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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1535)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call the meeting to order. This is meeting number 10 on this subject.

I'd like to welcome our guests here today, both here and on television. I want to welcome Mr. Frank Swedlove, president and CEO of the Canadian Life and Health Insurance Association, and Mr. Stephen Frank, vice-president of policy development and health at CLHIA. I want to welcome, by television, Anita Huberman, CEO of the Surrey Board of Trade.

I'm going to ask Anita to go first. I'm going to ask you to speak slowly because we have translation here and we need to keep up. We have 10 minutes maximum for each presentation, and then we have questions after that. We'll most likely be very interested in asking questions.

Perhaps you would go ahead and make your presentation.

Ms. Anita Huberman (Chief Executive Officer, Surrey Board of Trade): Thank you very much.

My name is Anita Huberman. I'm CEO of the Surrey Board of Trade, and thank you for listening to the business perspective on universal pharmacare benefits for businesses.

The Surrey Board of Trade is the second largest in B.C., with a membership of over 2,100 small, medium, and large businesses in shipping and transportation industries, manufacturing, high tech, consultants, non-profits, and small commercial enterprises.

The Surrey Board of Trade has prepared motions in favour of a universal public pharmacare system that improves coverage for all Canadians. The reason we have taken this position is that our members have expressed serious concerns in a number of areas.

There are strains on all businesses. Costs are high and uncontrolled for those who do offer drug coverage. Costs are an impediment for some companies to offer any coverage. There are concerns that a catastrophic public drug plan like B.C.'s still places a major burden on sponsors of private plans. Businesses are also very concerned about government passing a law that would make private insurance mandatory, as in Quebec.

When businesses come to us with concerns such as these, we have to respond by investigating and determining a policy direction that would best serve our members, the businesses of Surrey, British Columbia.

What we found is that there are inequities in access to care. Businesses care about the health and well-being of their employees, their families, and their communities, but the uncontrolled cost of private drug coverage in Canada means that our system has many gaps in coverage. We know that the committee has already heard that at least one in 10 Canadians does not take medications as prescribed because of cost.

Studies in the *Canadian Medical Association Journal* and by the Angus Reid Institute both indicate that access to medicine is particularly bad in B.C. This is because the deductibles under B.C.'s catastrophic public drug plan have been shown to reduce the use of preventative treatments that patients do not necessarily prioritize in ways that the health care system would want them to.

In the end, we all pay more when patients don't get the medications they need, because they end up in hospital, which can cost taxpayers a lot more than appropriate prescription drugs would cost in the first instance.

Inefficiencies of fragmented coverage is the next area. Businesses know better than anyone else how important it is to focus on core competency and to maximize the efficiencies of those processes. Canadian businesses are therefore concerned that the fragmented nature of drug coverage in Canada results in excess administrative costs, reduced purchasing power, and a silo mentality that may limit the overall efficiency of Canada's medicare system.

There is no doubt that the fragmentation of drug price negotiating power in Canada means higher drug costs. You have already heard government officials and academic experts say that our drug prices are higher in Canada than in comparable countries worldwide. I don't need to repeat the statistics that more informed experts can provide, but businesses are increasingly aware that the inefficiencies of the system are a drag on their competitiveness.

In our research we found a report by Express Scripts Canada that says $5 billion is paid out every year by employers and unions in order to cover poor drug choices and unnecessarily expensive pharmacy services, but individual businesses and employee groups are not in the best position to rein in these costs.

One of the problems with our system is that private insurance for drugs and public insurance for medical care creates a silo between the management of those critical parts of our health care system. It would be more efficient for the costs of medically necessary prescription drugs to be managed along with the budgets for other forms of care. In the Canadian context, that means it makes the most sense for those costs to be managed by provincial governments, in co-operation with each other and with the federal government.

Uncontrolled drug costs are a lost opportunity to improve workplace health. Having a universal public pharmacare system would not put an end to workplace benefits. On the contrary, it would provide an opportunity to enhance those benefits. The high price of medications today, many of which now come to market at prices of tens of thousands of dollars per patient per year, require coverage and cost-control policies out of the reach of the private sector in Canada.

It will be for tax experts to decide exactly how to fund a universal pharmacare program. Businesses in Canada must be at the table in negotiating that funding mechanism, but businesses would support the movement towards a public pharmacare program that achieved system-level savings that we would all benefit from. Importantly, the private sector in Canada can use the funding freed up by a more efficient pharmacare system to make other important investments in the health of our employees and in our families.

Governments have cut public coverage for a wide range of services that Canadians need. Vision care, dental care, hearing care, physiotherapy, and mental health are all areas where employers and unions could make new investments with savings stemming from the savings created through a universal public pharmacare program. These other benefits are essential to patients and, from a business perspective, they are more predictable and manageable than the now out-of-control costs of pharmaceuticals in Canada.

In conclusion, the Surrey Board of Trade firmly supports a universal public pharmacare program that would use bulk purchasing and evidence-based coverage policy to improve and assess medicines while lowering costs for all Canadians. We firmly hope that this committee of Parliament will understand that it is important to have the right system in place—and we're pleased to have you considering this today—a system that is equitable, efficient, and aligned with the other core components of health care in Canada.

We would respectfully request that the committee let businesses focus on running their businesses by putting the management of universal drug coverage in Canada in the hands of those managing our universal health care system. Businesses would support a policy that did this fairly and efficiently.

Thank you so much for the opportunity to allow me to speak to the committee this afternoon.

● (1540)

The Chair: You've packed a lot of information into eight and a half minutes, so thanks very much.

Next we'll go to Mr. Swedlove.

[*Translation*]

Mr. Frank Swedlove (President and Chief Executive Officer, Canadian Life and Health Insurance Association): Thank you, Mr. Chair.

The Canadian Life and Health Insurance Association represents life and health insurance companies accounting for 99% of the life and health insurance in force across Canada, and the industry provides supplemental health benefits to roughly 27 million Canadians.

I would like to congratulate the federal government for re-engaging in the health care system in Canada.

● (1545)

[*English*]

Let me congratulate this committee also for conducting hearings into this critical issue of how Canadians access their needed prescription drugs.

I want to very clear that Canada's insurers do not believe that the current system is working as well as it should, and we strongly support fundamental reform. No Canadian should have to choose between putting food on the table and their needed medication.

The good news is there are a number of simple policy measures that will make a significant positive impact with very little cost to either government or employers.

The best solution will be one that leverages the strengths of both the public and private sectors and brings them together in a coordinated way for the benefit of all.

As the committee is aware, the responsibility for prescription drug coverage is shared between the public and private sectors. In 2014, our industry directly reimbursed over $10 billion in drug costs. When you add in those amounts paid by individuals directly, over half of all the costs for prescription drugs are paid for privately.

Canadians place a high value on their private drug coverage, and for good reason. Private sector plans have been shown to have significant advantages over the public ones. Let me elaborate on this.

First of all, private insurers generally provide Canadians with access to far more drugs than public plans, and we allow access to new drugs much more quickly than public plans. This is a critical point because, contrary to what many advocates for reform suggest, nationalizing prescription drug coverage will result in a material pullback in coverage for the majority of Canadians.

Second, Canada's insurers have also introduced some of the most important patient-centred innovations over the past several years. For example, in 2013 the industry introduced the Canadian Drug Insurance Pooling Corporation. This pooling arrangement covers all fully insured drug plans and helps small and medium-sized employers maintain their drug benefits even in the face of recurring high drug cost claims.

It is also now standard for insurers to offer a full range of innovative solutions to plan sponsors that incorporate clinical evidence into plan formulary designs while also improving patient outcomes and reducing costs. A good example of that is what we refer to as case management.

I'd like to provide a couple of examples. Let's look at Mary. Mary has a prescribed biologic drug that needs to be injected. She was having trouble injecting herself, and as a result was not compliant with the new therapy. The case manager identified that Mary was having issues and worked with her to find resources and training to help her become more comfortable with the injections. As a result, Mary was able to administer her medication and comply with her therapy.

A second example is John, who is on Humira, but the medication was not achieving good results. The physician then increased the dosage by four times the recommended dose, which increased the potential for side effects and significantly increased costs. The case manager worked with the physician to suggest an alternate medication that had the added benefit of being lower in cost. John was prescribed the new medication and started to improve, a good example of improving patient outcomes while reducing cost.

There is no similar case management program support for those on public plans in Canada.

Finally, I would highlight that we take our responsibilities to reduce inequities in access to drugs seriously. For example, just last year, private insurers worked closely with rheumatologists from across Canada and agreed to a common national clinical standard for access to biologic drugs for patients with adult rheumatoid arthritis.

[*Translation*]

In our view, however, neither governments nor Canada's insurers can independently solve the long-term challenges facing the system. The best solution for Canadians will be the one that leverages the strengths of both the public and private sectors and brings them together in a coordinated way.

[*English*]

I will now provide some specifics.

Broadly, we believe there are two major issues that need to be addressed. The first relates to putting the system on a more sustainable path financially, and the second relates to greater equity around access.

The good news is that there are already solutions to both of these challenges that could be implemented quickly, with minimal changes to the structure of the system and with minimal costs. As the committee is aware, the provinces, and recently the federal government, work together through the pan-Canadian Pharmaceutical Alliance, or pCPA, to jointly negotiate lower drug prices. The pCPA helps reduce drug prices not only for new patented drugs but also for generic drugs and subsequent entry biologics, or SEBs. The difference in pCPA's approach for generics and SEBs versus patented drugs is instructive and, we believe, points us in the right direction going forward.

With respect to generics and SEBs, the pCPA leverages the government's buying and regulatory power to reduce prices for all Canadians equally. Regardless of whether individuals get their generic or SEB drugs reimbursed by the public or the private sector, everyone pays the same lower price. This has been enormously helpful in reducing the costs for all Canadians over the past number of years.

Unfortunately, the pCPA's approach to lowering prices for new patented drugs does not follow this approach. Rather, for patented drugs, the pCPA negotiates confidential lower prices that apply only to the minority of Canadians covered under the government plan. Those with private coverage or paying out of pocket are left to pay the much higher list prices. This is not an equitable or sustainable approach.

There is a very simple solution to this: namely, allow private insurers to join the pCPA. Having Canada's insurers in the pCPA would allow negotiators to leverage the volumes of the entire Canadian market when negotiating lower patented drug prices. Critically, this will ensure that all Canadians are paying the same lower price and improve the financial position of all plans over time. It is important to note that this would not require any incremental cost to governments and could be accommodated within the current system. There is really nothing holding us back from doing this.

Another important issue we would like to see addressed with respect to pricing is reform of the Patented Medicine Prices Review Board, or PMPRB. This is particularly germane to this committee, given that accountability for the PMPRB falls exclusively within federal jurisdiction. The PMPRB has a mandate to act as a consumer protection agency by capping prices of new drugs at levels that are deemed “not excessive”. Unfortunately, the way in which the PMPRB does this has resulted in list prices in Canada that are among those of the top handful of countries globally, and certainly well above the OECD average.

We believe the PMPRB's mandate needs to be reformed. It should be to establish price ceilings that are as low as possible, rather than simply “not excessive”.

Finally, we acknowledge that access to drugs remains unacceptably uneven across Canada. Different drugs can be available to patients depending on their province and/or the plan design chosen by their employer. This may be particularly pronounced for new and expensive drugs. We need to do better. The industry supports the establishment of a common national minimum formulary. Such a national minimum formulary would ensure a baseline of coverage for all Canadians and would reduce some of the existing complexity in the system. This approach would still allow those provinces, plan sponsors, or individuals who want additional coverage to have it.

With respect to very rare drugs, or “orphan drugs”, we equally believe that governments and private insurers need to work together to develop a common approach to providing access to these medications. If there is one area where a common approach is critical, it is for those drugs that have very small patient populations, yet have very significant costs associated with them.

● (1550)

[*Translation*]

In conclusion, any long-term solution will require both governments and private insurers to make adjustments to their programs and to work better together going forward.

The good news is that there are a number of simple policy measures we can take in the short term that will have a significant positive impact, with little to no cost to either governments or employers.

We look forward to the continued dialogue on this critical issue and would be pleased to answer any questions you may have.

Thank you.

[*English*]

Thank you very much.

The Chair: Thank you very much.

Now it's Mr. Frank.

Mr. Frank Swedlove: Mr. Frank is with me, so both of us made the statement.

The Chair: Oh, I'm sorry. We have done all introductions, then.

We are going to start questions. We are going to start with Mr. Ayoub.

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

My question will be in French, if you don't mind.

[*Translation*]

I have prepared a number of questions, but in going over your presentation, some others came to mind.

Everyone is in favour of reducing drug prices and improving access to better drugs. You said there were some very simple solutions that could be used to bring down prices. There may be a lack of dialogue or a lack of consistency, if you will, around drug pricing or regulation. If the solutions are so simple, why hasn't it been possible to come to some agreement prior to now? What are the previous pitfalls attributable to? The committee's examination presents us with an opportunity to talk about that. What were the first pitfalls due to?

Mr. Stephen Frank (Vice-President, Policy Development and Health, Canadian Life and Health Insurance Association): We are talking about a process that's fairly new for the provinces. The pan-Canadian Pharmaceutical Alliance, or pCPA, is a system for negotiating drug prices that has been around for four or five years. This is a rather new concept in Canada and shows that progress is being made on the issue.

As Mr. Swedlove mentioned, we believe that progress can continue with the inclusion of private insurers, as is done for generic drugs and subsequent entry biologics. This concept is new to the system, and we are maintaining good dialogue with the provinces and the federal government.

Mr. Frank Swedlove: Our association was also invited to join the pCPA. We expressed our interest but are still waiting for the governments' answer.

Mr. Ramez Ayoub: Very well.

So the solutions have been known for some time. They are already on the table.

The Canadian Life and Health Insurance Association makes a number of recommendations in its report, including one about the approval of new drugs. Could you explain to me why Health Canada takes longer to approve new drugs than regulators in Europe or the U.S.?

Why do you think the process is longer in Canada than it is in European countries or the U.S.?

● (1555)

Mr. Stephen Frank: Unfortunately, we don't have an answer to that.

Our involvement in the system begins once the drugs are approved and introduced to market. We know the process of approving new drugs in Canada is longer than it is elsewhere, but we haven't probed the issue any further.

Mr. Ramez Ayoub: You don't even have the slightest idea as to why? It's rather concerning that you have no—

Mr. Frank Swedlove: It's the government that decides.

Mr. Ramez Ayoub: I understand that, but when you work in a specific field, you generally try to figure out what the source of a problem is. You look at what's going on and where the stumbling blocks are coming from. You really don't have an opinion on the subject?

Mr. Frank Swedlove: No.

Mr. Ramez Ayoub: Another one of your recommendations is to give pharmacists more flexibility to substitute drugs or therapies.

Would you mind elaborating on that a bit?

Mr. Stephen Frank: We believe pharmacists' expertise could be applied in many more situations than it currently is. We think it would be a value-added service for our members if pharmacists were able to substitute drugs and offer patients other types of services. That's why we support this approach.

In collaboration with pharmacists in every region of the country, insurers have tried a number of models to find a way to compensate pharmacists for the services they provide to our members. Insurers are keen to find a way to put pharmacists to better use within the system. We believe that, by extension, pharmacists could help bring drug prices down and improve patient outcomes. That's something we are very interested in.

Mr. Ramez Ayoub: I think those sorts of practices are already happening in Quebec. The province is open to that idea. More recently, they have become more and more involved. Are you familiar with what's happening in Quebec?

Mr. Stephen Frank: Are you referring to drug substitutions, in particular?

Mr. Ramez Ayoub: I'm referring to pharmacists' involvement in drug therapies.

Mr. Stephen Frank: The relationship with pharmacists varies from province to province. Some very meaningful discussion on the subject is happening right now in Quebec, and we are paying very close attention. We are in favour of leveraging pharmacists' expertise more than is currently the case.

Mr. Ramez Ayoub: But you haven't seen any results on that front yet, have you?

Mr. Stephen Frank: As I just said, every province approaches the process differently. Alberta, for example, gives pharmacists a lot more power than Quebec currently does. Each province has its own approach, but we support the idea of getting pharmacists more involved.

[*English*]

Mr. Ramez Ayoub: Mr. Chair, how many minutes do I have left?

The Chair: You have 47 seconds left. Use them wisely.

[*Translation*]

Mr. Ramez Ayoub: You talked about changing the fee structure as opposed to capping prices. While it may seem like a straightforward option, would you mind explaining the difference between the two?

Mr. Stephen Frank: The PMPRB has a mandate to ensure that prices are not excessive. We believe, however, its mandate needs to be changed so that the board can work to establish the lowest prices possible for Canadians.

Given how the market works, price ceilings are going to stay, but the level they should be set at needs to be determined. We believe it could come down if the PMPRB's mandate were changed so that the board could really work to achieve the lowest possible prices for Canadians.

● (1600)

Mr. Ramez Ayoub: Thank you.

[*English*]

The Chair: Dr. Carrie.

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

I thank the witnesses for being here.

Mr. Swedlove, in your opening statement on page 2, you actually say, "...private insurers generally provide Canadians with access to far more drugs than public plans and we allow access to new drugs much more quickly than the public plans."

Some of the witnesses we heard earlier don't think the same way as you do on that. Do you have any numbers to support that statement?

Mr. Frank Swedlove: Well, there was some work that was done by researchers with the Canadian Health Policy Institute, which is a health think tank. They did a survey of drugs in 2012, and of the 36 new drugs that were approved by Health Canada, 92% were covered by at least one private drug plan in that year, compared to only 11% that were covered by at least one public plan.

In terms of time, the private drug plans took about 143 days to approve a new drug on average, while the public plans took 312. That's significantly faster approval of new drugs than the public plans managed to do.

Mr. Colin Carrie: You mentioned as well your experience with the pCPA, and basically we've heard that it does take them a long time to approve and negotiate these things. It seems it would take years for a government pharmacare agency to renegotiate these thousands of drugs and thousands of contracts out there with drug companies. If my memory serves, they said they've done about 100 now, or something along those lines.

Can you tell us what you would expect the initial cost the government would have to absorb would be, say, on day one, if the government were to undertake a national pharmacare program? How much more would this cost the Canadian taxpayer if the government just decided unilaterally to implement something like this?

Mr. Frank Swedlove: Some of the advocates who have supported the concept of a public plan talk about the significant savings associated with having one national plan. The concept there is, of course, that you'd have one bargaining unit that would significantly reduce the cost.

Our view is that the concept of having one unit negotiate the cost with the drug companies is a valid one, and we would support that. We believe that could be done through the pCPA. However, if you were to establish tomorrow or next year or whatever date you choose for establishing a single entity that would do the pharmacare, they would still need many, many years to negotiate the thousands of drugs that are in place. It would take maybe 10 or 20 years to negotiate all the drugs, so the savings that one thinks you might get by establishing this new national pharmacare would take a very, very long period.

On day one, what would have to occur is that the federal and provincial governments would have to pay essentially what the private sector now pays, less, maybe, the fact that they don't cover some, plus some generic substitutions that would take place. If you take those two elements out, we figure we would be still left with about $13 billion that would have to be covered by the government on day one.

Mr. Colin Carrie: That's not quite what we've heard from other witnesses, so I wanted your opinion on that.

In your opening remarks you talked about the pCPA and how their pricing could be applied to all Canadians, private and public, and Canadians would benefit from cost savings. I think some other witnesses said that wouldn't be the case, because you guys would simply eat it up in profits and stuff like that, because you're the big, bad corporation. I'm quite curious about what benefits Canadians would get. Would they be guaranteed to get better prices?

Mr. Frank Swedlove: Well, it's a highly competitive industry. I believe we have roughly 30 companies that are involved in the business, and they compete very actively for that business. There's not a lot of excess profit in that business. We have been aggressively pushing for lowering the cost of drugs for a long time now, and we want to see that because we want to see that money being reinvested in other health opportunities. I think that's a very important part of it.

● (1605)

Mr. Stephen Frank: Maybe I can spend a quick second explaining how the flow-through of costs works on the private side.

The majority of Canadians would be covered in the type of plan that we would call administrative services only, which means the employer pays the cost of the drug and the insurer provides administrative services. In that scenario, which would apply to the vast majority of people, any reduction in price gets passed immediately through to the consumer on day one, the first time they present at the pharmacy.

For those plans that are insured, insured plans are repriced on an annual basis, and they get a price based on the trend. If the trend has come down in the previous year because of price reductions, that would get reflected in their premium increases. There would be a lag there for those who have insured plans, but you're probably talking maybe 12 months before that would be reflected in their premiums.

The message is that the cost of the drug is sort of an input to the service we provide to employers, and it's a direct pass-through for the majority. For the rest it's not, it's an indirect one, but it's certainly a very quick follow-on.

To the nub of your point, there's no chance that the insurers are going to be absorbing any of those benefits. Those would get passed through to our plan members and plan sponsors.

Mr. Colin Carrie: Some people talk about some monopoly type of system. I'm sure some Canadians wonder if the government-run monopolies always work all that well, and coming from Ontario, I can tell you that is our experience.

With regard to issues in other countries that have these monopolies, as we've heard in relation to the U.K. and New Zealand, do you have any data from those countries in which they have a different system? I know it's hard to compare apples to apples and to oranges and that type of thing, but with these systems that are more of a monopoly type of system, what are we seeing on the ground there?

Mr. Stephen Frank: I think it's fair to say that those two countries in particular have done a good job of controlling cost. I think the bottom line is that the way you tend to control cost is by restricting access. That's the trade-off you have to balance in these things.

When you look at the U.K., particularly with some of their.... We're getting some interesting data around cancer survival rates in the U.K., which are slipping and falling behind, and they've been slower than other countries to approve new cancer drugs. There's a link there, to the point that the government in the U.K. has just had to introduce a completely new program to start re-funding cancer drugs again so that they can do a catch-up. They may have overreached there.

New Zealand is a very low-cost environment but has an extremely restricted formulary. Polling of doctors there suggests that 75% of them in the last year have wanted to prescribe a drug that they've been unable to prescribe because it's not on their closed formulary.

So this is a trade-off. We could design a system in Canada that would be very cheap, but it would come at the expense of access. That has outcome consequences and implications for patients.

I think the New Zealand and U.K. examples are often used, but I think we need to be a little cautious as to what direction they point us in.

Mr. Colin Carrie: If I could ask you an opinion question—

The Chair: I'm sorry, but your time is up.

Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you to the witnesses for being here.

Mr. Swedlove and Mr. Frank, you represent the Canadian Life and Health Insurance Association. Would I be correct in thinking that your members make money from the administration of private health care plans? Is that right?

Mr. Frank Swedlove: Well, yes, they could make money; otherwise, I assume they wouldn't be in the business.

Mr. Don Davies: Would it be the case, then, if Canada were to move to a public, single-payer, first-dollar-coverage system, that your members would not make money? Would that hurt your business interests?

Mr. Frank Swedlove: They would redirect the capital into other businesses.

Mr. Don Davies: Right.

Ms. Huberman, the number of employers offering health benefits to new employees has fallen from 62% in 2002 to 49% in 2011. We already know that one-third of Canadians who are employed full-time have no drug coverage, that three-quarters of Canadians employed part-time have no drug coverage, and that one in 10 has difficulty paying for drugs even if they do have drug coverage.

My question is, why are employers no longer offering these kinds of benefits to their employees?

● (1610)

Ms. Anita Huberman: Well, really it's the bottom line. The cost of drugs is really eroding their bottom line, in small and medium-size enterprises especially.

Surrey is a small and medium-size business community, and they have to take a look at what they're spending their money on. That's why we're advocating for a universal pharmacare program in which the provincial governments and the federal government work collaboratively towards a solution whereby workers can have access to the drugs they need so that they can continue to be productive in the workplace.

Mr. Don Davies: Let me have a follow-up to that question. Many of the criticisms I hear today, some that you're hearing actually at this meeting, expressing why a universal first-dollar single-payer system won't work say that it's too expensive, that there will be reduced choice for consumers, that they won't be able to get the drugs they want. These are exactly the arguments that were made in the 1960s as to why Canada couldn't have a universal health care system—exactly the same arguments.

I'm wondering. A Canadian today can walk into a doctor's office, can get the treatment they need for whatever it is, from a broken finger to treatment for depression to treatment for psoriasis or whatever—literally thousands of different possibilities are treated by the doctor—and can walk out and not pay a penny. That service is paid for administratively under the single-payer system.

Is there any reason, in your view, Ms. Huberman, that a person couldn't walk into the pharmacy, hand over the prescription, get the prescription pills they need, and then that the pharmacist submit the bill, just as the doctor does in the health care system? Is there any reason we couldn't extend pharmacare under the same sort of principle and model that we already have for universal health care?

Ms. Anita Huberman: I think there's an opportunity right now for Canadians of today, in concert with business and government, to reduce the silos, to reduce the fragmentation. That type of model is definitely something that could be doable.

Mr. Don Davies: Mr. Swedlove, I'll come back to you.

Again, I'm going to quote some of the same figures. You just heard that under the private sector model, most Canadians who have coverage have it through their employer. About one-third of Canadians employed full-time, or 20% of Canadians, have no drug coverage whatsoever. That's seven million Canadians with no coverage whatsoever, or poor coverage. There is a reduction in the number of employers who are giving coverage to their employees today. Clearly, more and more Canadians are going without prescription drug coverage.

What would be your answer to that? How can we ensure that 100% of Canadians get access to the medicine they need?

I'll just add one more thing. You commented on strategies that might reduce the price of drugs, but that doesn't do anything for a person who has no coverage.

Mr. Frank Swedlove: I'm not sure of your statistics and I'm not sure where they're coming from in terms of the calculations.

I haven't seen stats that say that a third of full-time workers don't have coverage. Our stats suggest that 27 million Canadians have health coverage through our members, so it doesn't match up with your numbers

Mr. Don Davies: It's from the Health Charities Coalition. I'll send you the information afterward. That's where the data comes from.

Mr. Frank Swedlove: I'd appreciate that.

There's no question that there are gaps. We as a society should try to find ways to fill those gaps. We're certainly willing to work with provincial and federal governments to find ways of doing that.

The vast majority of Canadians can go into a drug store and get at least a very large proportion of their drug costs paid. They're paid by their employer, for the most part, or through union contracts.

Where there are gaps, we need to work to find solutions.

Mr. Don Davies: Yes, and I'm asking you, how would you fill that gap for that minority that can't?

Mr. Frank Swedlove: The provinces and the private sector could sit down and work together to identify those gaps, because it's not 100% clear where those gaps are, frankly. Generally, people at the very lowest income level or who don't have jobs get covered by the provinces. Seniors generally get covered by the provinces.

First of all, let's identify those gaps and let's try to deal with them.

● (1615)

Mr. Don Davies: You stated, as Dr. Carrie said, that private plans provide greater access than public plans and greater access to new drugs. I would put it to you, Mr. Swedlove, that this is not inevitably the case. We could certainly construct a national plan that has a wide formulary and finds a way to get new drugs onto that formulary in an effective way.

That's not impossible, is it?

Mr. Frank Swedlove: It's not impossible. Provinces choose to reduce access relative to the access our members have in order to reduce costs. I don't know whether a similar kind of pressure would exist with respect to a universal public pharmacare plan.

Mr. Don Davies: Thank you.

The Chair: Mr. Levitt, welcome to the committee.

Mr. Michael Levitt (York Centre, Lib.): Thank you very much, and thank you for your testimony here today.

Mr. Swedlove, my understanding is that when a private firm contracts with an insurer, there is an administrative fee for drug management that covers checking the status of the claimant, processing the claim, and issuing payment.

What is the average administration fee as a percentage for private sector plans, and can you tell us a little bit about how those fees are determined?

Mr. Stephen Frank: The average fee would be in the very low single digits. It would be determined based on the costs of the services you just identified. I'm not sure what else I could say on that.

Mr. Michael Levitt: Can you tell us about the process you or your members use to negotiate formularies, without going into necessarily deep specifics? How do the range of products come together?

Mr. Stephen Frank: When you say negotiate formularies, do you mean establish formularies, choices, or options?

Mr. Michael Levitt: Right.

Mr. Stephen Frank: An insurer would have a myriad of options they would offer an employer. Every insurer in Canada today has a fully managed, closed formulary they can offer to an employer, which means we assess every new drug that comes to market and we decide whether or not it is on the formulary. That could be offered as a solution to an employer.

We offer managed formularies as another option for employers, so you would say to an employer, "We'll give your plan members access to every drug on the market, but we'll tier those drugs", so drugs that are, in our view, clinically more beneficial will be in tier 1 and you'll pay a lower co-pay for those. It they're in tier 2, you'll pay a higher co-pay, and then in tier 3, you'll pay even higher. We would call that a managed formulary.

A lot of employers like that because it gives their employees choice and the ability to work with their physician for the types of therapies they should have. As well, there is any sort of combination in between, so we can design everything. Generally we would meet with an employer, and for the larger ones in particular there are highly customized solutions. We would work with them or their union and ask what kinds of benefits they would like and we would design those for them.

For smaller and medium-sized employers, we tend to pitch a sort of package deal to them.

Something I'll highlight that is really important is that we don't really sell drug benefits to employers; we sell benefits. Even within the design of a drug plan, you're going to position that within how you are managing your dental coverage and your vision coverage, how you are managing your disability benefits, what you are doing on your pension side, and whether you have a DC—defined contribution—or a defined benefit plan, a DB. That's the discussion you have with an employer. You don't go in and sell them their drug plan.

When employers look at how they want to structure things, they do that in the context of everything they're doing to try to bring in their employees.

That is, at a high level, the kind of discussion you would have when you're pitching a program.

Mr. Michael Levitt: Thank you.

Just as a quick follow-up on that, how do you adapt to the need for rare drugs? What pricing mechanism do you use to account for those needs in particular?

Mr. Stephen Frank: It's the same thing. Mr. Swedlove mentioned the Canadian Drug Insurance Pooling Corporation, which we created in 2013. That gives us an opportunity to spread the cost of recurring high-cost drugs for all fully insured plans, so that's something we've done.

We have started to do our own negotiations around pricing. The insurers that have sufficient scale have started to negotiate their own listing agreements on some of those high-cost drugs. It's another thing we do to help bring those costs down.

For things like case management, which Mr. Swedlove touched on in his speech, we use provider networks to try to reduce pharmacy costs. There is a whole suite of things that carriers do to manage costs and access, particularly for really high-cost drugs.

Mr. Michael Levitt: Mr. Chair, how much time is left?

The Chair: You have three minutes.

Mr. Michael Levitt: Are you aware of the September 2014 analysis published in the *Canadian Medical Association Journal* by Michael Law, Jillian Kratzer, and Irfan Dhalla, which looked at the efficiency of private health insurers in Canada?

● (1620)

Mr. Stephen Frank: I am.

Mr. Michael Levitt: This study showed that the medical loss ratio of group health benefit plans offered by private insurers in Canada fell from 94% in 1991 to 74% in 2011. Can you explain what the medical loss ratio is?

Mr. Stephen Frank: What I would say about that paper is that the methodology was incorrect and the data used was incorrect. They used numbers that included the disability business and a bunch of other things that are not related to supplemental health. We've communicated that to the authors, and they're well aware of that.

I would say that the difference shown there was predominantly due to falling interest rates and their implications for the disability side of the business. It really had nothing to do with the supplemental benefits.

Mr. Michael Levitt: Thank you.

The Chair: That completes our first round.

Just before we go to our second round, I'd like to ask a question.

We've heard several witnesses now over 10 meetings, and it sounds to me as though the pricing of pharmaceuticals is chaotic. I might be wrong.

I think you said you represent 30 insurance companies. Did I get that right?

Mr. Frank Swedlove: We represent more than that, but in terms of the ones that are active in this business, there are 24.

The Chair: Do they all pay different prices for the same pharmaceutical? Do they all have to negotiate a price, or is there a price for a particular drug? I know you'd like to join the pCPA to get the advantage of more volume, but does everybody pay a different price?

We've also heard talk about rebates and things like that, and confidentiality agreements.

Are the practices of the pharmaceutical business different from those of others?

Mr. Frank Swedlove: Yes.

Mr. Stephen Frank: The answer is yes. The prices will vary by payer, and we don't think that's the right way to go. We shouldn't have 24 or 26 prices for the same drug. That's one of the reasons we do advocate for doing more through the pCPA. The pCPA has managed to bring some harmony to the public payers for branded drugs. It's been very successful bringing harmony to payers on the generics and SEBs for everybody.

As I said earlier, it's an evolving mechanism, and we think there is a lot of opportunity to continue to expand it. If insurers were at the table, you'd end up with people paying the same price in Canada. There would be one price for everyone. Presumably it would be a lower price on average than what we pay now, because we'd be pooling all of our resources to do that. We do think it's a direction we should be pushing in, and as quickly as we can.

The Chair: You mentioned 24 companies earlier. Are you saying they might all pay a different price for the same pharmaceutical?

Mr. Stephen Frank: Yes.

The Chair: We heard talks about rebates. I don't like to use the word “kickback”, but that word was raised. Is that part of the pharmaceutical business? Are there rebates to some companies if they...?

Mr. Stephen Frank: Yes.

The way this is done is through rebates. Even the provinces are getting.... When we talk about lower prices, it's probably not technically the right way to think about it. They're paying a list price, and then at quarter end or month end they're getting a rebate from the manufacturer, so the effective price is lowered over time.

One of the reasons for that is the drug manufacturers are protective of that list price, given the way they have to price things globally. The world we're in is one of rebates and reduction after the fact. That's the world of getting lower prices. That's how it works, and that's honestly probably how it's going to continue to work going forward.

The Chair: Thanks very much.

Now we'll go on to the second round of five minutes.

Go ahead, Ms. Harder.

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

Mr first question I'm going to direct to you, Mr. Swedlove, if you don't mind.

If a one-buyer national pharmacare program were introduced, I would imagine your industry would be significantly hurt by this movement, or this change in direction.

I'm wondering if you can quickly spell out for us what your expected losses in terms of jobs would be, either directly or indirectly. Do you have some sort of idea?

As well, would you see any health insurance companies closing their doors in Canada, and would this have an impact on the insurance products that are available?

Mr. Frank Swedlove: I don't think we can give you a number. There are a number of companies that operate exclusively in the supplementary health business. Of course they can continue to offer the non-drug portion, but their business would be affected. That would be the Blue Cross types and the several not-for profit companies in the field. They would be particularly hurt, and their employees would be particularly hurt.

I would note that a lot of these organizations provide the administrative work and all the back office work to governments and essentially run a large part of the operation of the government plans themselves. Those people also serve the governments. The governments turn to our industry to provide that work because we do it more effectively and more efficiently than the governments can do it.

● (1625)

Ms. Rachael Harder: Let me pick up on that, because I think you make a good point.

Other presenters, include the other one who is here with us today, Anita, have mentioned that they feel that government could do it more efficiently and with less cost. Can you comment on that for me?

Mr. Frank Swedlove: I think the basis of that thinking is the fact they can negotiate a lower price because they would be using the entire Canadian market. That is an important factor, and that's why we say if we are able to join with the provinces to negotiate a price that reflected the entire market of Canada, then we would all share in those lower costs. That's where you save the money.

Ms. Rachael Harder: What you're saying is that if you were given access to the drug costs at par and you were able to join, coupled with the lower administrative costs that you're able to deliver, you would be able to be more efficient and more effective than a pharmacare program?

Mr. Frank Swedlove: Yes, we believe that we would be.

Not only would there be innovation that would continue, which would help reduce the cost of drugs over time, but there would also be more choice if an employer wanted to offer more drugs. That would be available to that employer.

I know unions often negotiate to improve their drug plans because they want to see more opportunities for their members than are generally offered either in the public plan or in many private plans.

Ms. Rachael Harder: Excellent.

Along those same lines, I have another question.

Any time I watch a government department put in an administrative system, particularly with regard to IT, I watch them put millions if not billions of dollars into their IT program in order to do administration, and then I watch it fail, or come very close to failing, and many dollars are wasted.

Would you guys or private companies be in a position to come up with an effective system to administer drugs and remunerations, based on pharmaceuticals, and could you do that in a cost-effective manner and in a timely fashion?

Does that make sense?

Mr. Frank Swedlove: I think we already do that, and the fact that the provinces use us for that function, I think, reflects a realization on their part that we can do it cheaper than they can do it.

Ms. Rachael Harder: Would you have the technology in order to do it well?

Mr. Frank Swedlove: We already do, and we continue to work with the various players, with IT providers and with pharmacists, to continue to lower the costs associated with providing the drugs to consumers.

Ms. Rachael Harder: Thank you.

The Chair: Okay.

Dr. Eyolfson is next.

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

I'd like to thank all of the witnesses for coming today.

Ms. Huberman, you were talking about the potential benefits in the workforce and in the economy of making sure everyone could have their medications covered.

By profession, I am an emergency physician. Our patient population is a little skewed, and I probably agree with the estimate that at least 10% of the population doesn't get adequate coverage. In my environment, it's estimated that because we have so many low-income people—working poor, uninsured—it's estimated that six in 10 prescriptions in emergency departments aren't filled.

Given that many of these diseases are very expensive if left untreated, would you not agree that this might be a missing piece of the puzzle about how much a pharmacare system would cost versus how much it would save in decreasing hospital costs by making sure everyone had their medication and didn't get sick?

Does that sound like a reasonable part of this puzzle?

● (1630)

Ms. Anita Huberman: It's a reasonable part of the puzzle for sure. In B.C. we have the highest child poverty rate, and taking that part of the puzzle into account in a universal pharmacare program is integral. Again, this is an opportunity for the committee, in concert with business, to take a look at what the right model might be and what the gaps are.

We heard from the additional two witnesses that they're willing to explore lower costs in providing drugs to consumers. It's taken until this time for them to say that, but I look forward to more dialogue on this issue, especially on the gaps that we should be looking at, sir.

Mr. Doug Eyolfson: All right. Thank you.

Mr. Swedlove, you had a letter that you wrote to the health minister, Minister Ambrose, in 2015. You referred to the researchers who promoted pharmacare, you said there were a lot of errors in their analysis, and you said that there would be an immediate $14 billion that would have to be covered by the public purse. What was the source and evidence behind that figure?

Mr. Frank Swedlove: I'll ask Mr. Frank to go through the analysis. It's quite simple, actually.

Mr. Stephen Frank: To begin, there's $15.5 billion reimbursed privately in Canada today.

We looked at some research that the PMPRB has done on generic penetration rates in Canada, and they've estimated that there's about a —and I'm going by memory—6% gap between public and private payers on the penetration rate on generics, so we did some estimates, looking at real data on our private payers, as to how much that would save for the system if they were immediately flipped onto the cheaper generic. That gets you about $900 million.

Then we asked for a list from the pCPA and the Government of Ontario of every drug that they've negotiated a private listing agreement on, and we assumed they were getting a 20% savings off of those prices. We then looked at our volumes on those drugs and calculated what you would save if you were paying those lower fees. That gets you about another $400 million.

Therefore, in the best-case scenario, if you were to take all of that in and pay that immediately out of government funds, you're going to get $15.5 billion. You're going to have to move...I don't even want to speculate how many people off their therapies onto the generics, which is a different discussion. You can do that over the first year and you'll get those price savings, so we feel the best case on day one is about $14 billion.

Mr. Doug Eyolfson: Thank you.

The issue of choice comes up, and how some plans might have decreasing choice if there is a mandated formulary.

An earlier witness talked about how on some private insurance plans you have more choice in different types of medications. We know from a lot of the empirical data that there are much more expensive alternatives that are becoming more popular and that physicians want to prescribe, but the evidence doesn't actually show that there's an increased outcome.

Therefore, are we perhaps overestimating the importance of choice? As an alternative, we could have a formulary simply saying that our evidence shows this cheaper drug is the best alternative.

Mr. Stephen Frank: I'll say that we don't think prescribing practices are as good as they should be in Canada. We do think there's room to improve there. Our view is that you should address it directly with the physician versus looking for the payer to be policing that through the back door.

The other thing—and as a clinician, you'll understand this clearly —is that the evidence on these drugs is on a population level. The evidence tells you what the average person's response will be to a drug, and there are all kinds of distributions around that. We feel generally that more choice is better than less where you can afford it and where it can be made available. That's an approach we would take to that question, but clearly we need to do a better job at getting evidence built into our formularies.

There are different ways of doing that. We looked at the managed route. We do have closed formularies. We do all that stuff, but we let the consumer decide what is best for them.

Mr. Doug Eyolfson: This is the second time I've heard the phrase “population-level evidence”. What other kind of evidence is there?

● (1635)

Mr. Stephen Frank: That's the gold standard, there's no question, but for any drug, there is going to be someone who is a super responder and there might be someone who doesn't respond at all. Sometimes you have to try a few before you hit the magic sauce, so you want to have options for people. That's where the choice and the options, we feel, are important.

Also, for a lot of the very new and expensive drugs, the evidence is very unclear. Clinical trials that have been done may not have been great and it's not obvious whether the drug will be effective or not, so reasonable people land in different places as a result. If you had 10 drug plan managers at the table with us, they would all say that they have an evidence-based formulary, and they've all landed in slightly different places with what they cover. It's not the case that there's this one absolute answer to these things. We think choice and some variability are important.

The Chair: Your time is up.

Mr. Webber is next.

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

One of the disadvantages of being later on in the session is that a lot of your prepared questions have already been asked, so I'm left here now just wondering who you think is going to win the hockey game tonight.

Voices: Oh, oh!

Mr. Len Webber: No, in all seriousness, Mr. Swedlove, you talked a bit, of course, about the pan-Canadian Pharmaceutical Alliance, the pCPA. What I have been led to believe is that the provinces are dealing with these pharmaceutical manufacturers and getting lower costs because of their large buying powers, and life insurance companies such as yours would pay inflated prices.

Mr. Casey asked you a question regarding why the group you represent would not come together just like the pCPA to build up that number in purchasing power. You stated that your companies pay different prices for pharmaceuticals. I just don't understand why you would not form a private company alliance like the pCPA to get that large purchasing power.

Mr. Frank Swedlove: Well, one of the nice things about being government is that you're not subject to the Competition Act.

Mr. Len Webber: There you go. That's a very good point.

Yes, I think it's going to be Pittsburgh winning tonight.

Voices: Oh, oh!

Mr. Len Webber: I'm going to pass it off to Dr. Carrie now, because my questions have already been answered.

Mr. Colin Carrie: Thank you very much.

I do have a question. My colleague brought up a really important thing about prescriptions not being filled. Some of the witnesses here have assumed that it's because people can't afford to fill the prescriptions, but I've had a slightly different experience on that.

Do you have any information on why people don't fill prescriptions? Is it that they feel better the next day or that they don't like the drug that was prescribed? Do you guys collect any data on that?

Mr. Frank Swedlove: I'll ask Mr. Frank if he has anything to add to this, but we're not certain of the basis of the work that's been done in terms of how the question was asked on this issue about whether they fill their drugs or not.

I'll just anecdotally note that the last time I went to the doctor, I got five prescriptions because I have grass allergies, and three of them were prescriptions that were optional as to whether I would get them or not. I didn't fill them because of the co-pay. There was a small cost to me, and I figured I wouldn't fill them if I didn't need them. If someone asked me if I didn't fill out a prescription because of costs, I would have said yes, because I didn't fill those prescriptions for allergy medicine.

It would be interesting to know a little more detail about how that question was asked.

Now I'm sure there are cases of people not filling their prescriptions because of costs. Those are the gaps that I talked about earlier, and we support the idea of getting more information, getting a better understanding of those gaps, and trying to deal with them, because it has always been our position—it's not the first time that we've stated this—that Canadians should never have to choose between putting food on the table and getting drugs.

We strongly believe that and we've been stating it for many years. In fact, we put out a paper six years ago saying so.

● (1640)

Mr. Colin Carrie: I just wondered if you had the data, because I've heard that before and even I know that sometimes a physician will give you something and say, “I'm going to give you this just in case it gets worse.” There are different reasons that they're filled, or not, and certain assumptions have been made.

I want to ask you too about this whole idea of over-prescribing. You talked about that. It seems that there are certain over-prescribed medications out there, and one of the concerns is that if you start covering all of this stuff, that may be a simple solution instead of perhaps looking into the problem a little bit more deeply.

Do you guys have any data on mis-prescriptions, or what would be the word—overprescribing? I know one of the witnesses said 40% of seniors had improper prescribing. We've heard about the opioid crisis, too—about how physicians are trained to prescribe, but maybe not to wean people off.

Do you have any data on over-prescribing and how much that costs Canadian taxpayers or the industry today?

Mr. Stephen Frank: No, we don't, but what I would say on the prescribing issue is—and this is in the paper that Frank referred to—that we do think we are not at the gold standard on prescribing practices in Canada. You can look at other prescribing guidelines and structures that have been put into place in other countries where they've made efforts, to your point, at getting at the root of the issue. Let's get our physicians prescribing appropriately and put some training incentive and process around that so that we can improve things. We'd be very supportive of that effort.

We, as an industry, become involved once the prescription has been presented at the pharmacy. That's when our interest directly starts, but we acknowledge that there are issues upstream in the system that could certainly be improved, and it could have benefits for us if we do better as well.

Mr. Colin Carrie: This the opinion question that I didn't get to ask you last time. We had one witness ask this question: do you think the system is working now? Do we have to throw out the baby with the bathwater?

Do you think the system is working well now? Is it working okay?

Mr. Frank Swedlove: In terms of the cost of drugs, our answer would be no.

We're not here to argue the status quo; we're here to support reform, but a reform that can be done without increasing cost to government and without increasing the role of government. It would be for us to partner with government to get the lowest cost possible, and we think it's totally reachable.

Mr. Colin Carrie: For access?

The Chair: You're out of time.

Mr. Colin Carrie: I'm done. Maybe I could have a quick answer.

Mr. Frank Swedlove: In terms of access, we suggest a bit of formulary so that everybody has at least the minimum standard that is applicable.

The Chair: Ms. Sidhu is next.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair.

Thank you for all of the presentations. They were very informative.

My question is to Ms. Anita Huberman.

Can you explain a little bit more about your organization's position on adopting universal drug care? Can you explain more about having a universal drug coverage system? Is it easier for small and medium-sized businesses?

Ms. Anita Huberman: Well, I think what we're looking at right now is that Canada is burdened by what we believe is an inefficient system of public drug coverage. It does fall heavily on businesses. Surrey, as I mentioned, is a small and medium-sized business community, and small businesses are the least likely to offer drug coverage. Few entrepreneurs and independent contractors are covered by any drug benefit plan, so this harms the efficiency of our economy, because many Canadians are forced to choose where to work based on access to insurance rather than aptitude and passion.

Our assessment, our analysis, is that up to $5 billion is spent by Canadian employers on private drug benefits, and that's wasted money, because private drug plans are not well positioned to manage drug pricing or the prescribing and dispensing decisions of health professionals.

I want to underscore that businesses should not be making drug decisions; it's doctors and health managers who should be making those decisions.

Ms. Sonia Sidhu: Thank you.

Can you quickly explain why case management is a mainly private concept? Do you not think that personalized medicine could be factored in under the national pharmacare plan?

We have heard from other witnesses that it's possible to do it publicly, as in other countries.

● (1645)

Mr. Stephen Frank: For personalized medicine, what were you referring to?

Ms. Sonia Sidhu: No, case management.

Mr. Stephen Frank: Oh, case management.

Well, our observation would be that we are doing it on the private side and it's not being done on the public side. It's an example of something you would lose if you were to nationalize drug coverage.

We do a whole bunch of things on the private insurance side that are not done by the provinces. Another example would be the use of preferred provider networks, whereby we leverage the pharmacy to a much greater extent than we have in the past. We negotiate cost savings for our plan members. We get enhanced services provided to them when they approach the pharmacy. There are lots of interesting pilot projects and things going on.

On the private side, Frank mentioned innovation and choice, so it's a very dynamic environment. It's not acknowledged as much as it needs to be. It's not as well understood as it should be. You risk losing that if you move to a system that doesn't have the incentives for that kind of innovation. I think that's one of the things we're cautioning against.

Ms. Sonia Sidhu: Thank you.

My next question is this: if Canada decided to move forward with some form of universal public pharmacare coverage, what would your organization's effective role be in that?

Mr. Stephen Frank: You're saying if you—

Ms. Sonia Sidhu: If Canada decided to move forward with universal drug care coverage, what would your effective role be to support that? What would your organization's actual role be?

Mr. Frank Swedlove: Well, we don't think that's a good idea.

First of all, it would be a significant cost that the governments would have to cover on day one. As Mr. Frank has told you, we estimate that to be about $14 billion. How is that going to be paid for?

Second, it would be the end of offering any kind of choice in terms of the drug plans that are available. In our view, that would restrict access to many drugs for Canadians, and also it has been shown that the public sector takes longer to introduce drugs, so that would have an effect.

Also, the whole aspect of innovation and improvements, I think, would be put into question as they try to manage a very large, single universal plan that doesn't have any competition or any attempts to innovate, in our view.

The Chair: You're done.

Mr. Davies is next.

Mr. Don Davies: Thank you.

Mr. Swedlove, you've mentioned cost a number of times. It's pretty much accepted at this committee, by witnesses that we've heard, that Canada pays the second-highest prescription costs in the world. We've had a privately delivered system, basically, for the last five decades.

If the private system is so efficient and works so well, why is it that today, in 2016, we have 20% of Canadians who have no coverage or are under-covered, and we're paying the second-highest prices in the world? Why is that?

Mr. Frank Swedlove: What I have stated many times is that what's not working well are the costs associated with drugs that Canadians have to pay. What we've proposed are some ways of dealing with that, such as changes in the PMPRB, which encourages high-cost drugs. There is also the lack of an ability for us to negotiate for lower-cost drugs using the entire Canadian marketplace. Those are things that could be done within the present system.

Mr. Don Davies: Why haven't they been done?

Mr. Frank Swedlove: I think that's a good question to ask governments: why they don't allow us to join the pCPA and why PMPRB continues to support high-cost drugs.

Mr. Don Davies: I'm going to challenge you a little more again on your assertion that a public system necessarily results in less choice.

When I go into a hospital, which is a public facility, and I need prescription drugs, I can get every single drug I need. I'm 53 years old, and I've never heard a story of someone going into a hospital and coming out of surgery or going into surgery who couldn't get a prescription drug. In fact, the stories we're hearing at this committee are the opposite: the problem is that people go into an acute care system in the hospital, get the prescriptions they need, come out of hospital, and then for a variety of reasons, if they don't have private coverage, can't get the prescriptions they need. Then they get incredibly sick and end up back in the acute care system, which is far more expensive.

Can you explain to me why, if the public health care system is unable to provide the full variety of prescriptions we need, this is not the experience we have when we go to hospitals, which are public institutions?

● (1650)

Mr. Frank Swedlove: I think it is accepted by everyone that the public plans are more restrictive than the private plans. If you're telling me that under the public plans people get more access to drugs and under the private plans they get less, that's totally inconsistent with everything I've heard.

Mr. Don Davies: You're talking about Canada, but it's also well known that Canada is the only country in the world that has universal health care coverage and does not have some form of universal prescription coverage.

If we compared Canada with Germany or Belgium or the Netherlands or Denmark or Norway or Sweden or France or Britain, would you still say that those countries, those populations are not getting the variety of drugs that we're getting in Canada under private plans? Is that your testimony?

Mr. Stephen Frank: I guess the obvious answer is that the countries you quoted have a mixed system. The German system is delivered privately, as is the Dutch. The Australians have a mixed system.

We would agree that we don't have universal access to drugs. We have gaps in Canada. That does not lead necessarily to the conclusion that there's a binary choice here of total privatization or of nationalizing. When we look globally, we see that most countries have a mixed system, just as they do in the provision of general health care.

Our view is that we need to work with the system we have. We need to make it better. We're proposing solutions that are relatively easy to implement that will have huge positive benefits. That's where we would suggest we should focus our effort.

Mr. Don Davies: Ms. Huberman, is there any jurisdiction in the world that you could point us to that you think might be a model Canada could look to for delivering the kinds of services your members are looking for?

Ms. Anita Huberman: I don't have an example; I leave it to the experts.

The Chair: Mr. Davies, you're done.

Mr. Don Davies: Thank you.

The Chair: That brings to a conclusion our official question period.

I'm a little confused again. You're saying that a national pharmacare program would cost the government $14 billion. Many of the witnesses are saying that we as a country would save $6 billion. That's a $20 billion gap.

I know we're comparing apples with oranges, but can you reconcile those differences?

Mr. Stephen Frank: The difference is that individuals who make that claim are overestimating the administrative costs in our system and are assuming that there is a way to very quickly and immediately cut the price of literally thousands of drugs on the market. We're not aware of any way you can do that.

Dr. Carrie is right. The pCPA has negotiated about a hundred agreements so far. Depending on how you want to count them, there are 6,000 or 7,000 drugs in Canada. At 100 agreements over three years, it's going to take decades at that pace to work through this number.

The challenge is that there's the transition issue that you're going to have to think about. We believe there are significant savings if we start negotiating drugs collaboratively, and we want to start doing that. Let's start doing it and let's start realizing those savings.

If you want to start shifting $15.5 billion around in the system, I don't know how you can realistically say that you're going to take $7 billion, $8 billion, $9 billion of it out in any reasonable time frame. I think that's the challenge you need to present to some of these folks who throw those numbers around. We don't see how you get there.

The Chair: Thank you very much, everyone.

Thank you, Ms. Huberman, for joining us and for sitting there for two hours or an hour and a half. We appreciate it very much.

We don't have your brief yet; it's coming, and we're anxious to get it as well.

Again I want to thank the witnesses. You've brought us a lot of good information. There's a good chance we'll be back to you before we're done.

We're going to take a little break and then we're going to move in camera. We'll reconvene in a couple of minutes.

[*Proceedings continue in camera*]