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## **Standing Committee on Health**

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**EVIDENCE**

**Wednesday, June 1, 2016**

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**Chair**

**Mr. Bill Casey**



## Standing Committee on Health

Wednesday, June 1, 2016

• (1535)

[English]

**The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)):** We have quorum. I will bring the meeting to order and welcome our guests.

We're not too far off schedule—a little bit, but not much—so things should work out.

Thank you to our guests for coming to help us with this study. Each organization will have 10 minutes to open. When you hit 10 minutes, I'll pick up the hammer, just to let you know. We will have two rounds of questions. The first round is seven minutes for each questioner, and then five minutes after that.

We'll get this under way. We still have some other committee members to arrive, but we won't hold up the meeting.

I think we should start with the presentation from the Canadian Association of Retired Persons.

**Ms. Natasha Mistry (Director, Stakeholder Relations and Community Development, Canadian Association of Retired Persons):** Good afternoon, Mr. Chair and committee members.

First, thank you for the opportunity to appear as a witness on this important discussion. I am Natasha Mistry, director of stakeholder relations and community development at CARP.

CARP is a non-profit organization committed to enhancing financial security and improving health care for Canadians as they age. I am here today representing the more than 300,000 CARP members across the country, and to share the perspectives of retirees, seniors, and older Canadians. CARP has long believed that Canadian drug policies need improvement. The status quo is no longer a sustainable option. Reform is required to ensure that drugs are affordable and accessible to Canadians regardless of age, income, and geography. When used appropriately, these medications help seniors manage their conditions.

For example, drugs for MS patients slow down the progression of disease and ward off the advancement of physical disabilities. For people living with inflammatory bowel disease, specialty medications, such as biologics, have increased remission rates, reduced hospitalizations, and postponed the need for surgery—surgery that entails removing large sections of their gastrointestinal tract.

Seniors, especially those living with chronic health conditions, comorbidities, and disease, face challenges in accessing the medications they need. Among CARP members, 10% have admitted to skipping prescription medications because of costs. In 2014 a

CARP survey on pharmacare revealed that 85% of CARP members have drug coverage. Nearly half, at 49%, commonly held private plans, and 28% received drug coverage through provincial plans. However, approximately 700,000 Canadians have no insurance coverage at all. Regardless of private or public coverage, the vast majority of CARP members support the development of a national pharmacare program. Access and affordability are key factors in ensuring better health care outcomes for all Canadians.

At CARP we have the following three recommendations for improvements: one, create national pharmacare standards; two, facilitate bulk buying to reduce costs; and three, have the federal government lead this process.

Recommendation one is to create national standards for pharmacare. Roughly 11 million Canadians are eligible to receive drug coverage through one of 19 provincial and federal public drug programs. Prescription drugs in Canada are currently financed by a fragmented patchwork of public and private drug formularies that vary by province. Each province manages its own health and drug plan. This results in varying programs for drug coverage across the country, with Ontario and the Atlantic provinces as the few that continue to provide public pharmacare coverage specifically for seniors.

As the boomer generation transitions from private to public plans, they place greater pressure on existing provincial drug budgets. This was a key instigator in B.C.'s decision to move from an age-based program to an income-based one. Private coverage too has its challenges, and it should not be assumed that private insurance provides sufficient coverage. To further complicate matters, approximately 40% of Canadians lack adequate private coverage for reasons of being self-employed or underemployed. For people living with chronic conditions or illnesses, insurance companies will often attach higher premiums or even decline applications in order to balance the cost of the benefits against the risks assumed by the insurer.

Recommendation two is to facilitate bulk buying to reduce costs. CARP members are in favour of national drug purchasing as the best way to bring down the cost of drugs. CARP supports the work of the pan-Canadian Pharmaceutical Alliance to jointly negotiate and help lower the cost of treatments. We appreciate the sophistication with which these negotiations take place; however, we encourage decisions to be made on a timely basis and financial challenges not to delay access. The way it stands, pharmaceutical costs should not be viewed in a silo, but instead be integrated into the health care system. In reality, provincial drug programs are kept separate from other health care budgets.

• (1540)

This makes it harder to evaluate the real value of drugs or the health care savings that result from pharmaceutical compliance. Because data on the cost of drugs and the cost of other health care are separate, the benefits of drug access will not be accounted for in understanding their impact and savings to the overall provincial health budget. We understand that provinces face difficult financial situations, and we all need to ensure that health care expenditures are judicious, with demonstrated improvements and outcomes.

With new technologies, drugs are lowering hospitalizations, surgeries, and emergency visits. Standardization and the creation of robust formularies are a way to achieve universal access no matter where Canadians reside. Without standards, drug access will continue to hinder access.

For example, the Gastrointestinal Society, together with Crohn's and Colitis Canada, recently produced a report card that graded provinces on access to biologic treatments for people with inflammatory bowel disease. The report card showed that because of varying criteria and formularies, access was inequitable in different provinces for people with gastrointestinal disease. Worse yet, in order to get access, gastroenterologists have expressed the desire to misdiagnose patients in order for them to qualify for treatments gastroenterologists believe would help their patients achieve remission. This example demonstrates how formularies are out of step with the medical needs of patients.

The same drugs at the same price should be covered in every province and territory. Uniform standards among provincial catastrophic drug programs and public drug formularies are necessary to achieve equity. However, these standards must be robust and not merely reach minimum levels of drug coverage. There should be no race to the bottom. We must carefully review the best practices, the best criteria, and the best formularies to ensure adequate coverage and options. Patient choice must be made available to allow Canadians the most appropriate treatment.

To do this, governments, both provincial and federal, should work with medical practitioners and patients to devise appropriate standards for provincial catastrophic plans and formularies. The federal government should partner with provinces and territories to create a robust set of conditions that make drugs accessible.

This leads me to CARP's third recommendation: federal leadership for a pan-Canadian approach. CARP believes that creating a national pharmacare plan would require governments to jointly negotiate prices and access with private-sector insurers and pharmaceutical manufacturers. The federal government has a

responsibility to play a strong role in the development of a national pharmacare plan. CARP has been recommending universal pharmacare for many years, calling on the federal and provincial governments to work together in the best interests of Canadians. We look to an expanded role for the federal government, one in which it would co-operate with provincial counterparts in creating the best plan possible.

As you have most likely heard from witnesses before me, Canada is the only country with a universal health care system that lacks universal coverage for prescription drugs. We need to do better, and the time is now. Each of you as a committee member has a crucial role to play in setting the course for the future of Canadian pharmacare. I urge you to devise recommendations that help to enhance pharmacare and that will allow our decision-makers to take these recommendations and implement change.

Thank you.

**The Chair:** Thank you. We appreciate that presentation; you've put a lot of thought into this.

Next up is the Canadian Medical Association.

• (1545)

**Dr. Cindy Forbes (President, Canadian Medical Association):** Thank you, Mr. Chair.

On behalf of the Canadian Medical Association and our over 83,000 physician members, I appreciate the opportunity to appear before the committee as part of its study on the development of a national pharmacare program. My name is Dr. Cindy Forbes. I'm a family physician from Nova Scotia and president of the Canadian Medical Association.

Prescription medication plays a critical role in health care. This is indisputable. However, Canada stands out, as you've heard certainly from the last speaker and I'm sure from many others, as being the only country with universal health care that does not also have universal pharmacare coverage. As a result, there are far too many Canadians who simply cannot afford to take the medication that they need.

Allow me to share some examples that illustrate the scope of this issue. At the national level, The Commonwealth Fund's 2013 international health policy survey revealed that 8% of Canadian respondents had either not filled a prescription or skipped doses because of cost. At the provincial and territorial level, there is wide variation in average household out-of-pocket spending. According to the 2014 survey of household spending, the poorest Prince Edward Island households spent more than twice as much, so \$645, as did the poorest in Ontario at \$300. We're also seeing patients being released from hospital having their prescriptions suddenly cut off, or we see patients covered for a drug in one province but not covered in another. This is especially common with cancer drugs, which are particularly expensive.

We all know that we can and that we must do better. However, we're unlikely to address the significant access gaps in prescription medication coverage without the leadership and support of the federal government. The CMA is therefore putting forward three recommendations for federal action to improve access to medically necessary drugs.

Our first recommendation to the committee is that the Parliamentary Budget Officer conduct a detailed examination of the financial burden of prescription medication coverage across Canada and develop costing options for a federal contribution to a national pharmacare program.

We recognize that these are fiscally challenging times at all levels of government. That's why our second recommendation, a proposal for a federal funding program, is fully scalable. We're recommending that the federal government establish a cost-shared program of coverage for prescription medications as a positive first step towards comprehensive universal coverage. This gradual and scalable approach would help ensure that Canadians have comparable access to the prescription drugs they need regardless of their ability to pay and wherever they live in Canada.

Finally, there are several other crucial elements that must be addressed in the development of a national pharmacare program. These include the need to influence prescribing behaviour, to advance electronic prescribing, and to mitigate drug shortages.

To ensure that these elements are captured in work going forward, our third and final recommendation is for the federal, provincial, and territorial health ministers to direct their officials to convene a working group on a national pharmaceuticals strategy. This working group would consult with stakeholders representing patients, prescribers, and the health insurance and pharmaceutical industries, and report their recommendations by the spring of 2017.

Few would argue that prescription medications are less vital to the health and health care of Canadians than are hospital and medical services. We would not have the medicare program that Canadians cherish today without the leadership and financial contribution of the federal government. Similarly, without it now we will not have any form of a national pharmacare program in future.

I thank you for your time, and I'd be pleased to answer any questions you may have.

**The Chair:** Thank you very much.

Now we have Consumer Health Products.

**Mr. Gerry Harrington (Vice President, Policy and Regulatory Affairs, Consumer Health Products Canada):** Thank you, Mr. Chairman and committee members, for providing Consumer Health Products Canada with this opportunity to contribute to your study of pharmacare.

My name is Gerry Harrington. I'm vice-president of policy with CHP Canada, and my colleague is Kristin Willemsen, our director of scientific and regulatory affairs.

Our organization represents the makers of evidence-based over-the-counter medicines, or non-prescription drugs, and natural health products. These products fall into the broad category of consumer health products and are used by millions of Canadians every day to manage their personal health and to treat minor ailments. They are products like sunscreens, vitamins, pain relievers, and allergy medicines, to name just a few.

Let me begin by putting everyone at ease and say that I am not here to advocate for the broad inclusion of consumer health products in any potential national pharmacare plan. That may be a conversation for another day. This afternoon, I'd like to address the important role consumer health products play in the broader context of access to affordable medicines, and the specific way in which they would impact the development of any national pharmacare plan.

Over the years, CHP Canada has commissioned a great deal of research to look at how Canadians deal with their health concerns, including how they respond to minor ailments like colds, flu, allergies, heartburn and the like; how they manage the pain of arthritis; and how they invest in prevention with things like smoking-cessation aids. We have learned, consistent with international research on this, that their responses vary widely in terms of how they deal with those health concerns. I'd like to highlight just a few key findings from our most recent surveys that I think would be of interest to the committee.

In 2015 we surveyed 1,200 Canadians who reported having suffered from a cough or cold, headaches, allergies, heartburn or indigestion within the past 60 days. Over three-quarters of these Canadians told us that they generally preferred to self-manage these ailments without seeing a doctor, and that's great. It's also worth noting that those who self-managed these ailments were just as happy with the outcome as those who did visit a doctor.

I'd like to talk a little bit about the 14% of Canadians who did go to the doctor for these minor ailments. The motivations of this group would be, I think, particularly relevant in the development of a pharmacare environment. When we looked a little more closely at this group, we found that university-educated Canadians were 35% more likely to visit a doctor for a minor ailment than those with a high school diploma or less, and higher-income earners were 22% more likely to see a doctor. That may seem initially a little counterintuitive, but it makes perfect sense if you take prescription drug coverage into account, because in fact 26% of those who saw the doctor and received a prescription told us they did so precisely to have it covered by their pharmacare plan.

That explains the correlation: Higher incomes and education are correlated with drug-plan coverage.

I want to be clear that we are not advocating against physician care of minor ailments, or even against prescription treatment for those ailments where appropriate, as can be the case where the diagnosis is unclear or, perhaps, the underlying condition of the patient is complex. But it's worth noting that even relatively modest shifts in these kinds of behaviours can have a major impact on the health care system. For example, our research indicates that roughly 2% of all the people who suffered from one of these four minor ailments said that they went to the doctor even though they had self-assessed their symptoms as being relatively mild. That 2% does not sound like a very large number, but 2% of all minor ailment-sufferers in those four categories represents three million doctor visits a year. If we were to target those people who represent one-seventh of the one-seventh who do go to a doctor, we could free up an awful lot of physician resources, roughly the equivalent of what it would take to give access to a family doctor for 500,000 Canadians who currently don't have one.

Now, I know we're here to speak about pharmacare and not physician shortages or health system economics, but the point I wanted to make is that the design of a pharmacare system can't be done in a vacuum, because there could be far-reaching effects on the rest of the system as a result, especially if the result drives more Canadians to seek out prescription medicines when they might not otherwise do so.

At the same time, we're not advocating for new barriers to physician care or prescription medicine access, even for minor ailments.

• (1550)

Instead, we're asking you to consider including in your recommendations some things that would lower the barriers to self-care for those Canadians who would prefer to manage their own ailments.

I'm going to keep up with my colleagues at the table and offer you three recommendations on matters you may not be aware of. Just to preface this, many over-the-counter medicines on the market today began life as prescription drugs. They are made available to Canadians through a process known as the Rx-to-OTC switch. I'm talking about such things as ibuprofen or Advil, naproxen or Aleve, mometasone or Nasonex, etc. Even nicotine patches began as a prescription drug. Unfortunately, in Canada the process of switching products from prescription to non-prescription status has underperformed relative to that in other jurisdictions, such that Canadians are getting access to these products on average seven to nine years later than their U.S. or European Union counterparts are.

The first of our recommendations is aimed at trying to close that gap and provide earlier access to these medicines for Canadians. That addresses the mishmash of federal and provincial regulations that govern this process.

Currently, after Health Canada reviews all of the evidence and approves one of these switches, the manufacturer must then negotiate a process at the provincial level that reaffirms the switch and attaches additional conditions of sale. This decides whether the product is available only in pharmacies, perhaps just from behind the dispensary counter, and so forth. That process can delay product launches by up to two years in some provinces. It leads to different outcomes in different provinces, and discourages innovation by making this process extremely onerous for the manufacturer.

We believe Health Canada could play a leadership role in integrating the switch and drug-scheduling processes. In fact, Canada is the only jurisdiction right now that uses provincial pharmacy acts to fulfill that role. We think the dialogue that will go on between the federal government and the provinces over the potential development of a pharmacare program presents an ideal opportunity to begin the discussion around integrating those two processes. That is our first recommendation.

Our second recommendation is on the need to bring the treatment of intellectual property within the Canadian consumer health product regulatory framework into line with that of our major trading partners.

When a manufacturer submits evidence to Health Canada to support one of these switches and that switch is approved, the data package that has been provided by the manufacturer then becomes available to all competitors, and in fact second-entry manufacturers actually pursue a shorter regulatory approval process to get to market.

Combine this with the delays we experience around the scheduling front and the six-month notification process we have to go through for the World Trade Organization, and—it has happened before—the second-entry product actually hits the market before the innovator's does. This acts as a big disincentive to manufacturers applying for these switches.

Our major trading partners, such as the U.S., the EU, and Japan, offer between one and six years of data protection, so it's not a patent. Other manufacturers are free to conduct their own research and submit it in support of the switch, but the data submitted by the original manufacturer is protected for a period of one to six years. We believe Canada should match the three-year period that is offered by the U.S.

Finally, our third recommendation concerns the tax status of these products. It's ironic that when Health Canada approves one of these products for use without a prescription, with the aim of making it more accessible and more affordable to Canadians, that product goes from being GST-exempt and eligible for the medical expense tax credit to being taxable under the GST and exempt from the METC.

We think it would be very helpful if the committee were to recommend a reassessment of this tax treatment in Canada and to try to get a better alignment between tax policy and health policy.

While I recognize that the subject of the study is pharmacare and that I've made a number of recommendations related to products that are typically outside the scope of most drug plans, the point we are trying to make here today is that we believe the committee would be remiss if it did not consider pharmacare within the larger patient-centred context of how Canadians actually manage their own health and the things that drive that behaviour.

Thank you for your time. I look forward to your questions.

●(1555)

**The Chair:** Thank you for your presentation. It was very interesting.

We're going to start questions now with round one. It will be seven minutes.

We have Ms. Sidhu.

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

Thank you, panel, for sharing all the valuable information.

My question is to Ms. Mistry.

If we implement pharmacare, what do you think is the first step the Canadian government should take to implement that?

●(1600)

**Ms. Natasha Mistry:** That's a good question. I think what really is necessary is a partnership with the provinces, and not only with the provinces. There also needs to be dialogue with patients, with patient representative groups, and with the medical community as well. I think that type of advisory committee would help direct the next steps in implementing pharmacare. I don't believe that I alone can provide that type of direction. I believe the first step should be discussed among these key actors.

**Ms. Sonia Sidhu:** Okay. Your organization states that people over 75 years of age are taking more than 10 different prescription medications. Do you think with the national pharmacare program there would be less choice with regard to the medications?

**Ms. Natasha Mistry:** Your point is a very good one, and this is the fear that a lot of CARP members have. We don't want to reach minimum standards in terms of national pharmacare. We stand strongly behind patient choice and a variety of medications.

I'd like to highlight one of the examples I brought forward in my presentation. A person who lives with Crohn's disease or colitis, for example, does well on a biologic for several years. It's not a lifelong biologic, so when a person develops antibodies to that particular drug, they need to move on to the next level of biologic. So choice is very important for people who are taking medications.

**Ms. Sonia Sidhu:** Thank you.

My next question is for Dr. Forbes.

Do you have any recommendations regarding whether we should factor rare diseases into a national pharmaceutical strategy? Do you have any special policies to impact or manage rare diseases in the national pharmaceutical strategy because those medications are so expensive?

**Dr. Cindy Forbes:** We haven't specifically singled out rare diseases and the drugs for them. From a patient's point of view, the issues are similar whether they have a rare disease or they have a chronic disease that is more common. We really see that patients shouldn't have to make the choice between the basic necessities of life and their medications, and that a cost-sharing program with the federal government would be one way of ensuring that no one person or one family is devastated by their illness and the costs of their medications.

**Ms. Sonia Sidhu:** Thank you.

To Mr. Harrington, what would you like to see in a pharmacare system? What role do you think consumer health products can play?

**Mr. Gerry Harrington:** One of the things we've learned through our research is that the behaviour of Canadians when they're facing a minor ailment varies quite broadly. For some people a really important factor is the cost of medicine, and that can influence their behaviour. There are other Canadians who would far prefer to have the option of self-treating.

I think part of the underlying thinking behind the pharmacare program that we'd like to see is recognition that providing options to those Canadians who are able to self-treat can provide better access for those Canadians where cost can be a barrier. So there's a balancing act that I think really revolves around, as some of my colleagues at the table have mentioned, the idea of consumer choice. Broader access to consumer health products and a more efficient system for regulating can make a big difference that way.

**Ms. Sonia Sidhu:** Thank you.

Do I have more time, Mr. Chair?

**The Chair:** You do.

**Ms. Sonia Sidhu:** People with access to prescription medication are more likely to see their doctor than to try to buy an over-the-counter medication to stop their symptoms. Do you think that someone would be better off having medication if required, rather than trying to self-manage their symptoms?

•(1605)

**Mr. Gerry Harrington:** For those who prefer to use their drug plan, the question is whether it's economically driven or whether it's a matter of feeling more confident getting a professional opinion. I think it's important to separate those two scenarios. You don't want to discourage people who need that reassurance of a doctor that they're making the right diagnosis and that the product they're contemplating is the right product to treat that ailment.

At the same time, if that isn't the issue, if what we're looking at is an economically driven decision, and it has nothing to do with whether or not they feel this is the right medicine for them, then I think there's something inherently bothersome there, because resources that might be used for more complex cases are being taken up. Time is being taken away from care by front-line physicians when that matter could be taken care of by the patient themselves. It's not about taking away options; it's about lowering barriers. Giving options to those people who can effectively self-treat frees up resources elsewhere in the system for people for whom doing so is more of a challenge.

**Ms. Sonia Sidhu:** What would you like to see within a pharmacare system? What role do you think you can play on both sides?

**Mr. Gerry Harrington:** There has been discussion previously about the coverage of consumer health products. I don't think that's a priority for Canadians right now. It's certainly not the message we're hearing, and I don't think that's what the committee has heard thus far in terms of consumer health products.

Down the road, as the system evolves, it could be that this becomes a bigger issue. Some drug plans do allow them to be covered when prescribed by a physician. That's a potential role.

I think the far more important thing is along that same theme, the idea that by providing access for those people who prefer to self-treat, when Health Canada has determined that can be done appropriately, these products can be labelled in such a way that they can be used without medical supervision. Bearing in mind the really important role that pharmacists play in this country, and ensuring that we have the ability to interact with pharmacists, I think there's a great opportunity there to create conditions that make pharmacare more affordable.

**The Chair:** Dr. Carrie.

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

Thank you to the witnesses for being here today.

Mr. Harrington, I'd like to start with you, because I think you brought up how Canadians manage their own health. I think that is the question, because whatever system you put in, I think, has to be patient-centric and we have to look after the best interests of Canadians. One of the worries I have is that if you put too many

marbles in one pot... For a pharmacare program, for example, sometimes a pharmaceutical may not be the best treatment for someone. My colleague who is an emergency room physician brought up the issue of statins for cholesterol. Sometimes the harder treatment is exercise and maybe diet. If the government is covering a statin, I'll go that route. In the long term it may not be the best benefit.

One of my concerns is market distortion. I've seen it in my own community of Oshawa, where people have really great coverage. If they go to their physician, they get the coverage for 35¢, and that could be the over-the-counter cough medicine, or it could be something that is much more expensive. There's a bit of a distortion there, and I'm worried about that.

I was wondering if you could give us some advice on what steps could be taken within the design of any drug coverage program to ensure the patients do not seek unnecessary prescriptions when they're looking at the management of their maladies.

**Mr. Gerry Harrington:** Being from an organization that's focused on the consumer health product side, I can't say that we have put a lot of our policy emphasis on the design of pharmacare programs themselves. I'm afraid I'm going to return again to the idea of lowering barriers to the options outside the pharmacare approach and how that can free up space for the design of a system that is going to meet the needs of Canadians. We've heard repeatedly that there are Canadians who are unable to afford the medicines they need. That is a resource issue.

In terms of the design, some jurisdictions have taken the approach of co-payments that are roughly equivalent to the OTC equivalent. The only issue with that is that it is going to vary by patient. If we're going to take the truly patient-centred approach, we have to worry that what might be a trivial co-payment for some Canadians isn't for others.

I think you have better expertise that has visited the committee that could speak to that.

The focus that we return to is ensuring that there aren't needless barriers to the self-care option. There's a well there. From the research we've done, we know that the percentage of Canadians who really prefer to manage it themselves is quite high: 77% is the most recent finding we've had. It's consistently in that range. What's really interesting, with the change in the research over the last ten years or so, is that we're hearing more and more from Canadians that they're conscious of the need to be responsible with their use of health care resources, not just what's coming out of their pockets, but their use of the system. I think that's another consideration as well.

•(1610)

**Mr. Colin Carrie:** Thank you very much.

I'd like to talk for a moment or ask a few questions of Dr. Forbes.

First of all, thank you for the recommendations. One of your comments was on influencing prescribing behaviour. That comment has come up a few times here in committee, and I think the statistic was that 40% of seniors maybe have inappropriate prescriptions.

We heard that Canadians are the highest users of opioids, for example, along with the United States, and that there's a very high percentage of anti-depressants.

I was wondering about the challenge of the role the government would play in that regard, because there is an issue of prescribing, but I guess there's also the issue of de-prescribing. I was wondering what advice you give to your members. Do you have any programs on that? As gatekeepers for medication, how do we as a federal government work with our doctors not to be too overly prescriptive but to allow doctors choices with patients? How do we put in a system in which we won't see over-prescribing and the costs that go with that?

**Dr. Cindy Forbes:** Thank you for that question. It's certainly an issue that is talked about in many different forums and formats in the medical profession.

I can think of a reference to some of the work we've done around senior care, and in our document on a senior strategy, we do talk about de-prescribing and some of the issues around polypharmacy. It is something that the profession is aware of and there's certainly a movement.

You may be familiar with the Choosing Wisely type of program whereby we're looking not only at the issue of prescriptions but also at how to ensure that the use of health care resources, tests, and procedures is necessary and in the patient's best interest. There is a lot of focus within the medical profession on professional education around prescribing.

I do agree that being overly controlling, from a federal government point of view, could be a problem in practice, that there does need to be some flexibility for physicians to use clinical judgment. However, at the same time, some of the formularies do look at the cost-benefit ratios and can contribute to lowering some of the costs when it comes to looking at which of the drugs gives the same value at the lowest cost.

That's often a helpful thing. I find myself being educated on a daily basis with regard to our provincial pharmacare program when a pharmacist calls and says that one drug isn't covered and that another one is much less expensive. Those things are happening on the ground every day.

One of the things that we also mentioned, though, was the concept of e-prescribing and support for electronic prescribing as well. That is something that the federal government could assist with in terms of national support. This would not only allow a national database but also allow physicians to communicate electronically with the pharmacies and to have that information on which prescriptions patients are taking.

Sometimes, as a family physician, I don't actually know all the prescriptions my patients are taking because they may come from different sources, such as the emergency room or a walk-in clinic, so

I think a key component to improving pharmaceutical prescribing in Canada is to have a means of prescribing electronically so we can share data from across the country.

I hope that answers your question.

• (1615)

**Mr. Colin Carrie:** That's good.

Mr. Adams, you work with research policy and ethics. In your opinion, how big a problem is over-prescribing or prescription drug abuse, and how do you come up with a good balance between allowing a good doctor-patient relationship and also allowing government regulation and control? How do you balance that?

**Mr. Owen Adams (Chief Policy Advisor, Canadian Medical Association):** I'll have to defer to Dr. Forbes on that, sir. I'm not a clinician.

**Mr. Colin Carrie:** Okay.

I'm curious with regard to developing policy, because this is probably one of the questions we're going to have to answer.

What's your opinion on that, Dr. Forbes?

**Dr. Cindy Forbes:** Could you just restate that for me? I just want to be clear that I'm answering the right question.

**Mr. Colin Carrie:** How do you balance? How big a problem is over-prescribing or prescription drug abuse? Then how do you balance government regulation and control against the necessity of a good doctor-patient relationship?

For us looking at this issue, we might have to answer a question on how to come up with a good balance on that.

What would be your opinion about that?

**Dr. Cindy Forbes:** I think there are a couple of issues mixed in there.

With regard to prescription drug abuse, we're often referring to the opioid narcotic issue. That was a focus of our annual meeting last year in Halifax at which physicians came together to explore that issue from all sides, looking at it from the patient's point of view, from the physician's point of view, and from the addiction specialists' point of view. We recognize that it is an issue and that physicians have a role to play in trying to solve that problem.

We're looking at education for physicians; understanding other ways to manage chronic pain, which is often what leads to the initial prescriptions for opioids; and how to reduce the use of opioid prescriptions through other forms of treatment. That's one way of looking at this.

I think you're asking a really good question about balancing that, and I think it's going to require pharmacists, physicians, and patients getting together to have that discussion, but I do believe we can do that without it being too prescriptive from the point of view of government.

**The Chair:** Mr. Davies.

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

Thank you to all the witnesses for being here today.

Ms. Mistry, I'll start with you first. According to the Aon Hewitt 2013 Health Care Survey, the number of employers in Canada offering retirement health benefits to employees has fallen from 62% in 2002 to 49% in 2011. Another study from 2011 shows that nearly 80% of Canadian employers do not offer retiree benefits to non-union employees.

Does your organization agree with the general findings of these surveys; i.e., is it the trend that Canadian seniors are increasingly less likely to be offered retirement health benefits, including prescription coverage?

**Ms. Natasha Mistry:** Yes, and our current members will stand behind that trend.

We are seeing a decline in private coverage for seniors by their employers. The special thing about CARP members is that they're not only a group with self-interest; their concerns don't stop at senior citizens. They worry about their children's and their grandchildren's futures.

This is a disturbing trend, yes.

**Mr. Don Davies:** Thank you.

Dr. Forbes, it's good to see you again.

I'm going to juxtapose two things for you. In a 2010 policy paper entitled "Funding the Continuum of Care", the Canadian Medical Association recommended that governments establish a program of comprehensive prescription drug coverage to be administered and reimbursed through provincial and territorial drug coverage plans and private prescription drug plans.

From my research, in August of 2015—maybe it was in Halifax, but I'm not sure—your members adopted a resolution in support of "the development of an equitable and comprehensive national Pharmacare program" at your annual meeting.

I'm trying to make those two jibe. Is it the current policy of the CMA to go for universal national coverage for prescriptions?

• (1620)

**Dr. Cindy Forbes:** The current policy is that we want all Canadians to be able to access necessary prescription medications. You're asking about what we see as the actual funding model for that. We have recommended that there be a federal sharing of that cost and we've actually costed it out through a study with the Conference Board of Canada, looking at it from the point of view of no individual having to pay more than \$1,500 a year or 3% of their annual earnings. That is one example we have proposed of what we're talking about as a shared model.

The remainder of the funding could come from private plans or from provincial plans. It's really just a demonstration of one model that could work and could be a step towards a universal federal plan. This would be something that could still happen in the future. We have suggested this model of a shared plan between the federal government and private or provincial plans because it is completely scalable. The question of how much this is going to cost, I know, is huge. It would be possible to set that limit at a lower amount or at a higher amount, whether it be \$1,500 or \$2,000 or \$5,000. That is something the government could decide, along with the percentage—whether it's 3% of annual earnings or not. We really felt that it might be a way of initiating this type of federal involvement in payment with some safety parameters around it, such that you would have the ability to scale it up or down.

**Mr. Don Davies:** Would the—

**Dr. Cindy Forbes:** Excuse me, but I'm just going to ask whether Owen...because this is something he can—

**Mr. Owen Adams:** No, that's fine.

**Mr. Don Davies:** I'm just trying to determine whether the CMA would be opposed to a universal public pharmacare plan.

**Dr. Cindy Forbes:** No, we would not be opposed to that, if that was your question. That was a long answer, then.

**Mr. Don Davies:** Thanks.

My colleague asked you about prescribing practices, and you had some interesting testimony, I thought. In "Pharmacare 2020: the Future of Drug Coverage in Canada", Professor Steve Morgan and colleagues argued that

A single, universal formulary would also better guide prescribing than professional education alone and would likely improve the quality and safety of care received by patients.

You talked about the assistance that formularies give to physicians practising. Can you describe what impact formulary listing decisions have on prescribing practices? Is Dr. Morgan onto something there?

**Dr. Cindy Forbes:** I think certainly it can be very beneficial. I'm familiar with the situation in Nova Scotia, where I work. The formulary is determined by a committee that looks at evidence. They look at cost and they look at value. The fact that the formulary has been developed with these in mind gives us confidence that those things have been considered and provides a template for physicians to understand which prescriptions provide the best value for their patients.

There are times when we may wish to prescribe medications that aren't on the formulary, that aren't covered. Sometimes the reasons are very individual for a patient. Cost is always something we bear in mind, but it's one factor when deciding what medication to prescribe. Sometimes it has to do with compliance. Sometimes it has to do with the ease of use of a device or something like that, that we may choose a medication that isn't on the formulary. Then it becomes a discussion with patients as to whether they can afford it or not; it complicates things.

**Mr. Don Davies:** How am I for time, Mr. Chair?

**The Chair:** You have 17 seconds.

**Mr. Don Davies:** I'll be quick, then.

Mr. Harrington, do you know whether in any other country with universal public pharmacare there has been an increase in patient use of prescription medicines at the expense of over-the-counter medications? I know that's one of your concerns. Can you point us to a jurisdiction in which that has happened?

**Mr. Gerry Harrington:** No, I can't, because we haven't seen that transition any time recently. The main point I would make is that the fact that we lag behind all those jurisdictions in terms of the switch process may have something to do with the fact that we don't have national pharmacare. In other words, the consequences don't accrue to government, because there isn't a national pharmacare program that is paying for all those extra prescriptions.

Again, our concern.... It's not so much that we're concerned about it as that we think there's an opportunity to make pharmacare more affordable.

• (1625)

**The Chair:** Thank you.

Dr. Eyolfson, go ahead, please.

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

Thanks, everyone, for coming.

Dr. Forbes, as Don said, it's good to see you again.

**Dr. Cindy Forbes:** It's nice to see you.

**Mr. Doug Eyolfson:** We've been listening to various points of view on the development of pharmacare. We've heard that a couple of different stakeholders dispute some of the findings of the Canadian Medical Association studies, particularly the Morgan study's findings on monetary impact. What is your response to the Morgan study's criticisms of the costs?

**Dr. Cindy Forbes:** I am going to defer to Mr. Adams.

**Mr. Owen Adams:** Let me say first that Steve's study was published in the *Canadian Medical Association Journal*. There's a firewall between us and them, so you should note that. I've certainly reviewed Steve's study. Like the assumptions, the methodology is very clearly specified. To some degree, it's benchmarking what would happen if you could reduce costs to a certain level. It's not unlike the findings of Marc-André Gagnon's study out of Carleton, in 2010. We've referred to both of those in our brief. I think it was carefully done.

**Mr. Doug Eyolfson:** All right, thank you.

Would you be able to comment on the potential savings within households and to the private sector—such as insurance agencies—if there were a universal pharmacare system? Do we have any idea of the scale of potential savings?

**Mr. Owen Adams:** We know that average out-of-pocket household spending was \$408 in 2014, according to Statistics Canada. I'm not familiar with good estimates in terms of what the overall administrative savings would be from that, whether from the provincial plans or private plans. I don't really know that

**Mr. Doug Eyolfson:** Sure. Okay.

I have an idea intuitively that this would be the case, but I don't have the data to actually say this.

Do we have an idea of the costs to the healthcare system of non-compliance due to decreased cost? I apologize to the committee, because they've heard me give this example many times.

If someone can't afford their insulin, what are the immediate costs for every occurrence of diabetic ketoacidosis, the cost of a heart attack, the cost of them going on dialysis? Do we have any idea of the savings, the potential downstream savings, to the health care system if everyone could afford their medications?

**Dr. Cindy Forbes:** I think the answer is that we don't have that information. I think that would be very useful information. I'm not sure whether it's even possible to gather all that information. I know from my own experience that patients don't often reveal that they're not taking their medications. They may not want me to know that they can't afford them. From that point of view, it's really difficult to know whether the outcome had to do with them not taking their medications or not. We have asked ourselves that same question, namely whether that evidence does exist, and we haven't seen it.

**Mr. Doug Eyolfson:** Thank you.

You talked about optimal prescribing as being a part of this. I couldn't agree more. We are privileged in the hospital environment, at least in Manitoba. We have a computer readout through an integrated system with the pharmacies. If someone comes to the emergency department, we print out a list of every medication they've been prescribed in the last six months, so we know what they're on.

Would a national pharmacare system help with the surveillance and guidance of physicians in their prescribing practices?

**Dr. Cindy Forbes:** I think it could. When we talk about getting the provinces and territories together with stakeholders, along with the federal government, to look at a pharmaceutical strategy, determining how it could best occur would be part of that. I believe that it definitely could help with that on many different levels. I mentioned e-prescribing, but there is also education around the choice of the medications that are on the formulary, allowing feedback on which drugs are covered as time goes on, and allowing some choice, which I've also heard from others.

•(1630)

**Mr. Doug Eyolfson:** All right. Thank you.

Mr. Harrington, we talked about the use of over-the-counter medications. Of course, they do much different things from a lot of the prescription medications. Antibiotics aren't over-the-counter. Cancer drugs aren't over-the-counter. Has there been any data showing any improvement in morbidity or mortality associated with the use of over-the-counter medications among consumer health products?

**Mr. Gerry Harrington:** That's a tough question to answer. I mean, generally speaking, where you have two products in the same therapeutic category, one on prescription and one available without a prescription, we know from the standards that Health Canada uses to approve these drugs that the risks are generally lower with the OTC version.

But to extrapolate from there to a better outcome, I don't think there's data out there that would necessarily support that. We do have data in terms of outcome satisfaction from the individuals who use these products. There have been studies done, in a number of Rx-to-OTC switches, saying that outcomes tended to be the same as when the product was available as a prescription drug. I couldn't speak to any sign of an improvement through a switch.

**Mr. Doug Eyolfson:** Okay. Thank you.

I'll go back to you, Dr. Forbes. We've heard about the current patchwork we have, a system with private coverage, public coverage, non-coverage, with a lot of physicians spending time doing workarounds. I think you and I are very familiar with what has to be done.

Are you getting a sense of how your members are dealing with that, or of how much time they are dealing with all these workarounds they have to perform? Do you have any idea of the amount of time and resources physicians are putting into these workarounds to make sure their patients can afford their medications, or to get them when they can't afford them?

**Dr. Cindy Forbes:** I'm not sure if we're talking about workarounds in the same sense. The workarounds I'm familiar with are usually me filling out special authorization forms or special requests for things that aren't covered, which is paperwork.

**Mr. Doug Eyolfson:** That counts.

**Dr. Cindy Forbes:** Yes, that counts. There's definitely an administrative burden, and a burden on physician time, in dealing with the exceptions, which sometimes seem to be the rule. I would hope that the vision of a national pharmacare program would not be based around increasing the administrative burden on physicians, because that would not be a success, to my mind. There's also the

administrative burden, or the complications or barriers, let's say, for patients who often have to submit a lot of claim forms. Sometimes they're complicated, and it's often difficult for people to complete them on their own.

**Mr. Doug Eyolfson:** Thank you.

**The Chair:** That completes round one.

We'll now go to round two. These will be five-minute question periods.

Ms. Harder.

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

My first question I will direct to Gerry and Kristin.

I understand that your organization deals solely with the supply side of the industry. Is that correct? I'm hoping you can explain for us some of the existing hurdles that products face in order to get onto the public formularies that exist. What are some of those hurdles compared with the ones on private insurance formularies?

**Mr. Gerry Harrington:** I would have to say, right off the top, that since about the mid-1990s, virtually all major formularies, primarily in the public plans, have cleared out non-prescription medicines from the plans. This was a movement that took hold around 1990-91. I think at this stage there are very few formularies.... I think the NIHB is one of the few major drug plans that still reimburse non-prescription medicines.

•(1635)

**Ms. Rachael Harder:** Okay.

**Mr. Gerry Harrington:** That's a pretty big hurdle.

**Ms. Rachael Harder:** Would you then be advocating for non-prescription drugs to be considered under a public pharmacare program?

**Mr. Gerry Harrington:** Generally not. I think we may be evolving in a direction where that becomes more likely further down the road. We see a lot of jurisdictions in which the kinds of things that are switching to non-prescription status are things that you may want to include on a plan.

**Ms. Rachael Harder:** Right.

**Mr. Gerry Harrington:** Even today I think there are examples—and I think smoking-cessation aids are a good example—of how economically it makes a lot of sense to make those accessible.

Our focus really is more on ensuring that we have a regulatory system to put these products on the market in a way that they're accessible to Canadians more quickly than they are now. They're waiting seven to nine years in comparison to how long U.S. and EU residents are waiting, and there are many Canadians who would prefer to take that control over their own health that way, and could do so successfully, who right now have no choice but to go to the doctor to get a prescription. These are for ailments that have already been clearly diagnosed, when the patient is very confident and able to self-treat.

So we look at it more as a matter of lowering barriers outside the pharmacare to make pharmacare more affordable.

**Ms. Rachael Harder:** Okay.

That opens the door quite wide. I feel very uncomfortable with that.

What comes to my mind is the image of a long line of people waiting to get their free Tylenol and Advil, etc., because it's covered under a national pharmacare program.

Am I understanding what you're advocating for here?

**Mr. Gerry Harrington:** I'm sorry if I'm not communicating clearly.

No, we're not talking about including these products on the formulary or on the pharmacare plan, at all. People have to—

**Ms. Rachael Harder:** Okay, thank you. I just wanted to clarify that. Thank you very much.

My next question here goes to the CMA.

Dr. Forbes, I read through the pre-budget submission that you submitted earlier, and in it your organization had two pharmacare recommendations. The first was that the private health insurance industry participate in the work of a pan-Canadian pharmaceutical alliance, because they cover the majority of working-age Canadians, of course. The second was to create a national catastrophic drug coverage plan for all Canadians.

You estimate that the cost of the catastrophic drug coverage plan would be about \$1.7 billion. My question is, why did you not recommend an all-out pharmacare program right off the bat? Why are you going towards a more incremental approach rather than an immediate pharmacare program that would cover the whole nation?

**Dr. Cindy Forbes:** Thank you for that.

I think I addressed that somewhat in an earlier question but our intention really—especially with the pre-budget consultations—was to look at measures that were able to be easily implemented in a short time frame. We really see that recommendation as a step towards national pharmacare if that's where we're headed, so we felt that this was a reasonable approach. Again, it is scalable, as I mentioned before, and would be administratively easier than some other approaches. Really, getting from here to there when it comes to a national pharmacare program is probably going to take quite a long time, and this would get us closer.

**Ms. Rachael Harder:** Do you have any idea how long that's going to take us?

**Dr. Cindy Forbes:** Would you like to comment on that?

Owen is very familiar with what's happened historically and over time. There have been a lot of attempts in the past.

**Mr. Owen Adams:** Well, I guess it's a challenge. If you really want a full public pharmacare program, you're talking about what you are doing about the \$17 billion in private expenditure as in 2014.

I do appreciate the modellings that show that there could be some savings from bulk purchasing and so on, but that's still quite a gulp, to say the least. That's why we don't see that happening overnight in

the same way that medicare came in during the sixties. It was a much smaller enterprise at the time.

**Ms. Rachael Harder:** Mr. Adams, are you suggesting then that the pharmacare program is actually going to cost us rather than save us money?

**Mr. Owen Adams:** I assume you are referring to a public program. If you look at 2014, almost \$29 billion total for Canada was spent. Of that, \$12 billion came from governments—federal, provincial, and territorial—and then \$17 billion came from private sources. It was \$10 billion from private insurance and \$6.4 billion out of pocket.

It was the National Forum on Health that raised this idea in 1997. It said that this money was being spent and it could be converted to public money. The question then is how you do that. The way it was done in medicare in the sixties was that the federal government stepped up to the plate and offered 50:50 cost-sharing to the provinces. It was phased in over several years and it did happen quickly, but I just think it's a much bigger gulp factor now than it was back then.

• (1640)

**Ms. Rachael Harder:** Thank you very much.

**The Chair:** Thank you.

Mr. Kang.

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

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

Natasha Mistry, Canadians face many challenges as we age. I joined the club on May 2. One of these challenges is the increased number of pharmaceutical medicines necessary to improve the quality of life for the elderly. Can you shed some light for the committee on how prescribing practices have changed for elderly Canadians, and outline how some of the vulnerabilities they face could be addressed with a national pharmacare strategy?

**Ms. Natasha Mistry:** Absolutely. I feel this may also address a lot of the questions surrounding whether or not prescriptions would get out of control if we did have a national pharmacare program. I think to answer that you need to look beyond pharmacare itself. I think the answer may lie in receiving multidisciplinary care. A lot of aging Canadians may live with one or more conditions. For example, if you live with rheumatoid arthritis, you may also suffer from depression, or you may also have to deal with inflammatory bowel disease. In the case of Canada, because we lack multidisciplinary care, treatments are offered by very different specialist groups. So you have a senior with three separate conditions, each of which may be treated individually.

National pharmacare may not address all those issues, but we hope that it may lead to more discussions around how Canadians, and seniors in particular, receive their care, and the means necessary to get access to all three doctors talking together, and receiving coordinated care to make sure that the medications they take are the ones that are most effective.

**Mr. Darshan Singh Kang:** CARP has been involved in challenging changes to pharmacare in Nova Scotia and in Ontario and other provinces. The concern was that higher-income elders would have to pay higher premiums. What were the exact proposed changes that CARP decided to challenge? Why has the approach of increased premiums on elderly Canadians failed to address the increasing cost of pharmaceuticals in Canada, and how could a national pharmacare strategy overcome this problem?

**Ms. Natasha Mistry:** Our community is very vocal about a lot of these changes. We usually support what our CARP members are calling for action on. Unfortunately, I cannot comment on particular issues in Nova Scotia and Ontario. This for me is day seven of working in CARP, but I do come from a long history of working in health care in general in Canada.

• (1645)

**Mr. Darshan Singh Kang:** Can you provide us something in writing to the chair on that question?

**Ms. Natasha Mistry:** Absolutely.

**Mr. Darshan Singh Kang:** Thank you very much.

Why has the approach of increasing premiums on elderly Canadians failed to address the increasing cost of pharmaceuticals in Canada? How could a national pharmacare strategy overcome this problem?

**Ms. Natasha Mistry:** Is that addressed to me?

**Mr. Darshan Singh Kang:** Yes, please.

**Ms. Natasha Mistry:** I would also like to provide that response in written format.

**Mr. Darshan Singh Kang:** Thank you.

To you again, many of your members are on fixed incomes, and some provinces such as British Columbia that introduced fair pharmacare have made a gradient for seniors. What are some of the provincial approaches to providing pharmacare that you believe have been beneficial, and what are some others that have caused more difficulty for those living on fixed incomes?

**Ms. Natasha Mistry:** Could you please repeat the question?

**Mr. Darshan Singh Kang:** Many members are on fixed incomes, and some provinces, such as British Columbia, have an income-level approach. What are some of the provincial approaches to providing pharmacare that you believe have been beneficial? What other approaches have caused more difficulties for those living on fixed incomes?

**Ms. Natasha Mistry:** As I stated in my presentation, B.C. is one province that we've pointed to as moving from a seniors-focused age-based coverage for pharmacare into one that is income-based. Often what happens with this is that our CARP members may not then benefit from specific senior-focused access to pharmacare. That is one example where it has not been successful.

I believe that seniors put in a lot of time, energy, commitment, and contribution to Canadian society, and we do know that there is an increase in seniors living in poverty. I believe strongly that a national pharmacare plan would support those seniors by allowing them to not have to worry about whether they could fill their prescription drugs.

We do know that 10% of our CARP members have stated that they are unable to afford their medications.

**The Chair:** Mr. Webber.

**Mr. Len Webber (Calgary Confederation, CPC):** Thank you, Mr. Chair. Do I have three minutes or five minutes? Five minutes. I may pass some on to my colleagues if you don't mind.

First of all, I want to thank you all sincerely for the work that you do, particularly the work that Mr. Harrington and Ms. Willemsen do with Consumer Health Products, because I rely on you and your products 100% of the time. I am terrified of doctors and I will not go to a doctor, so I always go to the London Drugs store to get what I need. Thank you for that.

I was very interested in the stats in your research and what you did with how Canadians respond to their health care needs. I, of course, respond by going to the counter.

You said your research showed that 2% of people went to a doctor even though they were self-assessed as having very minor ailments. I have always had an issue with people going to the doctor for maybe a little cough or something and costing a lot of money, and you mentioned the amount it costs. You mentioned the amount, and I wasn't even sure of that. I wanted to get some clarification on that. What is the cost of that to our health care system?

**Mr. Gerry Harrington:** I'll give a bit of a preface, and I'll ask Kristin to jump in with the numbers.

The thing about the minor ailments burden on the health care system is that even though we are talking about 2% of minor ailment sufferers, that numerator sits on top of an enormous denominator. These ailments are extremely common and are experienced by the vast majority of Canadians. It's always a bit of a surprise when you do the math back to understand just how great a proportion of the doctor workload those represents.

I'll let Kristin get into that, because she actually did a lot of work in that area.

• (1650)

**Ms. Kristin Willemsen (Director, Scientific and Regulatory Affairs, Consumer Health Products Canada):** Thank you.

In 2011 we did a close look at the economics of that. We found that one-quarter of Canadians do go to a doctor when they're faced with some minor ailment. We looked at coughs and colds, and for those who go to the doctor, those things alone represent about \$625 million in doctor visits annually. For the percentage of people who go despite having mild symptoms, if they practised self-care alone, that would save the health care system \$89 million annually.

We translated that into what it would mean in savings on doctor visits, and it would mean enough savings for 500 000 Canadians to have access to doctors' visits. That's not prescription drug costs. That's not testing. That's not other costs as well.

**Mr. Len Webber:** I guess the biggest concern I have is the mixing of my consumer products. If I take a cold medication at night along with perhaps something else to help me sleep, I worry about that. We have that issue with seniors right now with overmedication. I'm concerned about the awareness and the education of Canadians regarding the effects of different over-the-counter medications.

**Mr. Gerry Harrington:** It's a really important issue. There are a number of initiatives under way right now in terms of improving product labels, and the need for education.

One of the things, I think, that are really interesting about the Canadian market vis-à-vis other markets, particularly the big one to the south, is that Canadians are three times more likely to interact with a pharmacist when it comes to their over-the-counter medicines than U.S. citizens are. It's really important to continue to emphasize things like this, and the industry, I think, needs to do things like that to ensure that these products are used appropriately, because while they're safe and effective when used appropriately, that's the key condition.

**Mr. Len Webber:** Thank you for that.

Dr. Carrie.

**Mr. Colin Carrie:** We had some witnesses talk about the Canadian system. Overall there's fairly good coverage, but there seem to be some gaps when it comes to groups like the working poor and seniors.

I think it was Mr. Adams who said if we didn't have private insurance, then on Day 1, boom, the federal government would have to cover, I think the number was around \$17 billion, or a portion of that. Whatever it would work out to would be significant.

One of my colleagues asked if you were opposed to having a publicly funded pharmacare program. Are you opposed to having a hybrid program or an improvement of the program we have now, a mix between private and public, to allow better access, as you said, to certain medications that may not be covered because of cost constraints?

**Dr. Cindy Forbes:** Absolutely not. As I mentioned, the model we put forward, for a shared...could easily still be incorporated with private plans as well, so absolutely not.

**Mr. Colin Carrie:** Do I have time for another quick question.

**The Chair:** No, sorry.

Mr. Ayoub.

**Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.):** Mr. Chair, I will give my minute to Mr. Oliver.

**The Chair:** Okay. You're very generous.

**Mr. Ramez Ayoub:** Well, I'm generous today.

**The Chair:** I'll make sure he deserves it.

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

Thank you for your very interesting presentations.

The first question is to Mr. Harrington.

No disrespect meant to your presentation, but I found the relevancy of it for our study to be somewhat problematic. I think two or three times in your presentation, you said that you understood we were addressing national pharmacare, but your topic was more on OTC. You don't want the OTC incorporated into a formulary. The principal concern you have is that if we were to develop a closed formulary in a national pharmacare system, drugs would be expeditiously moved to the OTC side of things if there were reasons for that. Is that the main takeaway I would have, then, from your presentation?

**Mr. Gerry Harrington:** The main takeaway is that yes, there are things that are lagging right now in the regulatory system for OTCs that would enable the task of creating a pharmacare program.

**Mr. John Oliver:** So it's the earlier identification of when a drug can become an OTC and get out of the national pharmacare—

**Mr. Gerry Harrington:** And it's the removal of the red tape that currently....

**Mr. John Oliver:** Thank you for that then.

Dr. Forbes, this is going back to what my colleague Mr. Davies said. We've heard varying views and perspectives on national pharmacare. The Canadian Pharmacists Association had commissioned a paper, and one of the assertions by the author of that paper was that moving from the open formularies that we have right now to a closed formulary would reduce choice for patients and doctors, and that would have a negative health impact on patients. Do you support that perspective that the open formularies are better than a closed formulary model?

•(1655)

**Dr. Cindy Forbes:** First of all, I don't think it's quite that simple. Many patients who have private drug plans don't have open formularies. As a matter of fact, within some of the insurance companies, there are 10 different plans that your company could purchase. Some of them are much more restrictive than others.

It's possible to design a national pharmacare program that isn't as restrictive as what you're talking about. That's really up to the designers of the program looking at what the problems are with it being too restrictive, and how we can deal with that. One of the ways we deal with it now is by allowing for exceptions and special authorizations. As much as I complained about the paperwork, the fact that there is a process is very helpful, and I think we could mitigate that.

**Mr. John Oliver:** Does the CMA have any recommendation on a body that would be charged with the responsible development of a formulary? We've had CADTH present here. They're doing a ton of work across Canada. Is that what you view as the most likely place to park responsibility for that evidence-based approach to developing a formulary?

**Mr. Owen Adams:** That would certainly be something to consider, absolutely. They've been around. They have a solid track record.

**Mr. John Oliver:** Great. Thanks.

I'm trying to think through other advantages of a national pharmacare system for physicians. Right now, I think we heard one group say, there are more than a thousand different private insurance plans that pharmacists are working through for patients. The question seemed to me to be how we ever get to a comprehensive patient health record, and if a patient presented in a national pharmacare system, it would be quite obvious, and it would be easier to track what medications they were on and how those medications were being procured.

Would it be easier for either an emergency doctor or a family doctor to have those prescriptions easily identified as they look at a patient's history?

**Dr. Cindy Forbes:** It's possible. There are other ways to do it, and I think it is happening across Canada right now; more and more systems are being developed within the provinces so that we can see all of the prescriptions that might be coming from multiple drugstores.

But there's still a potential advantage to having one system. I'd like to point out that probably the best advantage of national pharmacare for physicians is being able to treat our patients, for them to get the medications that they need. That's really what we're talking about with all of this: the advantage to patients of not going without treatment.

I think we all recognize that this happens; I certainly see it every day. It's one of the questions I ask. As I'm writing a prescription or typing it on my computer, I'm asking some general questions about whether they're going to be able to afford it. I think that's the big event.

**Mr. John Oliver:** Is there any downside to a national pharmacare system, for a family doctor or for physicians in general? I was hard pressed to think of one.

**Dr. Cindy Forbes:** Right. I guess it really depends on its administration. If I were going to come up with something, it would be that it not be administratively burdensome. That would be an obvious one for me, and that it be more seamless. The upside would be perhaps better information, more guidance in more evidence-based formularies. That would be obvious to me.

**Mr. John Oliver:** Does Mr. Ayoub have more time or not?

**The Chair:** No, he hasn't. Your goose is cooked.

Mr. Davies.

**Mr. Don Davies:** Thank you.

On Monday, Dr. Robyn Tamblyn, a professor from McGill University, suggested a model whereby we have a national formulary

of essential and efficacious drugs, such as insulin or asthma medication, which are proven to work and which we know will, if taken properly, prevent more serious illness. She suggested a plan whereby those would be provided free to all Canadians, and then drugs that are more experimental or are more expensive, without any proven additional efficacy, might be offered to Canadians on a co-pay basis.

Is that a model that has some attraction for you, Dr. Forbes?

• (1700)

**Dr. Cindy Forbes:** I haven't considered it exactly in that form. In some ways, we have a sort of two-tier system, even with patients who have private plans and patients on pharmacare. If their medication isn't covered on the plan, they always have the option of purchasing it by themselves.

In some ways those decisions are being made when formularies say they don't think a particular drug works but that patients can buy it if they want to. That actually does occur somewhat, but I hadn't really considered it as a model to move forward with.

Do you have any comments on that, Owen?

**Mr. Owen Adams:** Briefly, it would depend on who else was then going to pick up the rest. Just how broad would it be, and then how would you cover the rest of it? That would have to be thought about.

**Mr. Don Davies:** If I understood you correctly, Mr. Adams, you made what I consider to be a fairly strong statement that you thought the movement towards universal pharmacare today is a bigger gulp than the action in the 1960s to create medicare for Canadians, to provide free physician and hospital care for all Canadians.

Do you think this is a bigger economic and policy move than the creation of medicare itself was? Do I have you correctly?

**Mr. Owen Adams:** Yes. For one thing, at the time of the Hall Report, I think prescription drugs accounted for 6.5% of total health spending, and today that number is about 13.4%, so it has grown in that sense. In terms of medicare, the first medicare payment was made in 1968-69, and it was \$33 million. Then it grew quickly thereafter. Of course, I haven't looked at the previous hospital expenditures, and those were ramped up.

As we said in our brief, the National Forum on Health recommended the shift, and at the time I think they were talking about \$6 billion and some further amount. That's \$9 billion in today's dollars, and actual spending is much over that amount. You've had growth in spending of about 200% versus population growth of 20%, to give you the magnitude of the shift.

**Mr. Don Davies:** Do you have data to support your statement, or are you just—

**Mr. Owen Adams:** It's all in the brief, sir.

**Mr. Don Davies:** But is there a study you could point me to that shows that moving to universal pharmacare today would be a bigger shift than to move to pharmacare as it was phased in? I'm just trying to find out whether this is your opinion or you have a study or data that backs up that statement?

**Mr. Owen Adams:** No, I have nothing definitively established. I'd have to think about how you would show that.

**Mr. Don Davies:** Okay, thanks.

Dr. Forbes, in terms of the public-private mix, right now Quebec has moved to a system under which the public carries everybody who doesn't have a private plan, and private plans from employers are mandated to provide coverage to their employees, so it's exactly a public-private mix, and we've heard criticism of that plan here on two counts.

Number one is that it has proven to be very expensive on a per capita basis because of the administration costs of the insurance plan. Also what they're finding is that the private plans are cherry-picking. They are dumping the expensive costs onto the public plan and cherry-picking the cheaper applicants onto the private plan. These are some of the criticisms, if I have that right.

Has the CMA looked at the Quebec plan and done an assessment of the issues around that?

**Dr. Cindy Forbes:** I actually can't answer that question. I've not seen any analysis that we've done on the Quebec plan.

**Mr. Don Davies:** Okay. Thank you. I'm done.

**The Chair:** And we're done.

We're going to have bells shortly and we have a little bit of committee business to do. I want to thank the presenters very much.

Ms. Mistry and Mr. Harrington, if you have written reports, we'd like to have them. Can we have copies of your presentations? There's information in them that we'd like to be able to go back over. We found them very interesting and helpful.

We'll just take a little break, and then we'll reconvene.

We have two quick issues I need to talk to you about.

• (1700)

\_\_\_\_\_ (Pause) \_\_\_\_\_

• (1710)

**The Chair:** We'll reconvene.

There are just two issues. Our next meeting is June 6, and we have a guest list, but for June 8 we don't. There are the supplementary estimates that we can or cannot look at.

Is it the wish of the panel to have a look at those on June 8 if we can get the proper people to come in and answer questions on them?

**Mr. Colin Carrie:** That would be great. Can we have the minister and her officials come by?

**The Chair:** We can invite. Normally we have the minister, do we? Or do we have officials?

**Mr. Colin Carrie:** We have both.

**The Chair:** We can ask for the minister.

Everybody has the supplementary estimates, I believe. They should have been distributed.

Are there any comments over here? You're a quiet bunch.

All right, we'll try to get the minister for June 8. If we can't get the minister, do we still want to go ahead with the supplementary estimates?

**Mr. Colin Carrie:** With the officials probably we could. My preference would be to have the minister.

**The Chair:** We could with the officials. All right. We'll see what we can do.

That's the first item. The second item is that tomorrow is the liaison meeting between all the chairs of committees. I'm going to tell the committee that we are intending to travel, but I need your direction on where you want to go.

I think you all have the proposed travel schedule. It's broken down into two options, option A and option B, although we can reconfigure them. Those are the recommended ones. Option A is the United Kingdom and Sweden; option B is New Zealand, Japan, and Australia.

**Mr. Colin Carrie:** Mr. Chair, my biggest concern is basically the cost. I'm just wondering whether my colleagues around the table feel that we would get more from actually going versus from using technology to get the testimony in order to have these organizations present.

• (1715)

**The Chair:** Here's my thought on that.

The time we had the presenter from British Columbia by video, I just felt that she was not part of the proceedings. She didn't have a presence. We weren't able to explore what she had to say, and I think she had a lot to say. I just felt that the people who were here got the attention and she didn't. That's what I felt.

**Mr. Colin Carrie:** Is there a way, though, we could maybe conduct the meeting a little differently to prompt people. I see that even among witnesses here, some are a little more aggressive when they come here. They've been here before. When they want to contribute something, they—

**The Chair:** They have to warm up, too, before they—

**Mr. Colin Carrie:** We're a pretty tough group.

I'd like to hear from other colleagues how they think it would enhance the study.

**The Chair:** Also, we don't have an amount because we don't know which one we're talking about and we don't know when. I think we should talk about where we think is the best value and the timing, and then we'll talk about how much it's going to cost. Then our researchers can put a value on it. I don't have to make this presentation tomorrow, but the meeting is tomorrow. I'd like to at least inform them that we're thinking about it.

Do we have a comment on these destinations?

Mr. Davies.

**Mr. Don Davies:** Thank you.

Well, to Colin's point, I appreciate the ever-present lens of asking the hard question about whether it's necessary. I think that's important, because I think there is unprofitable travel and there's profitable travel, and it's a wise question to ask. There's no question in my mind that if we're really going to understand what's happening in a place like the U.K., we have to go there. A witness on this might have an hour, and of that time they have five, six, seven minutes to answer questions. Imagine being in the U.K. for two days, where you're going into a room with health policy experts and leaders, and you have three hours with them to fully brief you and answer all your questions. My position is that absolutely this is essential for this committee. If we really, truly want to understand what they're doing in other countries, then the only way to do that is to actually go there.

I'm going to suggest a bit of a hybrid. I like option one. Since we're going to be there, I would—

**The Chair:** Excuse me, the bells are ringing, and I need unanimous consent to continue for 15 more minutes.

**Mr. Colin Carrie:** Is it a 15-minute bell or a half-hour bell?

**The Chair:** It's a half-hour bell. We'll go to 5:30. Is that okay with everybody?

The bells start at quarter to.

**An hon. member:** Do you want to do maybe another five minutes?

**Some hon. members:** Agreed.

**Mr. Don Davies:** I'll be quick.

I would add Netherlands to option one, because when we asked the witnesses where to go, it was pretty common to hear that we should go to the U.K., any one of the Scandinavian countries, and the Netherlands.

I like the idea of going to New Zealand. I think Japan is out. Japan has, from what I understand, a very different system. They have very different private health.... I haven't had a chance to read very much of their report. I think we can get to three different jurisdictions in a very economical travel package if we go to the U.K., the Netherlands, and Sweden.

**The Chair:** You're saying the U.K., the Netherlands, and Sweden.

**Mr. Don Davies:** I like option one with the Netherlands, because they're very instructive and they're close.

**Mr. John Oliver:** I just wanted to echo that. I think we heard that U.K. and the Netherlands.... And I think Sweden is interesting. I have a quick additional point. I agree that the lens of affordability has to always be on these, so I like that option. Often part of what you get when you visit, because I've done this in my hospital career, is to meet with the national health system, the political structures. You need to understand how it's being administered and couched politically in different countries because that has a very direct impact on how it's executed and delivered.

It's not just "tell us about your formulary system"; it's "let's understand how the health system works in England or the U.K.," and you can then get a better understanding of how it's being applied.

**The Chair:** Also, we'll get to talk to a lot more people and get a much broader perspective.

**Mr. John Oliver:** Yes.

**The Chair:** Rachael.

**Ms. Rachael Harder:** I understand Mr. Davies' point, but I actually would disagree with him with regard to his travel recommendation. I would actually say Japan is worth going to for the exact reason that he mentioned it's not. Its system is very different and more complex. Whereas the others might be more similar to some of the things we've heard here at this committee, Japan's is very different. For that reason, I actually feel that it's necessary to put our boots on the ground and see it first-hand so that we can fully understand the complexities of their system.

● (1720)

**The Chair:** Excellent.

Mr. Webber.

**Mr. Len Webber:** I guess my comment would be that perhaps we could do the different options in smaller groups. Some of us would go here and some of us would go there, and we cover the whole base. I'll throw that out there.

**The Chair:** Dr. Eyolfson.

**Mr. Doug Eyolfson:** I was just going to concur with what Mr. Davies said. I like that option; it being cost-effective, as it were. I also like the idea of possibly splitting us up so that some would go to one and some would go to the other. I think both are good options. I really like the option of the U.K., Sweden, and the Netherlands systems.

**The Chair:** Mr. Ayoub, you were next.

**Mr. Ramez Ayoub:** I just want to sum up that we all agree that we need to travel even if Mr. Carrie was kind of so-so. I think depending on which option...you could manage that later on.

**The Chair:** Did I see a hand waving over here?

**Mr. Colin Carrie:** You did.

I was wondering if the researchers, just for the meeting, could bring information back, because we're really looking at things like the best access and cost. I don't know if the OECD has ranked different countries with regard to those aspects. That might give us a little bit of a perspective on it as well before we make a decision on it, if we are going to make a decision to travel.

**Mr. Darshan Singh Kang:** I don't like this idea of splitting up. If one group goes to Japan, they will not know what works in the U.K. or Sweden. I don't think we'll be able to come to some kind of consensus. I don't like the idea of splitting up.

**The Chair:** We don't have to decide this today.

Let's go home and think about this a little more. We'll have another discussion on the 8th about this. I'll just tell the liaison board tomorrow that we're contemplating some travel.

**Mr. Darshan Singh Kang:** Keep \$29 billion in mind.

**The Chair:** Right, okay—you asked for \$29 billion.

The meeting is adjourned.







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