assumption that we would save 25% through bulk buying, when it appears to me that every other comparative jurisdiction we've looked at achieved savings higher than that through bulk buying. Finally, the PBO did not even assign cost savings to a number of known cost-savings drivers, such as cost-related non-adherence or streamlining the administration. Is that a fair summary?

● (1630)

Prof. Steven Morgan: Yes, it used an extraordinarily open formulary in the context of Canadian public drug plans. It had conservative assumptions about price savings, when even our analysis vis-à-vis the U.S. veterans administration right here in North America, right south of the border, shows that they save about 50% relative to Canada on generic drugs and about 40% relative to Canada on brands. We know they were conservative on price estimates.

They also didn't factor in some of the therapeutic substitution effects that could happen if we have an evidence-based formulary. Part of that was because they assumed it would be the Quebec formulary. If you have an evidence-based formulary, there are billions of dollars in additional savings to be had.

That's the job of a public drug plan. It's to say it's about value for money. We're going to say yes to covering everybody when the drug's the right price and the right value and we're going to say no when the drug is not the right value. That's where purchasing power comes from.

To the insurance industry's claims that they should be able to be part of the deals that the public drug plans negotiate, when part of your negotiating team says they'll buy anything at any price always, they're not increasing your negotiation power. It's like going into the auto dealer with your partner, who says he wants this car right away and doesn't care what it costs. You're not going to walk away with a good deal.

You have to have buying power. You have to have purchasing partners who are willing to say no when the pricing terms aren't correct.

Mr. Don Davies: Professor Morgan, I think it's obvious, but I'm going to ask this question. Given the nature of Canadian federalism and the fact that health care is constitutionally under provincial power, it appears to me that any attempt to set up a national universal pharmacare system will require federal and provincial and territorial discussions. Do I have that correct?

Prof. Steven Morgan: Yes. Almost without doubt, the provinces will either have to cede authority in some way—and some lawyers and health lawyers have looked into this—or we're going to need to sit down and negotiate.

This is consistent with Canada's framework for national health and social programs, through which we need to meet fundamental human rights. The federal government enables all the provinces to meet those rights because we provide grants, but we also hold them to meeting those rights by making those grants conditional on performance.

Mr. Don Davies: That's right. I suppose that other than a federal stand-alone financed program, it would require discussions with the federal, provincial, and territorial governments, correct?

Prof. Steven Morgan: Yes.

Mr. Don Davies: Okay.

Are we missing any barriers, any reasons, any information, or any vexing problem that exists policy-wise that would prevent us from commencing those discussions, say, sometime in the next year, Dr. Gagnon?

Dr. Marc-André Gagnon: Absolutely nothing. The Council of the Federation has taken major steps in that direction in building the pCPA, building collaboration among provinces. I would really like to see something like pCPA with CADTH and PMPRB merging to create a national agency to manage a national pharmacare system with the collaboration of the provinces. We have this already, for example, with Canadian Blood Services, by the way, which is a fantastic example of this type of collaboration that leads to fantastic results.

Mr. Don Davies: Yes, it's puzzling to me.

Tommy Douglas envisioned pharmacare decades ago. I think the Hall report, if I have that correct, recommended some form of pharmacare. I think the Liberals and the NDP have campaigned on universal pharmacare at one time or another in the last 20 years, but there always seems to be barriers to actually starting the implementation, so I want to remove those barriers.

I want you to give this committee a recommendation.

Let's say, Dr. Morgan, that you are Prime Minister and, Dr. Gagnon, that you are Minister of Health. What does the system to bring in universal pharmacare look like? Who does the formulary, who pays for it, and how does this work?

Prof. Steven Morgan: I think we already have the institutional capacity to do an excellent job of running a drug plan. Let's face it: our provinces already do a lot of work on this, and we have world-renowned experts and agencies like CADTH. We now have really good capacity within the pCPA to do price negotiations.

As per the “Pharmacare 2020” report, the summary of our recommendations after many years of research, we envision this as a federal, provincial, and territorial cost-shared program with a national agency that is given a defined budget to manage and that manages a formulary to that budget on behalf of its FPT partners. Real money comes in from the federal government.

The current medicare deal is that the federal government cost-shares about 25% of the cost of medicare services. That might be a fair starting point for negotiating a cost-shared pharmacare program.

You establish a national formulary that becomes the standard benefit for all Canadians. If provinces want to top up beyond that with their own money that's independent of the national agency, that would be fine. Of course, if employers and unions want to negotiate gold-plated drug benefits for medicines that aren't cost-effective, they're welcome to do that as well.

We definitely see value in an evidence-based, budgeted, national program that at least manages the formulary that defines the standard benefit for all Canadians. We also see value in that formulary being reasonably comprehensive, as it is in comparable countries abroad.

● (1635)

The Chair: Your time is up.

Dr. Eyolfson is next.

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

Thank you all for coming. It's good to see you all again.

Mr. Frank, we're talking about these different figures. We have different sources and different figures. A lot of the research we've read, particularly the work from Dr. Morgan, has a lot of very heavily referenced, evidence-based, peer-reviewed research.

The figure you're saying—that it would cost us $20 billion a year—tends to fly in the face of that. From what peer-reviewed evidence do you get that figure?

Mr. Stephen Frank: The $20 billion was in the parliamentary budget officer's report.

Mr. Doug Eyolfson: For instance, you're not saying it would save us $4 billion a year.

Mr. Stephen Frank: I think you can assume you're going to cut the cost of every drug in Canada by 25%. Work out the math; it will be a lot of money.

Mr. Doug Eyolfson: Yes, but—

Mr. Stephen Frank: Yes, there is money there if you can cut the cost of those drugs, that's for sure, and we're not disputing that. The way you're going to get most of those savings is by bulk purchasing those drugs and doing a better job of negotiating.

Mr. Doug Eyolfson: I know, but that's not my question.

Mr. Stephen Frank: Those are the facts, and that's what I was referring to.

Mr. Doug Eyolfson: Okay, you were referring to that fact, but again, the $20 billion doesn't actually come to the overall net savings of what is in the parliamentary budget officer's report. It is reporting an estimated $4 billion a year, which we believe, with a lot of intangibles. The fact that it is very conservative could mean an even greater net savings.

Mr. Stephen Frank: The PBO estimated it at $4.2 billion. I think you can change that assumption and assume 28% or 30%. If they put sensitivities in there, you'll get different numbers.

What I don't think anyone would disagree with is that it's billions of dollars that we could be using better if we got our act together and started to do a better job of bringing down the price of those drugs. We can do that collaboratively and we can start doing that really quickly.

Mr. Doug Eyolfson: All right. Thank you.

Dr. Morgan, you talked about the basket of essential medications that we could take at least as a starting point.

Is there anywhere a database that would be a starting point to establish 100 or so drugs that are essential? Does that basket that we could use as a starting point exist anywhere?

Prof. Steven Morgan: Roughly speaking, yes, in the sense that the World Health Organization manages what it calls the model essential medicines list for the world. That's the list it believes constitutes the drugs that every human being on earth has a fundamental right to access. That's the starting point.

Clinicians in Toronto, led by Dr. Nav Persaud and his colleagues at St. Michael's Hospital, have Canadianized that list by getting rid of drugs that just aren't needed by wealthy countries like Canada. They've added drugs to that list that we are lucky enough to be able to afford. It still comes up to just about 120 or 130 medicines on the list. It's a reasonable definition of essential medicines for the routine needs of Canadians. It includes things for HIV, rheumatoid arthritis, and some more serious conditions, but most of the medicines in there are the kinds of things that most Canadians might use: drugs to manage cardiovascular care, etc.

Those lists do exist, and Canada could fairly readily try to adapt one of those to whatever budget need we would have, or the budget level we would have if we were to move forward on a program to cover all Canadians.

Mr. Doug Eyolfson: If we use that as our formulary as opposed to Quebec's and we took that pile of medicines in your essential basket and the pile of medicines that are in the Quebec formulary, do you get a ballpark number for the price differential? How much more expensive it would be? We do know the Quebec formulary would be more expensive.

Prof. Steven Morgan: Based on the paper published earlier this year—and I would have to look at the precise figures—we estimated the incremental cost to government to develop a national plan to essentially provide all of these drugs was about $1 billion more than we're currently paying through public drug plans at present.

The total amount that was spent on Dr. Persaud's essential medicines list was, I believe, in the neighbourhood of about $6 billion or $7 billion in total, but most of that was already currently paid for by public plans or offset by other savings we can get through the plan.

We found in that analysis that the private sector would save about $4 billion in exchange for this $1 billion in increased public spending, for a net savings to the economy of about $3 billion. It's real money.

● (1640)

Mr. Doug Eyolfson: Sure. That is real money. Yes, I agree.

I'm going to throw this open to anyone who might have an idea about trends.

Dr. Raza, you work on the clinical side. You see patients who can and can't afford drugs.

Are you aware of any trends that are similar to what we're seeing in the States? We're seeing this even more with overall medical coverage when all of the insurance is either out of pocket or through employers. There are more and more media reports of employers who are either hiring people as part-time employees so that they don't have to pay them health benefits or are just simply hiring them as independent contractors. They are not employees; they're just hiring them as contractors so they don't have to pay them benefits. It appears to be happening more and more.

Is there any of that trend in Canada?

I'm going to ask Dr. Raza first, and then Mr. Frank.

Dr. Danyaal Raza: Yes, absolutely. There's this national conversation now about the rise of contract work, the gig economy, and precarious work. I see that play out with the patients in my practice.

There are patients who might have lost their jobs when they had a regular job with benefits, but they were converted to contract work. They don't know when that contract's going to end. Of course, it doesn't come with a prescription drug plan.

Mr. Doug Eyolfson: Sure.

Dr. Danyaal Raza: This is something we're seeing in offices across the country. Absolutely.

Mr. Doug Eyolfson: Mr. Frank, would you comment?

Mr. Stephen Frank: We collect data on this, obviously, as it is our business. In fact, the proportion of Canadians who have coverage is higher than it has ever been. The trend is up, not down. If you look at the data on our web page, you can see that.

We don't see any evidence that employer plans are being dropped or that the penetration of insurance in the workforce is in decline. It's just not.

Mr. Doug Eyolfson: Dr. Morgan and Dr. Gagnon, maybe you can you finish up.

Prof. Steven Morgan: I'm aware of a couple of surveys of employers that say they are very interested in a national public drug plan of some kind because they are finding themselves under great pressure.

I think you heard testimony from representatives of the employers in Canada who basically argue that the cost of medicines is out of control in the private sector and they don't have the capacity to manage it, nor do they have the moral authority to decide who gets coverage and who doesn't, based on the nature of the disease and which drug comes to market.

I think we're under a lot of pressure. We certainly see a lot of retirement groups starting to have conversations about whether the drug benefit will continue. That's probably why we see, for instance, the Canadian Labour Congress now fully committing to campaigning for a public pharmacare program. It's because their members are feeling the pressure.

Mr. Doug Eyolfson: Thank you.

Dr. Marc-André Gagnon: I would like to add that one of the trends we're seeing right now in terms of what I saw in conferences by human resources management and collective insurance group managers is a lot of what we call coordination between private plans and public plans.

A lot of provinces are offering catastrophe coverage, and it becomes an opportunity for different employers. When you have one employee with a rare disease, for example, that costs a lot of money, basically what you do is dump them on the public plan that has catastrophe coverage.

In fact, the public plans believe it's their job basically to cover these bad risks, but we end up with a system whereby we organize public drug coverage in Canada in terms of serving the commercial needs of private regimes instead of just providing good access for all Canadians.

Mr. Doug Eyolfson: Right. Thank you very much.

The Chair: Time's up. That completes our seven-minute round. We'll go to our five-minute round, starting with Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair. I would also like to thank our analysts for providing us with some quality questions for our round table today. I'm going to use some of your help and throw this question out to our round table.

Dr. Thomas Perry is the chair of the Education Working Group at UBC. He explained to our committee that the pharmaceutical industry has significant influence on prescribing practices through advertising, support for educational initiatives, and paying physicians to provide guidance on medications. Similarly, the independent Patient Voices Network of Canada raised the issue that patient organizations often receive funding from the pharmaceutical industry, placing them in a conflict of interest when advocating access to prescription drugs.

For anyone who wants to take this on, in your view, what steps could be taken to limit the influence of pharmaceutical companies on prescribing practices in patient organizations?

● (1645)

Dr. Marc-André Gagnon: The first thing you need is an evidence-based formulary. Prescribing habits must be based on evidence-based medicine, not on the promotional campaigns of drug companies. This is very important.

In terms of these conflicts of interest, for example, we're talking a lot about the opioid crisis right now. Keep in mind that you have this huge promotional campaign by a drug company that was basically providing claims that were bullshit. They had to pay $20 million because they were false claims. As soon as oxycontin was out, the attitude of private coverage was that we don't do any clinical assessments. It's approved by Health Canada, so we're covering it as fast as possible. Fantastic.

When we discover there is a problem, what can we do about it? Right now we don't even have the databases to understand what is being prescribed, where, by whom, or for which condition, and these are essential tools if we want to maintain a system based on evidence-based medicine instead of the promotional campaigns of the drug companies.

For me, universal pharmacare is also a way to develop institutional tools in terms of monitoring what is going on instead of saying that the drug is new, so let's go as fast as possible and we need to reimburse. No. We need to understand what this drug is doing. Is it a good product or not? How much do we pay for it? If there's no cap, if there are no standards to define this, then you end up with an open floor.

Keep in mind Steve's example of two guys going to the car dealer. What happens if every day exactly the same guys go to the car dealer? Will the car dealer provide a much better car at a lower price in the long run, or basically a scrappy car with a very high price? This is exactly what we have right now. Some drug companies focus on private plans. I include Valeant, because it is clear in their annual report every year that they focus on private plans, because there is no health technology assessment, so basically there is no cost pressure. They focus on them because they know that they will not be bothered with price sensitivity.

This is exactly the type of market we're developing with drug companies right now, and that's a huge problem. If you want a system that works well, if you want drug companies to do research on new products that do provide real benefits to the population, you need an evidence-based formulary for everyone.

Prof. Steven Morgan: Very briefly, I just want to add that both in the “Pharmacare 2020” report and in another report by our national research network called “A Better Prescription”, just published last year, we articulate how the appropriate use of medicines is one of the key pillars of a national pharmacare system. Appropriateness, affordability, and accessibility are things that are really key. I think you can embed a national strategy on appropriate use and safety into a rational pharmacare program, and as Dr. Gagnon said, that starts with making sure that what you cover is truly evidence-based.

Dr. Danyaal Raza: I was also going to bring up the point that pharmacare can actually promote medication safety. That is not something we've talked about, but it's an important part of the program. I also wanted to share an example that illustrates the point that you were making in your question.

There's a particular class of medication called proton pump inhibitors. They are used to treat GERD or heartburn, and every so often when one of these medications on patent is coming off patent, the drug company that's losing the patent will come up with a biosimilar molecule that's different enough that they can extend their patent but that offers no meaningful clinical benefit. That's the drug they'll go out and market. They'll lobby different insurance plans to cover it, and more often than not, the private insurance plans will say no. Even public drug plans, the ones that many of my low-income patients and seniors access in Ontario, said no, because they use some of the mechanisms that already exist, such as the common drug review, which is part of the process that CADTH employs to make the decision that we're only going to pay for medications that offer cost-effectiveness and meaningful clinical benefit. Otherwise, why are we going to pay for a medication that costs more but offers no added benefit?

The Chair: Go ahead, Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair.

Mr. Frank, the picture emerging in my mind is one of a universal national plan that's single-payer in the manner of the Canada Health Act. I'm having trouble seeing where private plans, such as yours, would fit into that model.

Can you fit into that model, and if so, how would you do that?

● (1650)

Mr. Stephen Frank: If the model is a first-dollar-paid public plan, then I suppose the role for private insurers essentially disappears. You'd have to define the model you're proposing a little more clearly for me.

There have been some interesting discussions around a national formulary based on the WHO definition of essential medicines and things like that. Those kinds of concepts I think everyone can get behind. I'd be surprised if there's a private insurance plan in Canada that doesn't already cover those medications.

Those are the kinds of practical discussions we should be having that help move the ball forward. It can be done quickly, and we can all get behind it. It could make a meaningful difference for people. That's the kind of thing I was referring to earlier. We need to be practical and start improving the system in ways that make sense within the current system.

Mr. Ron McKinnon: We're talking pharmacare here, but there's still room for private plans for things like dental coverage and eyeglasses and that sort of thing. Do you think that's a place where you could then specialize?

Mr. Stephen Frank: Absolutely.

Employers are going to presumably continue to want to offer health benefits to their employees. In every province where we operate in Canada, our business is slightly different. Every public program is different in every province. We adapt to that. We supplement what is there on the public side.

Decisions around what's going to be provided publicly will decide where and how we structure our offer to employers. It's a bit hypothetical. I don't know what the model would look like, but we would take stock of it and we'd see what the opportunities were to provide supplemental coverage on top of that, beside that, or whatever the case may be.

Prof. Steven Morgan: Can I quickly comment?

I think this committee also heard from the CEO of the Surrey Board of Trade, a board of trade in my province that brought up to our provincial chamber of commerce a motion in favour of a universal public pharmacare plan, which was passed.

One of the arguments that was made in moving that up to a formal policy or request of that organization was that a public pharmacare program makes extended health insurance more affordable to more small employers. Small businesses in Canada, which are the driving force of the modern economy, are having a hard time continuing to sustain extended health benefits against the high cost of pharmaceuticals, which can be in the order of tens of thousands of dollars if you have an individual patient with a particular need.

If you got that off the books, there would be more opportunity for employers to start investing better in mental health services, dental care, vision care, and so on.

Mr. Ron McKinnon: Professor Morgan, you mentioned the creation of a Canada pharmacare plan as opposed to expanding or enhancing the Canada Health Act. Would you expand a bit on why you would see us doing that?

Prof. Steven Morgan: The principles of the Canada Health Act, particularly as they relate to accessibility, actually forbid there being extra billing or user charges of any kind for what are called “insured services under the act”. The insured services, if you were to add pharmaceuticals, would have to be defined in relation to some sort of national formulary, which would be the minimum package of drugs available to Canadians.

The terms of the act would preclude you from having a copayment on those drugs, and in many cases you probably would want what's again referred to as a value-based copayment that says if the drug is preventative and best value for money in our health system, it's free for patients. If it's more discretionary and perhaps a second- or third-tier drug, value-based formularies internationally might see a patient pay $50 or even $100 for a prescription if it's not a first-line therapy.

The Canada Health Act would preclude you from doing that unless you had specific carve-outs in the act. I don't mean to dissuade you from going down that path in terms of making a recommendation; it's just that you could have a parallel act that had much the same intent, purpose, and outcome as the Canada Health Act, but didn't hold pharmacare to the exact standards of the CHA.

Mr. Ron McKinnon: Thank you.

The Chair: Now we'll go to Mr. Van Kesteren.

● (1655)

Mr. Dave Van Kesteren (Chatham-Kent—Leamington, CPC): Thank you, Chair, and thank you all for being here.

Could anybody tell me what the five top drugs administered are? Does anybody know? If we had a health care system, what would be the top five? Maybe, Mr. Frank, you would know that from the insurance industry.

Mr. Stephen Frank: Do you want to know by drug or by category?

Mr. Dave Van Kesteren: Somebody mentioned heartburn medicine. You don't have to name the product line, but what would it be? Would it be drugs for high blood pressure?

Prof. Steven Morgan: The leading therapeutic categories are drugs to treat cardiovascular risks, drugs to treat anxiety and depression, drugs for diabetes management, and drugs for asthma and COPD, or airway diseases. There are a handful of therapeutic categories that dominate.

Mr. Dave Van Kesteren: What are the ones that dominate? Doctor, you must know. What are the ones that dominate in your practice?

Dr. Danyaal Raza: I can only tell you from my own experience. I can't tell you what the top five definitely are.

Mr. Dave Van Kesteren: What about the top three?

Dr. Danyaal Raza: What I will say is that the way people get sick has changed. When medicare was founded and prescription drugs weren't included, people were breaking their bones, having heart attacks, going to hospitals, being patched up and sent home. A lot has happened since the late 1960s and the 1970s. Now when Canadians get sick, they get sick with chronic diseases like cardiovascular disease, high cholesterol, diabetes, high blood pressure, rheumatoid arthritis, osteoarthritis.

All of these chronic conditions require chronic medications. Rather than just taking antibiotics for seven to 10 days, people are now using prescriptions in other ways. Many people need medications every single day. My patients and patients across the country are facing bigger cost issues and more medically necessary prescriptions. Our insurance system needs to evolve to capture these changes in the way Canadians are getting ill.

Mr. Dave Van Kesteren: I would agree with you when you say that things have changed. We used to hear that an ounce of prevention is worth a pound of cure. It wasn't the other way around. What would you think if we had better control over sugar, if we had a better grasp on the effects of processed foods? I've talked about alcohol abuse, lack of exercise, smoking. What effect do you think it would have on the drug industry if we had a better grip on these things?

Dr. Danyaal Raza: I don't know what specific effect it would have on the drug industry, but one thing you have hit on is that there are many things that influence people's health, such as their social determinants, their income, and their employment status. It's the employment status that I think is having the biggest impact on people's access to insurance.

Mr. Dave Van Kesteren: That's your opinion. We need a study.

Mr. Stephen Frank: One of the reasons people value their private insurance coverage so highly is that we focus on wellness, which is now the biggest trend and driver in a lot of employment plans. Pilots studies on better treatment of diabetes, better treatment of hypertension, better treatment of mental health issues, health coaches and other types of supports—these are the kinds of things we need to be doing more of. When you look at some of the innovation on the private payer side, you see a lot of really exciting things.

Mr. Dave Van Kesteren: I used to be on the finance committee and we used to hear a lot of presentations. There were always recommendations made when the finance minister was going to prepare his budget. In the Conservative Party, we used to ask how we were planning to pay for all these wonderful things. Were we going to cut something out of the budget, and if so, what? How were we going to pay for it all?

Go ahead, Mr. Morgan.

Prof. Steven Morgan: We're already paying for it. In fact, we're already paying billions of dollars more than—

Mr. Dave Van Kesteren: If it's going to be billions more, how do you propose we pay for these things?

Prof. Steven Morgan: This program will cost billions of dollars less than Canadians are already paying for prescription drugs. What we need is to find a revenue tool to move some of the money that is in the private sector—some of the money for publicly financed private drug benefits for people like me, a public employee—into the system. We don't need new money in Canada to run a pharmacare system; we just need a new tool to move the money we're already spending into the system so that it functions more equitably and efficiently.

Mr. Dave Van Kesteren: Everybody wants that, and it's all wonderful, but I'm a speaking as a Conservative. This is what I've been entrusted to do. I would recommend that all of us look at what we're really called to do, and that's to balance the books.

Are you suggesting that if we have a pharmacare program, we'll actually save money in this country? Is that what you're suggesting?

● (1700)

Prof. Steven Morgan: There's no doubt it will save Canadians money at the end of the day, because there's only one taxpayer. Only one source of money goes into buying drugs today.

In the provinces there has been talk about catastrophic drug coverage as being at least a minimum safety net. That requires that every year people with chronic illnesses pay 3% to 10% of their household income on prescription drugs before benefits kick in.

The cost of a public pharmacare system, in moving money around into such a system by way of federal funding, would be approximately the equivalent of less than one-half of one per cent of taxable income, one-sixth the amount that we think of as a reasonable deductible under a public drug plan. It wouldn't be that dramatic as a way to move money around.

Dr. Marc-André Gagnon: On the macroeconomic impact of introducing universal pharmacare, in terms of additional public spending, you can do that with an increase in corporate tax because of the savings on labour costs. You could do it with a payroll tax, earmarked tax revenues, whatever the solution, but the macroeconomic effect is an increase in the disposable income of Canadian households, and it means reducing labour costs for employers.

I was in discussion with an actuary yesterday, and in Quebec drug benefits represent between 2% and 5% of total payroll for an employer who provides group insurance to employees. In any economic textbook, reducing labour costs for employers is how you create employment, so the macroeconomic impact would be very positive. It would have the same effect as a very significant tax cut.

The Chair: Time's up.

We go now to Mr. Oliver.

Mr. John Oliver: Thank you.

Thank you very much. I get to go around again.

I want to come back to this point we've been discussing, the burden on the federal government, because it's not $20.4 billion or $19.3 billion. The public plans will kick in, and $13.1 billion of that is already covered. I disagree that a major conversion is required. These are patients who are in the system, already seeing their doctors, already getting their prescriptions at pharmacies, being reimbursed by the provinces and territories. The challenge, I think, is with the 15.6 million people employed right now in 2017—that's up considerably since October 2015, I might add—and most of them will have some degree of drug coverage through their employers. Those public and private employers spent $9 billion to insure those people.

What would you recommend? The PBO said that after the public plans there's a $7.3 billion shortfall, but the employers spent $9 billion. I'm old enough to remember when we moved from Green Shield and Blue Cross for all care, and in Ontario OHIP and the health plan kicked in, and contributions were made by employers in return for ensuring their employees made contributions.

Do you have any advice or comment on that? Should this $9 billion that the employers are spending today just be there as a windfall, or do we try to capture some portion of it, giving them a windfall but also using it to cover that part of the population?

Prof. Steven Morgan: I'll wade into this one. I think this is the territory in which you need to sit down with representatives of employers and unions and talk about what would be a fair bargain.

Eric Hoskins and Kathleen Wynne suggested that they will be doing this in Ontario with OHIP+. That's a massive windfall for the private sector because of children and youth being covered who are otherwise covered through family health plans or extended health benefits.

Based on what I've heard from employers and unions in talking about pharmacare for the last several years—decades, really—both groups seem to be willing to come to the table to talk about some kind of combined contribution that would move a portion—not all, but a portion—of that money into the system, because they're going to see more money in return.

Mr. John Oliver: I might also add that I've heard from a number of people in the employee insurance field who say this is a rapidly evolving, changing coverage. Because of the high cost of some drugs, many employers are down to 50 % or 60% coverage, and some of the really expensive drugs, some of the biogenetic drugs, are blowing some of these smaller plans out of the water, so there is a need. Any Canadian who thinks they're secure because they're employed and they have their own plan already.... I think a change is happening in the sector.

The worst-case scenario is $20.4 billion. It looks as if we can cover all the employees and their families with some kind of payroll support and still give back a windfall to the private companies. What do you think is the real cost to the federal government?

● (1705)

Prof. Steven Morgan: If I fell back on the medicare formula at a 25% contribution, the federal government would put $5 billion into a $20-billion plan and the provinces would come up with the balance necessary to get themselves to $15 billion and you'd be there.

In reality, I think the PBO report underestimates the copayment revenue that would be possible. An extraordinary share of the prescription volume in the PBO report was exempt from copayments because people were over 65. Not all, but many people over 65 could afford that $5 prescription, which might have been a source of revenue, particularly for discretionary treatments that aren't about prevention and keeping people out of hospitals.

The maximum would be somewhere in the neighbourhood of $5 billion to run a fairly comprehensive program. Evidence from other countries, from the USVA and the New Zealand PHARMAC system, shows that they do go ahead and budget based on a conservative estimate like the PBO's, because they know they're going to live within the budget initially. What that will do is actually embed the ability for that system to sustain cost pressures, at least for the first several years, because they'll be able to garner savings from older medicines over time, which will allow them to bring newer medicines into the program at pretty close to a constant budget.

Mr. John Oliver: Dr. Gagnon, what's your estimate of what the cost is to the federal government?

Dr. Marc-André Gagnon: As I mentioned, we need to consider tax subsidies as well. It depends on how you want to do the financing of the disparity in the numbers. As I said, you can go with a payroll tax. We have one of the lowest corporate tax rates, but at the same time implementing universal pharmacare would massively reduce labour costs for Canadian companies. If you increase the corporate tax by 1%, which will still remain one of the lowest corporate tax rates, you would offer much lower labour costs to employers in Canada and at the same time be able to fill the gap for the active population that had private plans before.

Mr. John Oliver: It does seem that if the burden of paying $9 billion to insure their employees and their families is taken off their books, anything under $9 billion distributed out is going to be a savings for them and a windfall back, not to mention the 4% to 5% admin fees that are charged by the private insurance companies to oversee those accounts. They would get a windfall in many different ways here. This is not increasing the burden. It's decreasing the burden on employers.

Dr. Marc-André Gagnon: Absolutely.

Prof. Steven Morgan: Best estimates are that the private sector would get $2 back for every dollar it puts into a more efficient publicly run system. The thing about this is if we do it right and if we budget appropriately—not being cheap and making sure the system can be reasonably comprehensive—then in the future the private sector will be an ally and will realize the value you're providing for them as the pressures are taken off them.

Mr. John Oliver: Yes, and I think any progressive employer costs out pharmacare benefit costs separately from extended health benefits. I just disagree with your answer there, Mr. Frank.

The Chair: Time's up.

You did ask for a quick answer, so, Mr. Frank, could you just give us a quick answer?

Mr. Stephen Frank: I think people are sort of dancing around using the term that you're going to have to raise taxes to pay for the $9 billion. There's a transition that's important to consider, and this is one of the reasons I would say the PBO is very, very optimistic. They do reference that in the paper. They assume that between December 31 at midnight and January 1 at midnight and one second, you'd magically cut the cost of all prescription drugs in Canada by 25%. That will not happen. There will be a transition there. You will have to raise taxes and you'll have to find a way to defend it.

The Chair: Thank you.

Mr. Stephen Frank: Look, we can get those savings without having to reorganize the whole system, without having to incur those costs, and we have outlined what we think makes a lot of sense today.

● (1710)

The Chair: Thanks very much.

Prof. Steven Morgan: Your member companies haven't obtained those savings for the last number of decades, so how can you tell us you can get the savings now? What are you waiting for?

Mr. Stephen Frank: We're waiting for an invitation—

The Chair: Time's up. Sorry. We have to go to Mr. Davies now for three minutes.

Mr. Don Davies: Thank you. I have three minutes, and I simply want to clarify.

Done properly, there's no cost to the federal government because this is a cost shift. As a country, we're spending $24 billion now. We would spend $20 billion. All the money that's being spent now would be redirected into a streamlined, centralized system. The provinces are paying $13 billion now. The private sector is paying $9 billion now. Instead of that $9 billion being paid out, if it were redirected to the federal government, it shouldn't cost the federal government anything, if done properly, except for the initial start-up costs.

Do I have that correct, Dr. Morgan?

Prof. Steven Morgan: Yes. Just to be clear and to correct Stephen Frank, if you were to raise $9 billion in new taxes to pay for this system, the federal government would be a net winner by $5 billion a year on that system. You'd be bringing in money that would be paying for other federal programs.

Mr. Don Davies: Right. It could either be a money-maker, or better, they could take that surplus and redistribute it amongst all taxpayers so that the real savings of a universal pharmacare system would be to the people who pay it now, Canadian taxpayers.

Prof. Steven Morgan: Yes. At the end of the day, every reasonable analysis shows that you'll save billions of dollars. There's no question. Most importantly, getting back to the original purpose, you will provide access to medicines that Canadians need. That is a fundamental human right, and Canada is the only wealthy country with a universal health system that doesn't provide it.

Mr. Don Davies: That's where I want to go next. Dr. Raza, we're talking numbers here; let's talk people.

There are between three and seven million Canadians walking around who can't get the medicine they need that keeps them healthy, or in some cases, keeps them alive. That's what this is about.

What are the costs, health-wise, to not bringing in universal pharmacare?

Dr. Danyaal Raza: We don't avoid costs by not having this program; we just downstream costs. In the case of my patients now who can't afford to pay for their medications out of pocket, who don't have an insurance plan, their diseases aren't going away; they're just being left untreated. For example, I have patients with diabetes who can't afford their oral medications, such as metformin. Their sugars aren't going away on their own; they're continuing to cause chronic health conditions and increasing their risk for heart attacks and strokes. Rather than paying for cost-effective medications now, we're waiting for these folks to develop heart attacks to present to the emergency department. Then we'll pay for incredibly expensive treatment and they'll suffer the health consequences.

Mr. Don Davies: Not to be melodramatic, but does anybody die in this country as a result of their inability to access medicines they need?

Dr. Danyaal Raza: People certainly die from complications of their medical conditions that often are untreated because they don't have access to—

Mr. Don Davies: Dr. Morgan, one thing I've said and I've heard in the House repeatedly from this health minister and the previous Liberal health minister is that we can't bring in universal pharmacare. We have to contain costs first. Then we can bring in pharmacare.

What's your comment on that?

Prof. Steven Morgan: This has been a long line: no pharmacare until there's cost control.

I think the evidence is fairly consistent, both in terms of the analysis that's been done by the PBO and independent academics and from the international experience, whether it's the VA in the United States, the U.K.'s NHS, Australia's PBS system, or New Zealand's PHARMAC, that there's no real cost control without pharmacare.

At some level we have to recognize that you ramp up to a system that will cover all Canadians. That's the way you actually ramp up the savings that we're talking about in these models. You can't realize those savings. Manufacturers will not give you 25% off on prices if a major payer in your system will pay no matter what anyhow. Essentially, there's no real cost control without pharmacare.

The Chair: The time is up. Thanks very much for the very last question—official question, anyway.

Now I have to ask the committee if they want to give us unanimous consent to have one more round of three-minute questions, because the bells are going to ring in a few minutes, and I need unanimous consent.

Do I have unanimous consent for three more questions?

Some hon. members: Agreed.

The Chair: Okay.

Just before we continue, we have one little bit of business. We do not have our agenda scheduled for November 2, November 7, and November 9. We already have antimicrobial resistance studies planned out. I just need the committee's permission to go ahead and invite the guests for that. We've already agreed on the meetings.

Now we'll start our round of three-minute questions.

We're going to start with Mr. Fraser. Welcome to the committee.

Mr. Colin Fraser (West Nova, Lib.): Thank you very much, Mr. Chair, and thank you to the witnesses for being here. I'm not a usual member of the committee, so forgive me if I ask a question that has already been covered in the first round of your testimony.

With regard to copayments, Professor Morgan, specifically how does that work in other countries? What would happen if a person were not able to pay a copayment in a universal pharmacare-type system? Are there allowances for that in other jurisdictions that have the type of plan that we're discussing here today?

● (1715)

Prof. Steven Morgan: Most of the universal public systems that we would compare to—the U.K., Sweden, Norway, Australia, New Zealand—have fairly limited copayments, with the exception of Australia. Australia has about a $35-per-prescription copay for general beneficiaries. If you're disabled, low-income, or over 65, you pay what's called a concessional fee, which is significantly less.

Unfortunately, in countries that have high copayments for all medicines, such as Australia, patients do go without prescriptions, just like Canadians do when we face deductibles and co-insurance.

This is why countries such as the Netherlands and most health management organizations or health maintenance organizations in the United States and other systems use what's called tiered copayments. The stuff that is truly essential, proven clinically effective, cost-effective, and preventative is free.

The stuff that is more discretionary, or second-line therapies, may have copayments. Again, in most comparable systems those copayments are relatively modest unless it's truly a third-line therapy that patients shouldn't be taking unless they've gone through prior therapies. Again, in most of these countries that we would compare to that are universal, the rate of access barriers are very low, with 4% or less of their population reporting those problems.

Mr. Colin Fraser: Okay. Thank you.

At the pharmacy itself, when a prescription is being filled under a type of universal pharmacare program, do you see any differences in how people are able to get their prescriptions filled right now under this type of scheme, where it's being paid for, rather than going through an insurance company or being out of pocket? Is there a difference when it's done through a copayment under the universal plan?

Prof. Steven Morgan: It would be very similar to the way that our drug benefit programs work in most provinces for populations that are eligible for public plans that exist today. Most of them they present their CareCard and pay their copayment. If they were exempt, they would pay nothing and get the prescription. It would be much like the systems today. In fact, I think it would build on the systems today, because the provinces would continue to run them. Some provinces even use third-party payers such as Green Shield and Blue Cross to do the processing for the provincial plans. That may not change.

Mr. Colin Fraser: Okay.

I can ask Dr. Gagnon a question as well.

What challenges do you see in other countries? I know other countries have a type of universal pharmacare program. What challenges do you see in those types of systems that we would want to avoid here in Canada if we were to implement a pharmacare program here?

Dr. Marc-André Gagnon: There are a variety of regimes with

[*Translation*]

very different terms and conditions.

[*English*]

In the end, in terms of tiered copayment, for example, in France the problem is that you have complementary insurance. You have a system to promote or guide the use of the most cost-effective prescription drugs, but then you have complementary insurance that eliminates the work that has been done with these tiered copayments by reimbursing everything. This is one of the issues.

We need to absolutely avoid any type of co-insurance or deductibles based on the listed price of the drug, which reflects nothing now, because it's all about confidential rebates. Any co-insurance copayment based on the listed price should be avoided. At the same time, what is needed is a drug plan that is not an open bar and builds the institutional tools necessary to promote a more rational use of medicine. This is what we see in Australia, for example, with the NPS MedicineWise system. This is what we see in the Netherlands with the Institute for the Rational Use of Medicine. These would be the tools needed in order to make sure that this public drug plan works efficiently to the benefit of the whole population and monitors what's going on to make sure that we always have the highest standards in terms of prescriptions.

The Chair: Okay. Thank you very much.

Time is up. I'm going to have to keep everybody to three minutes.

Ms. Gladu is next.

Ms. Marilyn Gladu: This question is for Mr. Frank.

My concern is if we take all of the private systems today and we roll that all into the public system, I assume then that all the people who work for Sun Life, Great-West Life, and all those different companies will lose their jobs.

Do we know how many people work in those industries today?

● (1720)

Mr. Stephen Frank: No, and I think this goes back to my comment earlier about administrative costs. We don't sell drug coverage. We have a sales force, an executive team, back office people, and they are supporting a whole suite of things.

To give you an analogy, if Canadian Tire stopped selling automotive supplies tomorrow, and that whole wing of the store went away, they're not going to fire every employee in the store, right? The business gets resized, but you still have to support everything else you're doing. It's hard to estimate what the effect would be. There would be some job losses there for sure, but the costs to the system don't go away. Most of the people would stay in place; they would just be redirected to other services that we would continue to offer to employers.

Ms. Marilyn Gladu: Okay. Very good. Thank you.

I think it was Mr. Gagnon who talked about how Canada has the second-highest prescription drug use in the world. If we think about the amount of money per capita that we're paying for our drugs, it's the most in the world. It might have been Mr. Morgan.

The example was that there are other places, such as Australia, New Zealand, and Norway, where the cost is much lower. I'm interested to know what they're doing differently. It can't be a volume leverage, because there are only 24 million people in Australia, five million in New Zealand, and five million in Norway.

How are they getting such a low drug cost per capita? Does anyone know?

Dr. Marc-André Gagnon: In terms of drug costs, there are two things: price and volume. On the issue of price, we're doing a bad job in terms of pricing, so we could reduce price. For that, basically a national formulary is the best tool to build bargaining power. In terms of volume, it's promoting a rational use of medicine. This is exactly what I mentioned with Australia, with the Netherlands, with the U.K., and with NICE, for example. These are the tools absolutely necessary in order to make sure.... There is an issue of under-prescription in Canada, there's an issue over-prescription, and there's an issue of misprescription as well, and we don't have any tools to act on these issues right now. A drug plan's purpose is not only to make sure that those who do not have access to the drugs they need will have access now, which is absolutely important, but it's also a way to promote more rational use of medicine, avoid over-prescription, and eliminate misprescription as well.

Ms. Marilyn Gladu: Someone made a statement that we don't know who the people are who can't afford insurance. Do we really not know? Is it not low-income people and seniors on fixed incomes?

Prof. Steven Morgan: I think it's safe to say we do have a fairly good idea of people who can't access medicines. It is people with lower income, and not having coverage is the most significant determinant of whether or not you are going to fill a prescription. In fact, a high-income person without insurance is more likely to not fill a prescription than a low-income person with insurance. This is a big issue.

I have a paper in the *Canadian Medical Association Journal* from this year, which the analysts might be interested in seeing, about the differences in volume in therapy purchased by comparable countries. It's not that big. The difference is in prices and the difference is in product selection decisions. It's about whether lower-cost options are being used more often versus higher-cost ones.

The Chair: Go ahead, Mr. Davies.

Mr. Don Davies: Dr. Gagnon, you've already talked about the inefficiencies you see in the private system. You said that "$5 billion a year is wasted because private drug plans pay for unnecessarily expensive drugs and dispensing fees", without any evidence of increased efficacy, I take it. You talked about "administration costs of for-profit private plans". You've described them as "enormous: around 15%, while administration costs for public plans are less than 2%."

Given these inefficiencies associated with private coverage, is a public single-payer pharmacare program, in your view, preferable to a mixed private-public system from a fiscal perspective?

Dr. Marc-André Gagnon: Yes, absolutely. The $5 billion in waste among private plans is a number by a pharmacy benefits manager, Express Scripts Canada. On administration costs, you mentioned $9 billion. Keep in mind that you have $5 billion in waste and you have $1.4 billion in tax subsidies, so basically this is public money spent for private regimes. You have the administration cost differences, $1.6 billion, and you have another 30% for the private coverage of public employees. If you do the math, we're beyond $9 billion.

Mr. Don Davies: On math, Dr. Morgan, you, in your 2015 study, did a range of best-, worst-, and mid-case scenarios.

You said:

> Universal public drug coverage would reduce total spending on prescription drugs in Canada by $7.3 billion (worst-case scenario $4.2 billion, best-case scenario $9.4 billion). The private sector would save $8.2 billion (worst-case scenario $6.6 billion, best-case scenario $9.6 billion), whereas costs to government would increase by about $1.0 billion (worst-case scenario $5.4 billion net increase, best-case scenario $2.9 billion net savings).

If we brought in universal pharmacare, what do you think we would save as a country annually, after the rollout period?

● (1725)

Prof. Steven Morgan: I think the best estimates are that we'd save about 30% of what we're spending at that time, and at the time we did the *Canadian Medical Association Journal* study, that was about $7 billion of the drugs eligible for coverage. By the time Canada rolls such a program out, it will be a different number. It will be bigger than $7 billion or around $7 billion, depending on whether or not we're able to keep the spending levels constant right now under the pressures we're facing.

Mr. Don Davies: Approximately how long will it take, do you think, before we start realizing net savings?

Prof. Steven Morgan: I think, particularly under an essential medicines list, you could realize it within a year, because it's inherently feasible to start running a program of that kind, and then it will take a couple of years to move forward on a larger formulary. Just bear in mind that our comparator model in North America might be the USVA. They nationalized their system of drug benefits to a national formulary with national purchasing strategies. Initially they were able to roll out savings in the very first year, and then it took a few years for them to determine how far they were willing to go together as regional—

Mr. Don Davies: Is there any reason we should wait?

The Chair: Sorry: time's up. We have 19 minutes until the vote.

Go ahead, Mr. Eyolfson, for three minutes.

Mr. Doug Eyolfson: To Dr. Raza, you were asked a question before. Here's something that Mr. Van Kesteren and I agree on, which doesn't happen very often.

We know we could decrease costs if illnesses were better controlled, if people's weights were controlled, if their diets were controlled, if they had better exercise, and if they didn't smoke.

What economic strata do people fall into who don't have these things well controlled? Are rich people more likely to be obese, or poor people?

Dr. Danyaal Raza: These sorts of factors are more prevalent among people who have a low income.

Mr. Doug Eyolfson: Smoking?

Dr. Danyaal Raza: Low income.

Mr. Doug Eyolfson: Uncontrolled diabetes?

Dr. Danyaal Raza: Low income.

Mr. Doug Eyolfson: Lack of exercise?

Dr. Danyaal Raza: Low income.

The other thing I will add is these are some, but there are also many underlying issues besides income, as people such as racialized Canadians and women face systemic barriers to education. There are a whole host of these social factors, these social determinants of health, that result in Canadians getting sick and in different types of Canadians getting sicker than others.

Mr. Doug Eyolfson: Professor Morgan, this has been a big interest of mine, as you know from previous meetings. I'm an emergency physician. I would see these people first-hand who couldn't afford their medications. A patient would come in with diabetic ketoacidosis and end up in the intensive care unit. You could have a $50,000 admission. Every patient on dialysis costs our system about $70,000 a year. All these examples add up.

What would be your best estimate, based on your research, as to what the annual cost is due to cost-related non-compliance?

Prof. Steven Morgan: The estimates that are available for Canada are not great. We don't have gold standard science at present, so they range from $1 billion to $9 billion, depending on which study you look at.

In using studies that have been done in the United States about the effect of getting access to preventative medicines for patients insured in the U.S., they actually find that you save as much money in the rest of the system as you spend on the coverage. That would also put this in the range of billions of dollars. We're not talking about small amounts of money in terms of health system savings, or at least, in reality, it's reduced pressure on an already overburdened health system.

Mr. Doug Eyolfson: Thank you. I have no further questions.

The Chair: Thanks very much. We have 17 minutes before the vote.

I want to thank our witnesses again. This committee must have the best, highest-quality witnesses of any committee in Parliament.

On behalf of the whole committee, I want to thank you all for sticking with us. Some of you have been here for 18 months, as we've been going through this process, but it's a great process. We have different perspectives and our witnesses do not always agree, but we get the very best perspectives. We're lucky to have that.

This is the last committee meeting on pharmacare. The next thing will be our report.

I also want to thank all the committee members for doing a great job. It's an important issue, perhaps the most important one being talked about on the Hill. Again, thank you very much to the witnesses.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

SPEAKER'S PERMISSION

The proceedings of the House of Commons and its Committees are hereby made available to provide greater public access. The parliamentary privilege of the House of Commons to control the publication and broadcast of the proceedings of the House of Commons and its Committees is nonetheless reserved. All copyrights therein are also reserved.

Reproduction of the proceedings of the House of Commons and its Committees, in whole or in part and in any medium, is hereby permitted provided that the reproduction is accurate and is not presented as official. This permission does not extend to reproduction, distribution or use for commercial purpose of financial gain. Reproduction or use outside this permission or without authorization may be treated as copyright infringement in accordance with the *Copyright Act.* Authorization may be obtained on written application to the Office of the Speaker of the House of Commons.

Reproduction in accordance with this permission does not constitute publication under the authority of the House of Commons. The absolute privilege that applies to the proceedings of the House of Commons does not extend to these permitted reproductions. Where a reproduction includes briefs to a Committee of the House of Commons, authorization for reproduction may be required from the authors in accordance with the *Copyright Act.*

Nothing in this permission abrogates or derogates from the privileges, powers, immunities and rights of the House of Commons and its Committees. For greater certainty, this permission does not affect the prohibition against impeaching or questioning the proceedings of the House of Commons in courts or otherwise. The House of Commons retains the right and privilege to find users in contempt of Parliament if a reproduction or use is not in accordance with this permission.

Also available on the House of Commons website at the following address: http://www.ourcommons.ca

Publié en conformité de l'autorité du Président de la Chambre des communes

PERMISSION DU PRÉSIDENT

Les délibérations de la Chambre des communes et de ses comités sont mises à la disposition du public pour mieux le renseigner. La Chambre conserve néanmoins son privilège parlementaire de contrôler la publication et la diffusion des délibérations et elle possède tous les droits d'auteur sur celles-ci.

Il est permis de reproduire les délibérations de la Chambre et de ses comités, en tout ou en partie, sur n'importe quel support, pourvu que la reproduction soit exacte et qu'elle ne soit pas présentée comme version officielle. Il n'est toutefois pas permis de reproduire, de distribuer ou d'utiliser les délibérations à des fins commerciales visant la réalisation d'un profit financier. Toute reproduction ou utilisation non permise ou non formellement autorisée peut être considérée comme une violation du droit d'auteur aux termes de la *Loi sur le droit d'auteur.* Une autorisation formelle peut être obtenue sur présentation d'une demande écrite au Bureau du Président de la Chambre.

La reproduction conforme à la présente permission ne constitue pas une publication sous l'autorité de la Chambre. Le privilège absolu qui s'applique aux délibérations de la Chambre ne s'étend pas aux reproductions permises. Lorsqu'une reproduction comprend des mémoires présentés à un comité de la Chambre, il peut être nécessaire d'obtenir de leurs auteurs l'autorisation de les reproduire, conformément à la *Loi sur le droit d'auteur.*

La présente permission ne porte pas atteinte aux privilèges, pouvoirs, immunités et droits de la Chambre et de ses comités. Il est entendu que cette permission ne touche pas l'interdiction de contester ou de mettre en cause les délibérations de la Chambre devant les tribunaux ou autrement. La Chambre conserve le droit et le privilège de déclarer l'utilisateur coupable d'outrage au Parlement lorsque la reproduction ou l'utilisation n'est pas conforme à la présente permission.

Aussi disponible sur le site Web de la Chambre des communes à l'adresse suivante : http://www.noscommunes.ca