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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): We'll call the meeting to order. Welcome everybody. I look forward to today's presentations. It looks like an interesting group. I'm sure we'll learn a lot today.

I was talking to Ms. Kurl, who has a plane to catch, so we're just going to rearrange the schedule a bit and ask her to make her presentation first, so that in the event she has to leave early, she can.

From the Angus Reid Institute, Ms. Kurl, if you could, go ahead and fire away.

Ms. Shachi Kurl (Executive Director, Angus Reid Institute): Thank you.

[*Translation*]

Good afternoon, ladies and gentlemen. My name is Shachi Kurl, and I am executive director of the Angus Reid Institute. I am very pleased to be here with you today to talk about a subject of great importance to Canadians.

Our institute, which was founded in 2014, is a non-partisan and not-for-profit polling organization. In order to promote a better understanding of the major public policy issues and trends in public opinion across the country, we make all of our polling data available to Canadians, free of charge.

[*English*]

Mr. Don Davies (Vancouver Kingsway, NDP): Mr. Chairman, could I pause for a moment? I notice that some of the witnesses are looking for their translation devices. Maybe we can make all the witnesses aware of the channel.

The Chair: There we go.

Ms. Shachi Kurl: In the name of transparency, and also to further the ability of policy-makers, interested parties, and the general public to understand where Canadians are at on particular and important issues of the day, we make all of our data and information available to the public at no cost through our website.

What we wanted to do with the study that was conducted in July 2015, in partnership with the Mindset Foundation, representing a general population sample of Canadians in every region and of the main census demographics, was to take the temperature of Canadians and get a sense of the prevalence and incidence of those Canadians facing cost pressures and other access barriers around their prescription drugs.

What we found, to begin with, was that nearly one in four, a quarter of, Canadians say they are either not taking prescription drugs, skipping doses, splitting pills, or finding other ways to reduce cost and access barriers to the prescription medications they are being recommended to take by their doctors and specialists. Right away, we were able to surmise that this is an issue and one that is putting some pressure on a not insignificant segment of Canadians in this country.

In terms of who is struggling most, that national number sits at just under one in four, but we tend to see a little more struggle and a little more cost pressure for those living in British Columbia and Atlantic Canada. There is some variability, and some of that may be attributable to the fact that in British Columbia, for example, provincial governments only have so-called catastrophic drug coverage. In Atlantic Canada there are other limitations to the nature of drug plans relative to other provinces such as Quebec and Ontario. When we use the word “struggle”, we're talking about those who are identifying themselves as not adhering to their prescription drugs by dosage and not necessarily filling their prescriptions as often as they should be because of the costs involved.

Costs and barriers do go hand in hand, and they affect Canadians on two different levels. One is by age. We do see barriers that are a bit worse for the youngest Canadians. This isn't entirely surprising, given that younger Canadians are often those who are dealing with the least stable work. They may not have jobs that offer comprehensive drug coverage or drug benefit plans of any king. For them, access to pharma is a little less stable, and they may be experiencing more pressure, although you do see almost as many Canadians aged 35 to 54 expressing that they are having some struggles as well.

Income is also a driver of that cost barrier. Those who have lower household incomes are expressing higher levels of struggle and problems with filling their prescriptions, but that isn't to say that higher-income earners don't struggle as well. The reason for that is that you can have brand-name drugs and experimental drugs that can be quite costly. Even though some Canadians are earning more, they may still be facing barriers. Indeed, 16% say they are facing those barriers because some drugs are prohibitively expensive. If people are not covered, then they're figuring out how to deal with that themselves.

● (1535)

We wanted to get a sense of how many Canadians are paying out of pocket for their drug expenses. Overall, you see that about 30% say they're paying some amount less than $100 per year. There are about as many saying they're paying $500 or more. Something like one in five, about 20%, are saying they're paying between $1,000 and $3,000 per year.

What's notable here is that those in that $500 or more out-of-pocket expense bucket include about one-third of Quebeckers. This may be attributable to the fact that they are dealing with monthly deductibles and other costs associated with that province's mandatory drug plan. Ontarians, by contrast, have some of the lowest out-of-pocket burdens. Only 14% say they paid $500 a year or more, in the last year, for their prescription drugs.

When we think about access to drugs and access to prescriptions, we also want to ask, “Are you worried about this? Have you been worried, and going forward is this something that's going to be increasingly on your mind?” A routine question we ask of Canadians every three months is, “What are the top issues now facing you, your family, your household?”

Of course, health care is always at the top of that list, along with the economy. But within that subset of health care, what this clearly tells us is that prescription drugs and drug coverage and access are at the top of that health subset.

In the last year, 25% told us they have been worried about how they or their family members would be able to afford prescription medication. Looking ahead, we asked them to think about a decade from now, when they're going to be 10 years older. In response, the level of worry jumped to nearly half, and 46% said they were either very worried or worried about how they were going to pay for their prescription drug costs 10 years from now.

From looking at Canadians' own experiences, at the personal or household level, of accessing drugs and being able to fill their prescriptions, we shifted to some broader opinions on where they stand on the idea of a pharmacare plan. I want to provide a caveat on this. We are experts in measuring public opinion and measuring where Canadians are on particular issues. We are not health policy experts. When we ask this question and present these data, we recognize that without further specifics on what a pharmacare plan might look like, there are some limitations on the interpretation of these findings.

I want to underscore that what I'm presenting is valid as an initial temperature-taking, as opposed to the final word, on public opinion on these issues.

We put a number of value statements in front of Canadians. I'm presenting three that speak to where Canadians are in their general views on pharmacare and access to prescription drugs. These are by no means all the statements that were put in front of Canadians. If more information is wanted, or a greater level of detail, I'm happy to provide that, or you can find it online at angusreid.org. We've provided that link for you.

What you see is that public opinion certainly tilts toward—albeit it's not necessarily a majority—value statements that indicate, on a conceptual level, that Canadians are in favour of access to prescription medication. They favour being able to get the drugs they need for their health.

On support for a pharmacare plan, we asked: “Do you yourself oppose or support adding prescription drugs to the universal health coverage of 'medicare'?” To further explain what we meant, we added: “so that all Canadians have access to prescribed medicines without having to pay out of their own pocket”.

● (1540)

Again you see very strong consensus for this concept. Only 15% oppose or strongly oppose such a plan; nearly a half say that they strongly support it. Again, it is conceptual. I have to underscore that again.

What's notable and significant in this finding is that when you combine it with some other findings, some 70% of Canadians think that the status quo in terms of drug coverage today is in need of improvement. Moreover, when it comes to reform, again, a great majority believe that the pharmacare coverage they face in their country—and, of course, it is a bit of a patchwork when you go from province to province—is better served by having a national plan across the board.

Now, who should pay? It's always easy to find Canadians in support of particular plans, or ideas, or policies, but when it comes to the stickier details of who administers and who pays, this is where we tend to find a little less consensus. On the issue of administration and who should be involved, you see that about a half, a very slight majority, believe this should be something that both the provinces and the federal government should have some involvement in and be working together on. The margins, about one-quarter, say that it should be the federal government that runs the show, about one-quarter say it should be up to the individual provinces.

How should it be funded? You see there at the top for context, again, that's your 87% overall saying that yes, there is support for adding prescription drugs to medicare. That's your reference point on support, but in terms of particular funding costs and funding options, the only funding option that reveals any majority and consensus support is around restoring a federal corporate income tax to its 2010 levels of 18%. Canadians are not particularly warm to an increase in the GST to pay for such an idea. They are not particularly warm to increasing the basic income tax on incomes over $40,000 to 23%. They are, at best, milquetoast on the idea of charging a pharmacare premium of $180 per year for all Canadians over the age of 18.

● (1545)

The Chair: Excuse me, I have to ask you to wind it up. The time's up.

Ms. Shachi Kurl: I'm all done.

The Chair: Oh, perfect. Thank you very much. I didn't want you to think I was cutting you off when you said the government was supposed to pay, but anyway....

Ms. Shachi Kurl: It's corporations that they want to pay.

The Chair: Now we'll move to Mr. Romanow, whose comments we look forward to.

You're going to share your time with Mr. Marchildon, I understand.

[*Translation*]

Mr. Roy Romanow (Commissioner and former Premier of Saskatchewan, Commission on the Future of Health Care in Canada, As an Individual): Thank you very much, Mr. Chair and members of the committee. It's a great pleasure and an honour to be here.

[*English*]

Thank you very much for the opportunity.

Greg Marchildon is my colleague. He's the executive director of my commission and currently the professor and Ontario research chair in health policy and system design at the University of Toronto.

We are each going to speak for five minutes. I'll address the recommendations of the royal commission relevant to the present mandate of your parliamentary committee and the leadership question of whether we can move forward. Dr. Marchildon will put forward two options describing how we might move forward as a country, especially in light of the public opinion polls we just heard.

Unfortunately, the challenge we identified in 2002—which seems like yesterday—remains the same today. In fact, there's a long history of commissions and studies recommending national pharmacare, dating all the way back from Emmett Hall's report in 1963-64, to my own commission report in 2002. While the current and potential benefits of prescription drugs are undeniable, the benefits will only be realized if prescription drugs are integrated into the system in a way that ensures they are appropriately prescribed and utilized, and that costs can be managed. As we said in 2002, the issues are national in scope, and the problems are similar in every part of the country.

As a consequence, we argue that only a pan-Canadian approach will allow us to address the triple challenge of access, cost, and integration identified in the report. While I'm pleased to say that at least modest improvements have been made in terms of catastrophic drug coverage in a number of the provinces since 2002, but access still remains limited and uneven. Poor working and self-employed Canadians continue to have no coverage. Roughly 50% of Canadians have no public drug coverage at all, which is one of the lowest levels of coverage in the OECD. Private sector, non-unionized employees, and women have far less job-based coverage than public sector, unionized employees, and men. There are also significant differences in provincial coverage for retired individuals 65 and over, and those on social assistance.

When it comes to cost, we have made little or no progress. We are second only to the United States in terms of costly generic drug prices, and near the top of the OECD group of nations for patented drug costs. This is directly due to the fragmentation between private and public coverage, the loss of leverage with the pharmaceutical industry, and variations in the practice by having disparate federal, provincial, and territorial programs.

We have made modest progress on improving coordination since 2002 through the common drug review program and the pan-Canadian Pharmaceutical Alliance.

I would say, Mr. Chairman, and committee members, that we need to go much further to achieve the kind of integration required to improve access and quality of service to average Canadians in a fiscally sustainable way.

This brings me back to the steps I suggested in the report and the steps that we need to take to achieve real progress on access costs and integration. They are as follows: one, the establishment of a single national formulary; two, the creation of a powerful national drug agency that would regulate both patented and generic prescription drugs, provide analyses of both clinical and cost-effectiveness, and be the guardian of a national drug formulary; three, the linking of medical management, best practices, and guidelines with primary health care services; four, doing a comprehensive review of the Patent Act to address continuing problems, such as evergreening and the proliferation of so-called me-too drugs.

I want to emphasize how important federal leadership will be to achieving the goals of a national pharmacare plan and getting us out of our current situation. I say this as a former premier. I'm talking about federal leadership, national leadership. The public wants a strong federal role in advancing this much-needed step forward in reform. Will Ottawa act on this issue, just as Prime Minister Pearson in a minority federal government in the 1960s did, by overcoming opposition to implementing the goals of medicare? This does not mean compulsion, but it will mean setting out a national vision with clear objectives, supported by some non-negotiable, national criteria, which must be accepted before any provincial or territorial government can gain benefit of the federal investment in pharmacare.

At this point, I'll ask Dr. Marchildon to review the two main options in achieving the national pharmacare plan, and in either case the federal government will need to take a strong leadership role.

Greg.

● (1550)

Dr. Gregory Marchildon (Professor and Ontario Research Chair in Health Policy and System Design, Institute of Health Policy, Management and Evaluation, University of Toronto, As an Individual): As Mr. Romanow pointed out, I am going to focus my remarks on two options. Both can achieve the job, but they each have very different trade-offs in terms of their relative strengths and advantages and their disadvantages.

The first is the traditional program that is financed in part by the federal government under a few national criteria, and then administered and financed for the remainder by the provincial and territorial governments. This is the way in which medicare was introduced, first through universal hospital coverage in the 1950s, and then through universal medical care coverage in the 1960s.

Although very few proponents of national pharmacare have spelled out the governance form it would take, I think this is really the approach that is assumed by most, because it is what we are all most familiar with. That came up in the Angus Reid survey, where 50% of Canadians seemed to agree with that kind of approach, I suspect mainly because of the fact that they are very familiar with it.

The first advantage of such an approach is that we already have some history and experience with it. However, there are also some very significant disadvantages, including the extensive time required for negotiation involving numerous veto points by individual governments, the dilution of accountability between orders of government, and the difficulty of monitoring and enforcing national standards, as we have experienced in medicare over the last 40 to 50 years.

The second option is a national pharmacare program financed and administered entirely by the federal government. While jurisdiction in most areas of health care is principally provincial, pharmaceuticals are one of the only subjects in which the federal government has a secure constitutional foothold. Coverage would be provided to all Canadians by the federal government and would replace private and public coverage plans currently in place with a single universal plan.

The advantage of this approach is that it establishes a single purchaser and a single regulator. This offers the greatest potential to keep costs down, to keep the lines of accountability as clear as possible, to establish—and, more importantly, maintain—a single national formulary based on both cost and clinical effectiveness, and to eliminate individual and regional differences in coverage and access to prescription drug therapies.

The disadvantages include the lack of experience with such an approach, the fiscal risk that is assumed by the federal government alone, and the possibility that some provincial governments might reject the approach, despite the clear financial advantages of having this major cost pressure removed from their own budgetary responsibilities.

However, I think that this last disadvantage can be addressed by allowing provincial governments to opt out—of course, they don't have to come in—and carry on with their existing programs, but without any financial compensation. In any event, this should also be the rule as applied to any federal-provincial-territorial program option, as I have described in the first option.

On this, we wish to thank the committee for this opportunity, and we look forward to your questions.

● (1555)

The Chair: Perfect. Thank you very much.

Now we move to Innovative Medicines.

Mr. Monteith and Mr. Skinner, are you going to divide your time?

Mr. Glenn Monteith (Vice President, Innovation and Health Sustainability, Innovative Medicines Canada): No, Chair, I'll do the initial address.

Thank you very much for having us here. I'm Glenn Monteith. I'm the vice-president, innovation and health sustainability, for Innovative Medicines Canada, the association representing Canada's innovative pharmaceutical industry.

With me is Brett Skinner, executive director of health and economic policy at Innovative Medicines Canada.

Innovative Medicines Canada represents more than 50 innovative pharmaceutical companies. Our membership includes start-ups through to well-established international pharmaceutical companies. Our association advocates for policies that support a strong and robust life sciences economy in Canada and that also ensure access to innovative medicines for Canadian patients.

Our sector is an important partner in Canada's health care system. We interact every day with public and private health plans. In addition, we're at the table with the pCPA as a trusted partner in the sustainability of Canada's health care system. The sustainability is fundamental to Canadians.

As a principle, we believe all Canadians should have fair, equitable, and affordable access to the medicines they need when they need them. We are therefore pleased to be here to speak on the topic of pharmacare.

I want to begin with some preliminary facts about the role of our member companies within Canada's current health care system. Spending on patented medicines has declined from 8.4% to 6.4% of total health care spending in Canada between 2004 and 2014. According to the PMPRB's most recent data, in 2014 the prices of patented medicines in Canada were on average 13% lower than the median international price and 31% below the international prices at market exchange rates. Another way to describe it that they were 19% below the median prices and 45% below the average prices at purchasing power parity.

Adjusted for inflation, per capita spending on patented medicines was lower in 2014 than in 2003. For 25 of 27 years under the PMPRB regulation, patented medicines' price increases were less than the consumer price index. What this means is that medicines have become more affordable over time relative to inflation. According to the PMPRB's annual report, in 2014 Canada actually ranked third of eight countries in terms of the average prices of patented medicines at market exchange rates. In same comparison using purchasing power parities, Canada ranks number four.

Rather than being a cost-driver in the health care system, innovative medicines contribute significantly to its sustainability, from avoided hospitalizations and shorter hospital stays to fewer invasive surgical procedures, and the avoidance of what sometimes can be a lifetime of chronic illness or disability.

Without access to medicines, these health care costs would become much greater and health outcomes poorer. Innovative medicines also lead to reductions in health system costs. For example, here in Ontario in 2012 we know that out of the $1.2 billion that was spent on six classes of innovative medicines, the expenses were offset by more than $2.4 billion in savings and productivity gains alone. Today in Canada, all hospital administered medications are publicly funded. Outside the hospital setting, the majority of Canadians have financial coverage for innovative medicines under a collection of private drug plans designed for the working population, as well as public drug plans run by provinces and territories that are focused on vulnerable populations such as seniors and those on social security.

The system works well for most Canadians. If pharmacare is only about saving money, there is a belief that the only way to do that is by severely restricting access to innovative medicines. I do not believe Canadians want this. However, we do believe a program or programs could be developed to focus on the following challenges in the current system.

First is the challenge of the uninsured and the underinsured. Despite the strength of our system there are Canadians who do not qualify for either public or private drug coverage, or who do qualify but still struggle financially to fill their prescriptions.

Second is the challenge of the quality of drug plan coverage. This is an issue with the number of drugs covered in public drug programs. In a study that we conducted, we found that of the 121 new medications approved by Health Canada from the period 2010 to 2014, only 37% received public reimbursement as of December 31, 2015, across the provinces accounting for at least 80% of the eligible national public drug plan population. As a result, Canada ranks 18th out of 20 countries in that regard.

● (1600)

Third is the challenge posed by the time to listing in public plans. Canadians in public plans also wait inordinately long to access innovative medicines. On average, it takes 449 days to list a medicine in a public drug plan, even after it has been approved by Health Canada. As a result, Canada ranks 15th out of 20 countries in our comparative study.

The fourth challenge, as indicated by data from another study, is that coverage in Canada's private drug plans is much better than in public plans. Of the 464 new drugs approved for sale by Health Canada during the period 2004 to 2013, 89%, or 413 were covered by at least one private drug plan compared to only 50%, or 231 drugs that were covered by at least one public plan as of January 31, 2015.

Our industry has defined a set of principles to guide discussions on the development of a pharmacare program as follows: first, our first priority is patient access to necessary medicines to meet diverse patient needs; second, we believe that maintaining the prescriber-patient relationship and choice are both critical and fundamental rights; third, we must address the gaps in care and access to treatment for the uninsured and those who cannot afford it; fourth, we believe in direct public funding for those most in need; fifth, the economic and societal benefits of medicines and vaccines must be considered; sixth, Canada's health care system must support innovation and the adoption of groundbreaking science and technologies to improve health outcomes; and seventh, any program must provide the best standard of care for all Canadians, not simply cost-containment driven solutions. Programs focused on cost-containment often mean reduced access to medicines, the exact opposite of what we would hope for Canadians.

I passionately believe that we should build systems that will facilitate greater and more timely access to innovative medicines, improving health outcomes, and securing the future of our Canadian health care system.

Thank you for your attention. I look forward to your questions and comments.

[*Translation*]

Thank you.

[*English*]

The Chair: Thank you very much.

Now, we'll go to our visitor on the screen. Dr. Monika Dutt, chair of the Canadian Doctors for Medicare.

I saw you taking a picture of us a little while ago.

Dr. Monika Dutt (Chair, Canadian Doctors for Medicare): I was going to apologize for that. I was excited to see Roy Romanow and forgot I was on screen.

The Chair: There we go. He's excited to see you, too.

Dr. Monika Dutt: Thank you very much for—

The Chair: Here I was, thinking you were taking a picture of me.

Dr. Monika Dutt: Oh, I took one of you earlier.

Thank you very much. Canadian Doctors for Medicare is grateful for this opportunity to present to the House of Commons Standing Committee on Health on the development of a national pharmacare program. Canadian Doctors for Medicare was established in 2006. We give a voice to physicians across the country who are dedicated to improving and protecting our single-payer medicare system. As medical professionals, we are firmly committed to evidence-based health care policy.

I know that across many hours and days you've been listening to a range of evidence, a range of testimony. I was trying to think of a comparison to what I do in my daily practice as a family doctor. I was thinking about a family coming to me to ask if they should vaccinate their baby. They've collected a range of information, a range of evidence from a number of different places, but as you can probably imagine, different evidence should be given different weight, and not all of the evidence or all of the information is always credible. As a family doctor I need to take into account the best available evidence, and of course, I would recommend to them that they should immunize their baby.

Similarly, I have no reservations in recommending to you that I think Canada needs a national pharmacare program.

Leaders across the country at different levels of government have been speaking in favour of national pharmacare to different degrees. At a recent press conference in January, after meeting with the federal, provincial, and territorial health ministers, Dr. Jane Philpott said that philosophically, the concept of pharmacare is an important one to address. I think as we've seen from the Angus Reid poll, Canadians across the country also agree that this is an important issue and something that Canadians do want to see happen.

Beyond philosophical alignments, popular support, and improved health outcomes, this committee is also considering whether or not implementing pharmacare in Canada is administratively feasible and fiscally responsible. Canadian Doctors for Medicare is pleased to provide evidence to the committee demonstrating that a publicly administered single-payer system is the drug insurance model best able to provide cost management, reduce administrative expenditures, maximize health effects, and lower costs to taxpayers.

In terms of where we are now, as was mentioned in the previous presentation, there are a number of people in Canada, about 60% of Canadians, who are covered by private health insurance coverage for health care services such as prescription drugs. As was also pointed out, often that coverage is not adequate or we don't get as good value for money as we could through these private insurance plans. Others either have no coverage at all or are covered by an assortment of public drug plans, with different criteria depending on the jurisdiction. In Ontario alone there are six different public drug programs that provide coverage for medication costs based on a range of criteria such as age, income, socio-economic status, and ailment.

To be frank, this model is fairly clumsy and more expensive than it should be. It falls short of what Canadians need, and often leaves many who are most at risk without drug coverage. Again, as a family doctor I see this often in my practice.

I can tell you about a teenage boy who has diabetes and requires insulin, whose father worked, actually, out in Fort McMurray prior to the fire. He works intermittently, so has drug coverage intermittently. His mother works full-time, but in a low-income job without benefits. Of course, they do the best they can to always ensure that their son has the medications he needs, but occasionally they struggle, and they can't pay for all their needs. That's when they come to see their physician, to see me, to ask if there's anything they can do, if there's a cheaper option, if I have any drug samples. That's not the way I want to practise medicine. That's not the way this teenage boy should have to deal with his health.

Then there are simple situations. I had a woman in her 50s who needed antibiotics for pneumonia. She didn't want to tell me that she couldn't afford her medications. She came back in worse condition than before, and then we ended up talking to the pharmacist, trying to find a different option, a cheaper option, and ended up giving her something that wasn't the first-line medication. Thankfully, she recovered, but again, that's not how she should have to deal with her health.

This current public-private mix of drug coverage programs does not work, and its effects are being felt by our families. And there is a cost to all of us.

In terms of cost, every emergency physician across the country weekly sees patients who are there because they cannot or did not take their medications, and that puts a cost burden on our health care system. Not surprisingly, we see that most often with low-income individuals who aren't able to pay for their medications.

● (1605)

We know that even a small cost barrier, say just $10, to pay for medications is a barrier that prevents them from taking their medications. Not only is the high cost of drugs a factor, but dispensing fees, co-payments, and deductibles also need to be considered. These costs have an impact on whether people take their medications at all or whether they take them consistently.

To illustrate this, I want to walk you through a study that was done in the U.S. It was led by a physician who noticed that people, after having a myocardial infarction or a heart attack, were not taking the medications they should be taking to prevent the complications that often come after a heart attack. His team divided people into two groups.

All of them had some kind of drug coverage, but in one group they topped up that group to have their medications fully paid for, and the other group stayed on their current drug coverage plan. What they found in the end was that the total number of vascular events or negative events that happened to the people who were fully covered was far less than the other groups. They had fewer strokes and fewer other health impacts than the other group. Not only that, they were far more likely to take their medications and, significantly, the total health care costs fell by $5,700 U.S. per person on average in the group that had their medications fully covered.

That study was replicated in Ontario by Dr. lrfan Dhalla. He looked at the costs and benefits of providing free medications to patients after they had a myocardial infarction or a heart attack. These are patients who either did not have private insurance or their public insurance wasn't sufficient to cover their medications. What they found, after providing free medication to these individuals to prevent illness after a heart attack, was that they had improved health outcomes and lower average costs than in the current system.

Within two weeks of the new government coming into power last October, a group of 331 health professionals and academics signed an open letter to Prime Minister Justin Trudeau urging him to put pharmacare at the top of the Canadian health care agenda. Getting this type of consensus, of this magnitude, is often a difficult undertaking. However, in this case, the letters had signatories from every province, including physicians, pharmacists, and nurses, professors from 34 universities across Canada, 10 recipients of the Order of Canada, and 11 Canada research chairs. These experts, like Canadian Doctors for Medicare, were swayed by a case based on strong data-driven evidence in favour of implementing national pharmacare.

As I mentioned before, as we speak about evidence again, we urge the members to consider the quality and source of the research that's coming to them through this process. For instance, one research paper challenged the accuracy of an article published in the *Canadian Medical Association Journal* that was praised by the Canadian Institutes of Health Research. The CMAJ article demonstrated the impressively low cost of implementing national pharmacare. The paper that criticized it was not submitted to a peer review journal where a baseline for research standards can be met. In addition, several sections in the report make contradictory claims about the cost. We've attached this analysis of that paper, which we shared earlier this year with the minister, and we encourage the committee, as we did the minister, to receive all of the evidence, but weigh its credibility carefully.

Perhaps even more importantly than focusing on one organization and one critique, it's essential that the committee also look at implementing a national pharmacare program that challenges the perspectives and current dominance of the pharmaceutical and insurance industries. If we only tinker with the public programs without challenging that infrastructure, we run the risk of causing more harm than good to the health of people across Canada.

Instead, what the federal government and federal representatives can do is to join the growing momentum across Canada. In the last week alone, both the Federation of Canadian Municipalities and the B.C. Chamber of Commerce formally adopted policies calling for action on pharmacare. Support for prompt action on pharmacare is literally growing broader by the day.

Canadian Doctors for Medicare joins those groups and hundreds of others in advocating for a prompt implementation of a national drug coverage program because we see first-hand the consequence that gaps in drug coverage have for the health of our patients. The cost of not implementing pharmacare is too high in terms of health and the public purse. We urge the government to work collaboratively with the provinces and territories, and provide national pharmacare to Canadians.

Thank you.

● (1610)

The Chair: Thank you very much.

As a committee we have had great presentations, including today. We're very grateful to everybody for making these presentations.

We'll now go to question period for our first round. Members each have seven minutes for questions and answers.

We will start with Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank all of you for your presentations. As always, they were very insightful, each with a slightly different perspective, so we're learning from every group that comes in.

My first question goes to Mr. Romanow. In your 2002 study, I think you debated the big gulp, as it were, versus an intentful, staged introduction of pharmacare in dealing with issues. That is before us today.

Some groups who have come before us, such as Innovative Medicines, have suggested that the status quo is working pretty well, but that for uncovered and uninsured Canadians we need to do something more incremental to cover them. Others have said that to really manage this, to achieve the savings that are there, to move this forward, we need to make a bigger change.

Do you have a view on that?

● (1615)

Mr. Roy Romanow: My view would be as follows: in the report of 2002 we wanted an introduction, if I could put it that way, to a national pharmacare plan, mindful of fiscal concerns and mindful also about the capacity or ability of governments and the various agencies of government to be able to accurately assess the efficacy of the drugs involved.

Since that time, which is now 14 years ago—how time flies, Mr. Chairman, when you're having fun—things have changed quite dramatically. I am coming to the view, and I think, perhaps, if I had to redo the report a second time, I would be saying, that we should be moving to a full-scale deal that covers people's demands.

I'm going to cite one little figure here, and I think you received this submission earlier. We looked at it. It was submitted, I think, on April 18, 2016, by Marc-André Gagnon of Carleton University. Total per capita prescription drug expenditures from 2000 to 2012 in the United States were $1010, and in Canada $865. ll the rest follows. We're right up there.

I think the urgency now is more pronounced than it was 14 years ago.

Mr. John Oliver: I have a quick question about who pays. Obviously, right now both public and private sector employers are providing drug benefits to their employees—most are—and about 60% of Canadians are covered through private insurance plans, both through public and private employers.

What's your view? There is clearly evidence that there would be billions of dollars in savings for Canadians as we move toward a pharmacare model, but the cost for the government to implement such as scheme is a taxpayer cost because they are taking on a greater burden on behalf of Canadians. Do you see a way to do this through corporate taxes? Would you recommend a change to maybe reduce the benefit costs that employers have, but at the same time capture some of that to help pay for a public plan?

Mr. Roy Romanow: I do see a way. With your permission, Mr. Marchildon and I have talked about this. May I have your permission for him to give the specific response?

Mr. John Oliver: Absolutely, yes.

Dr. Gregory Marchildon: You're correct, in that, of course, there are a number of private plans. That said, it's important to keep in mind that the public sector, for various historical reasons, has more of the so-called private plans than even the private sector. What we're talking about is that on the public side, whether you're talking about the federal government or provincial governments, it's really a reallocation of a public budget.

When it comes to the private plans, as we know, those have been shrinking in proportion to the number of Canadian workers simply because of the fact that these plans tend to be concentrated among the larger companies and more unionized workforces. We know that the level of unionization has dropped and that more and more companies have shifted, and are dropping or are reducing, their benefits and their private plans because of their cost.

Of course, that does not deny the fact that there is going to be some cost that would be required. There's no easy way to deal with that except for the federal government. Let's say it were a largely federally financed plan, as opposed to a federal-provincial plan. It's a little bit easier for the federal government to do this in a sense. It may involve a very small type of tax hike in the short run, but that too would involve largely a reallocation on the federal government's part, because currently the Canada health transfer is set at 25% and slightly above all provincial health expenditures.

I don't want to get into detail about this, but the earlier social compact on that was it was supposed to be 50% of all provincial medicare expenditures. It went down to 25% because of the block transfer through the EPF in the 1970s.

● (1620)

Mr. John Oliver: I have one more question I need to ask.

Dr. Gregory Marchildon: I will speed up.

The end result was that it was supposed to be 25% of medicare expenditures. Well, it's 25% of all provincial health care expenditures, so if the federal government were to take pharmacare out, it would be a very significant saving. The Canada health transfer or the amount distributed to the provinces and the territories could actually drop, and that money could then be used as part of start-up funding for national pharmacare.

Mr. John Oliver: It would be wonderful to see those two alternatives fleshed out a bit more, and their pros and cons. If you had an opportunity, it would be great to receive that at the committee level.

My last question is for Innovative Medicines. You're doing great work supporting research across Canada and working with the Canadian Institutes of Health Research and other groups. I do want to thank you for that.

I heard your testimony. Right now, in your view, the public plans are inadequate in bringing innovative medicines forward and making them available on formularies, but you seem to be running up against a very strong Canadian.... We heard that something like 91% of Canadians want this kind of change to happen.

Is there no way you can see a public-private partnership in the formulary development that will ensure that you have a voice and a say in a national pharmacare model with a national formulary to be bringing your clients medicines faster? Do you not see that there could be a win for your clients in this model versus simply a lost advantage to Canadians?

Mr. Brett Skinner (Executive Director, Health and Economic Policy, Innovative Medicines Canada): My first response would be to ask what the likelihood would be that benefits would improve under a national public plan, when we have existing public plans that are not providing adequate access relative to the private sector in Canada or to other countries' public plans. That's our main concern.

Mr. John Oliver: Do you see a role for yourself in making sure that doesn't happen? Do you see a way to engage with CADTH or whatever the groups are, rather than favouring the status quo, thinking that we'll never be able to change it?

Mr. Brett Skinner: Sure. I think our industry would take the position that it would be a willing partner at the table with any government decision to move forward in this area. Our main concern would be that we would move from a status quo position that would improve access for everybody and not require decreased access for any Canadian.

The Chair: That's it.

Mr. John Oliver: Thank you.

Seven minutes goes too quickly.

The Chair: Ms. Harder.

Ms. Rachael Harder (Lethbridge, CPC): All of my questions are for Innovative Medicines Canada. As I have seven question, I have one question per minute. You can help me pace this out.

My first question is for you, Mr. Monteith. The Canadian Generic Pharmaceutical Association says that the companies you represent are funding research at a historically low level. That is my understanding, yet Canadians are paying the second-highest cost of drugs out of any country in the world. I'm wondering if you can explain this for me today and/or clarify whether or not I understand this correctly.

Mr. Glenn Monteith: First of all, the way in which they measured or made the statement about research and development funding is on a very historical basis, going back to 1986 on the definition of what would be considered research and development costs. The evolution of drug development has changed dramatically. Back in the day, 30 years ago, a lot of that was really related to bricks-and-mortar equipment and technology. Now, it is heavily financed on clinical trials. In Canada, for example, we have over 9,000 clinical trials going on in Canada at any given time. If they are part of a multinational trial and that trial originates outside of Canada, none of those dollars are counted toward research and development in Canada. That grossly understates the spending.

Sorry, what was the second part of your question?

Ms. Rachael Harder: You answered it.

Mr. Glenn Monteith: Okay.

Ms. Rachael Harder: That was exactly it, that if it weren't true, could you help me clarify that? You have done that.

Mr. Glenn Monteith: Oh, yes, and on the statement that Canada has the second-highest prices, the PMPRB shows that this is actually not true. In fact, depending on how you want to measure it, for the comparator eight countries for the PMPRB—this is the government's own agency that watchdogs this—we are number three or number four, depending on what measure you want to use.

Ms. Rachael Harder: Mr. Monteith, I wonder if you can comment on the trends with regard to the cost of bringing new medications into Canada and putting them on the market.

Mr. Glenn Monteith: One of the major developments that have occurred over time—and it is both important and costly—is that the science is getting better. We are getting much better at understanding how diseases work, how illness conditions work, etc. However, that means that the folks whom we would be developing drugs to treat are more complicated and that we have to design our trials in ways that are very different from those in the past. That makes the clinical trials part of the drug discovery journey much more expensive than in the past.

Today, Tufts University in Massachusetts, which generally maintains the biggest database on the cost of R and D for pharmaceuticals, estimates that the average drug coming to market —this is worldwide cost, mind you—cost about $2.6 billion U.S. The vast majority of that is in clinical trials, because of the costs and sophistication of those trials. As we get more targeted in our populations, we have to do a lot more sophisticated trials to show the evidence that they work.

● (1625)

Ms. Rachael Harder: I have another question for you as an organization that represents the supply side of the industry. I am wondering if you can explain for us the different hurdles that are in place right now with regard to getting a product on a public formulary, compared to a private insurance plan, let's say. That is one question.

As well, I would like you to comment on the timelines for clearing those hurdles.

Mr. Glenn Monteith: It is fair to say that the timelines are getting longer, on average. I will quickly go through why.

The first step, prior to getting, or even seeking, public reimbursement—or, for that matter, private reimbursement—is that you have to go through the Health Canada process to get your market authorization to sell. Canada does a pretty good job on that process. Our HTA processes at CADTH, and INESSS in Quebec, are also quite well-established processes. There are a couple of factors, though. Health Canada, on average, tends to be slower to approve a drug than, say, the European Union and the FDA. There are some reasons for that we can talk about later. We also find that our members, on average, tend to file a little later, because we see them moving a little more slowly. You could find, for example, that an American or a European patient may have access to a drug that is available in the world much sooner than one in Canada, just because of the filing times, when they choose to file.

Once it comes through and gets a market authorization, it goes into CADTH or INESSS, depending on whether it is going for reimbursement in Quebec or the rest of Canada. That process runs fairly well. There was a bottleneck at some point in time. That determines, from an HTA or a health technology assessment point of view, the clinical goodness compared to other drug therapies, and establishes cost-effectiveness. A recommendation then goes out to the payers. What is now in place, through the pan-Canadian Pharmaceutical Alliance, is a negotiating table. The challenge of this table is that, when you go to negotiate, they have only so much capacity, and there has to be a minimum number of jurisdictions that agree to participate to make it worthwhile for both parties to do that.

Some of those go quite quickly. Some of those take very long. I will pass it on to Brett here, but I believe that, on average, that process—from time of filing at Health Canada to reimbursement—is now in the order of four years.

Mr. Brett Skinner: I don't have the data in front of me or committed to memory, but the time from the issuance of a notice of compliance that a drug is safe and effective and should be made available for sale in Canada, in other words approved by Health Canada, to final reimbursement in the public plan is 449 days on average.

Mr. Glenn Monteith: Some private plans do some processes, many do not. For example, in many of the union plans, it's written that if there's a notice of compliance, in other words if the drug is available for sale, and there is a price, it usually gets added within about 100 days.

Ms. Rachael Harder: Okay.

The Chair: Your time is almost up.

Ms. Rachael Harder: If Canada did move to a one-buyer system, could you foresee a situation where companies would choose to not offer certain products to Canadians, thereby reducing patients' choice? What would that look like?

Mr. Glenn Monteith: One of the challenges is that we struggle with “pharmacare” as a term. We hear it a lot, but it's sort of seeking a definition. It could mean making having a very all-encompassing program making many products available for coverage, or it could be highly restrictive. If it gets highly restrictive and it's very difficult to make drugs available, I wouldn't say that the drugs wouldn't necessarily get filed to come to Canada. That may happen from time to time, but the speed at which they would choose to file them in Canada might in fact slow down. This means the drug might be available in the world and still take that much longer for Canadians to have access to it.

● (1630)

The Chair: Mr. Davies.

Mr. Don Davies: Ms. Kurl, if my math is there, about 90% strongly support, or moderately support, a universal pharmacare system. Now, in politics, numbers like that make politicians do crazy things. Is it fair to say that this represents overwhelming support by Canadians for a universal pharmacare system?

Ms. Shachi Kurl: Mr. Davies, don't do anything too crazy just yet. Yes, that is an overwhelming amount of support, and it indicates a great deal of buy-in. However—and there are many howevers and caveats to this—we have yet to find a universally agreed upon number in terms of budget and administration and exactly what drugs are covered, and what are not, and how much such a plan might cost.

Mr. Don Davies: I'm going to stop you there.

But conceptually, I take it that the lesson we derive from all this is that Canadians want such a plan.

Ms. Shachi Kurl: Agreed.

Mr. Don Davies: Dr. Dutt, I want to ask you about cost-related non-adherence. We've heard a lot about that. I'm referring to how much it costs our medical system when people can't afford to take their prescription medicine. It's been difficult to get an actual number on that, for obvious reasons. Do you have a number for what that non-adherence costs our system today, or at least an idea of the significance of these costs?

Dr. Monika Dutt: We know that about 6.5% of hospital admissions in Canada are the result of non-adherence, or people not taking their medication. In light of the present over-capacity in hospitals, to decrease that by 6.5% would be significant. In Canada, non-adherence is estimated to cost between $7 billion and $9 billion per year. In the U.S., the costs are $100 to $300 billion in avoidable health costs. That has been costed out, and there is a large cost attributable to people not being able to take their medications.

Mr. Don Davies: What's the source of that information?

Dr. Monika Dutt: I can get that to you. It's all in the submission that was given.

Mr. Don Davies: That would be great.

Some have suggested that moving to a universal drug coverage plan of some public type would invariably result in reduced coverage or less access to innovative medicines. What's your comment on that? If we go to a universal system, does that mean Canadians won't be able to get the drugs they need?

Dr. Monika Dutt: No, I disagree. I think a system could be set up in which the medications that Canadians need most would be accessible through that system. If there were to be exceptions, a process could be put in place for that. The argument that having more access to more medications is better for people's health is not the right way to look at it.

One of the key parts of a pharmacare program would be the evidence-based aspect of it, including the evaluation of a medication's effectiveness and cost and what should be on the formulary, along with options for accessing some of the innovative medications. More medications and faster inclusion in a plan doesn't necessarily mean better health outcomes for people.

Mr. Don Davies: Mr. Romanow, it's a pleasure to have all the witnesses here, but may I tell you, sir, it's a distinct privilege to have you here today. On behalf of our committee, thank you for your service to our country and what you've done.

Mr. Roy Romanow: The honour is mine, I'll tell you that.

Mr. Don Davies: I'm going to ask you the hard question then.

Mr. Roy Romanow: Okay. I have Marchildon to answer the hard ones, and I take the easy ones.

Mr. Don Davies: That's experience.

Canada has unique challenges as a federation. I think you're uniquely positioned to know that, having been right at the table when we were discussing our constitution.

If universal public pharmacare were to be introduced, what do you think some of the difficulties or challenges in implementing a Canada-wide program would be? Do you have any recommendations about how we would approach federal and provincial jurisdictional discussions?

● (1635)

Mr. Roy Romanow: Clearly, I would favour holding discussions as a beginning, because I do believe that with rational men and women getting together for discussion and consideration of the facts —and these are not always absolute answers—compromise can result and allow the best plan to come forward. If I didn't believe in that, I would not have been involved in all of the experiences that I have been. Invariably we live in a federal system, which is a difficult system. Our federal system is a difficult system, and at some stage or another we may well find ourselves at an impasse. If I may take briefly some extra time to give you an example. Sometimes political will, in the best sense of the word—political, small p—simply has to be used.

I had the pleasure a few years ago of talking about health care at Saint FX University in the Allan J. MacEachen Lecture Series, and Allan J. was there. He was seated to my left. The president, Sean Riley, said, “Allan J. wants to say something after you finish your address”. You can imagine my trepidation at that. He described the political leadership in the following context, after describing the fact that the federal cabinet was truncated on the debates, numbers, and outcomes, and divided for a whole number of reasons and couldn't come to a conclusion about whether or not medicare should include pharmacare, as recommended by Emmett Hall back in 1964-65, and by me in 2002. MacEachen's answer was—and it'll be brief, Mr. Chairman, with your consent—that, well, it would be unnatural and unexpected for the provinces to remain silent. They took advantage of the divisions within cabinet by renewing their opposition to medicare—strike “medicare”, and put the word “pharmacare” in there. Pearson felt the full brunt of the provincial premiers' discontent on the subject of medicare. Eight provincial premiers confronted him with complaints that the federal government had no right to force the pace of medicare, and so on. It was in this atmosphere of provincial opposition and division within the cabinet that Mr. Pearson finally decided—according to MacEachen—that he would go ahead with the medicare program. Without this decisive action at this time, and because he finally made the decision, we may have lost the whole issue.

My point in retelling this is that there will be scientific debate about how the costs are to be judged or evaluated, including their distribution, and what that will mean for the system and outcomes. We've heard some of those comments today. If we have any model to build on, then it is this one that I give you. It took federal leadership by a federal government in a minority situation to implement medicare. I don't think anybody around this committee table would say that was a wrong decision. I could be wrong, but I doubt it. There were many doubts about it. There are many doubts about pharmacare, and perhaps even some competing figures in that regard. However, on the principle and the philosophy of it, since it naturally follows from medicare, and since the drug costs in our current system are the next highest to America's—all the others beat us, the European countries—I think there's a model there for us to follow.

Sorry to be long-winded, but I think that is exactly what I would say should be done, as a former practitioner of the dark arts of federalism, because of the evidence internationally and nationally

Mr. Don Davies: Thank you.

The Chair: Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): My first question is for Mr. Romanow. It's an honour to have you here, sir, after your remarkable work done in your public life.

Since the publication of your report "The Future of Health Care in Canada" in 2002, what major changes have been made regarding access to medication and access to health care in remote areas? What do you think needs to changed first when it comes to access to prescription medications?

Mr. Roy Romanow: With the permission of the committee, Mr. Chairman, we've agreed to divide this, because I rely so much on my chief executive officer, Dr. Marchildon.

Dr. Gregory Marchildon: There are really two questions here. The first is on rural and remote coverage, and I'll come back on your second question to ask you for clarification, but really, nothing much has changed on the rural and remote.

Of course, we're talking mainly about coverage here, as opposed to service delivery, and that deals with the area of primary care, the way in which prescriptions are provided, and the way in which follow-up is done. We can see from our studies on primary care that there is still the same fragmentation—the same difficulties—that we faced 15 years ago at the time of the Romanow report. There's really been no change there.

Can you clarify your second question a bit?

● (1640)

Ms. Sonia Sidhu: What do you think needs to be changed first when it comes to access to prescription medications?

Dr. Gregory Marchildon: The first thing is that in a multi-payer, fragmented system of both public and private payers, you have very different rules of access everywhere. They're by jurisdiction and they're by individual, depending on where that individual sits. Is that person on social assistance? What is their income, etc.? It depends on whether they have the kind of job that will continue to have an employment-based plan that will be fairly rich.

What can you do about access? Generally, in terms of this mixed picture, you can try to improve the equity of access so that there are not entire regions of the country, such as the Atlantic region, that really suffer in terms of access because they have very thin provincial programs and, on top of that, there are many fewer private plans. In a sense, you have a whole region of the country at a disadvantage.

That would be the first step. How do you address that?

It's very hard to address that issue through a very incremental approach when you have this kind of fragmented system. That's why you have had a lot of evidence before you over the last few weeks on the benefits of national pharmacare: because that's the only way you can really address the issue of equity of access in a really fundamental way.

Ms. Sonia Sidhu: I have another question related to that. Since your report, have you seen any improvements regarding access to medication?

Mr. Roy Romanow: Well, I haven't seen very much. There have been some individual plans. Even before my report, in Saskatchewan there was the beginning of a provincial pharmacare plan, but that changed as political circumstances changed. I think the evidence is quite clear in looking at some of the material filed before your committee. I'm overstating it, but to make the point, I don't think it has improved at all, and I think there is an urgent need.

I'll finish off by saying that if you look at the OECD numbers, it's either that the army is out of step or that Johnny is out of step. Somebody is out of step in this situation, both with respect to costs and with respect to health outcomes and coverage. I have seen very little evidence to refute that of the OECD and what we have in our report—which I think requires some updating—so to me, the answer is that this is, as Dr. Marchildon has pointed out, the number one essential reform that should be implemented. It may take federal leadership à la Mr. Pearson, the great prime minister that he was. It may take this committee. But that's what we need.

Ms. Sonia Sidhu: Thank you.

My next question is for Shachi Kurl.

Do you think there are intersectional challenges that we can specifically plan for where people face multiple barriers to prescription drug access?

Ms. Shachi Kurl: With the permission of the chair, could I ask you to clarify the question a bit for me?

Ms. Sonia Sidhu: Do you think there are intersectional challenges that we can specifically plan for when people face multiple barriers to prescription drug access?

Ms. Shachi Kurl: What I can tell you is that intersections certainly meet around coverage. Coverage is a key driver to worry and stress when it comes to Canadians and their pharmacare costs, and again to their income levels and the complexities of their own health.

We know, for example, that while seniors may have more complex care needs around their prescription drugs, they tend to have some of the greatest access to care, especially in some provinces more than others. That is versus younger, lower-income Canadians who are struggling a little more, but on the other hand may be dealing with simply better health outcomes at that stage in their life because they are younger and haven't had the wear and tear of life on them.

I think what Canadians will want to see in order to provide a more engaged opinion on this particular issue is more detail and more agreed-to detail around what such a plan might end up looking like. Again, that can be at a very high level or a very exploratory level. Without more information for them to digest, it remains at this point more of a value statement for most. For those who are suffering the most, again it is a cry or a call to action, but one that certainly bears deeper inquiry on our part, with the assistance of health policy experts who can prepare and provide agreed-upon information on what such a plan might look like.

I would be happy to come back to this committee and report on that when we have that information and can take deeper measurement on it.

● (1645)

The Chair: Sorry, the time is up. That completes our first round.

We'll move to the second round of five-minute questions.

Dr. Carrie, you're up.

Mr. Colin Carrie (Oshawa, CPC): I would like to ask Mr. Monteith a question.

You mentioned that we should be focusing on the uninsured and the underinsured. We hear a lot of numbers thrown around. Even at the committee today, I think Mr. Romanow said that 50% of Canadians don't have any coverage. I think Mr. Oliver said 60% of Canadians do have some type of coverage. We've heard other witnesses say that 70% of Canadians have coverage.

I am wondering what percentage of Canadians fall into the category of uninsured and underinsured in your opinion?

Mr. Glenn Monteith: It's a great question.

Mr. Colin Carrie: It sure is.

Mr. Glenn Monteith: There was a study done in 1999, I believe, that identified that approximately 20% of Canadians were uninsured or underinsured, and it really hasn't been refreshed— although that number has come to have a life of its own.

I'll use Alberta as an example, which is a province I know very well, having been the former drug plan manager there years ago. One of the challenges is that they technically have a plan that any Albertan can join. It has a premium, and any Albertan can join. If you were to take the survey, about 25% of Albertans would say they have no drug coverage—yet they actually have access to that coverage. Mr. Webber would know it very well, for example.

Would you say they're uninsured? Do they have access or not? This is where it gets into the area.... In Ontario, where they have the Trillium drug program, you may not have a private coverage plan, but you may be fine. At a certain percentage of your income—it's around 4%, which you absorb in drug costs—you can make an application and the Province of Ontario would cover that. So, are you uninsured or underinsured? I think this is part of the definitional challenges that occur.

I think the secondary and related question is, what drugs are you covered for or not covered for? That's highly variable from jurisdiction to jurisdiction as well. You may find in one province that you could apply because that drug is an eligible benefit in that circumstance, and in another province it might not be. It's a very, very difficult number to go....

The number of people who have access to some form of assisted coverage on a catastrophic basis is actually very high in Canada. However, that doesn't mean—taking in the survey data—it's easy for many Canadians to afford to get to that catastrophic coverage.

I would say, and Brett has done some work on this as well, that it's certainly lower than the 20%, but the exact number is hard to put a figure on.

Mr. Colin Carrie: Yes, it is.

When you ask some of these questions, it kind of depends on how you ask the question, because there can be other variables involved. I think Ms. Kurl would say that it's difficult to take all of those variables into account.

There are a couple of things you said that I want to see if you could clarify. You said that gaps needed to be addressed and then you mentioned public assistance for those in need. Those were recommendations of yours. I think if you look at the value statements that Ms. Kurl talked about, we'd like to see Canadians covered. We don't want to see any Canadian losing their home because of improper coverage.

How would you suggest we address these gaps, and how would you define and address providing public assistance for those in need?

● (1650)

Mr. Glenn Monteith: Gaps can come in two forms. One can be a financial gap that you have to bridge. Ontario Trillium is an example of where you have to absorb a certain amount of out-of-pocket expenditure of your family income before you have coverage. The second gap, going back to my previous answer, is which drugs might be eligible for that gap. When the provinces generally offer something, they relate it to their own benefit plan, so that can be variable. Some consistency across that would help solve that type of gap issue.

With respect to the financial gap, it really is to understand.... For example, Quebec uses a premium system for the members of public plans, whereas Saskatchewan and British Columbia use an income-deductible system. There will always be some people, when you pick a line of that sort, who will struggle for whatever reason—or in a particular year, their income may have gone up and down. In order to address that, if you talk to most folks who are familiar with that space, there are ways to adjust for that, using their health card back to the pharmacy, etc., but it's a much more active management than the traditional drug plan design is currently functioning under.

Mr. Colin Carrie: Yes: it's how you define need. Ms. Kurl put up a slide showing that 16% of people making over $100,000 self-report or at least say that they are having problems funding these things. It just seems to be very difficult to try to figure out all these variables.

Ms. Kurl, I know you may have to leave, but if you have time now, perhaps you could talk about the sample you chose of the 1,556 Canadian adults from the Angus Reid Forum. Who are these people? Do they represent average, everyday Canadians, or are they a special club? Who are these guys you talk to? What are their demographics?

Ms. Shachi Kurl: Briefing people on the ins and outs of survey methodology, and particularly online methodology, can be about a 40-minute process, but I'll give you the Coles Notes version.

Mr. Colin Carrie: You have four seconds.

Voices: Oh, oh!

Ms. Shachi Kurl: I have a little longer than that.

They are drawn from an online panel of approximately 130,000 to 140,000 Canadians. These are people who, yes, self-select into the panel, but that doesn't necessarily mean that they will all be asked all the same questions or be invited to participate in every survey. There is an element of randomness to the way selection is done.

We are able to control to ensure that the sample is drawn from and balanced to census data. On income levels, on age, on gender, on region, on first language, on education levels, and all the main basically census demographics we are able to balance the sample to ensure that the people we're speaking to and those who are responding to us do represent and reflect the Canadian population as a whole. When we talk to people who are dealing with income levels lower than $50,000 or higher than $100,000, they are reflective of the actual totals within the population.

Mr. Colin Carrie: Did you actually ask them if they knew if they had coverage or not? I think we've heard research that many individuals interviewed will say they have problems getting coverage, but they don't even realize they have coverage. As Mr. Monteith was saying, with Trillium and things along these lines they have access.

Do you take that variable into account when you're asking your questions?

Ms. Shachi Kurl: That's one of the first questions we ask: are you covered and do you have access? Again, we're able to tell you that coverage, the level of coverage, is a big driver of whether or not people are struggling with their costs and dealing with barriers or not. Obviously, those who have no coverage or the least amount of coverage have the highest propensity to report that, yes, they are struggling.

To your point around whether you are covered or even know if you're covered, again, that requires a deeper dive into this subject that would certainly benefit from further investigation. We can only ask questions: Are you covered? Are you fully covered? Are you partially covered? Are you not covered at all?

Whether or not people realize they have access to it but haven't themselves gone out and gotten it, that represents a gap. I would suggest that where coverage exists and people are not taking up that coverage is something for those providers to speak to. We can only speak to what people think they have.

● (1655)

Mr. Colin Carrie: I'm covered.

Voices: Oh, oh!

The Chair: You're covered.

The Chair: At this point, I understand you have to catch a plane, Ms. Kurl, so thank you very much for your input. We appreciate it very much.

Ms. Shachi Kurl: Thank you very much to the committee for the opportunity.

The Chair: And have a good flight.

And now we go to Dr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Very quickly, I have more a statement to make to Dr. Dutt.

I'm an emergency physician. I did that for 20 years, and what you said about emergency physicians dealing with patients who can't afford their medications is true. I spent 20 years encountering that. You nailed the point as to what a problem it is in that environment.

It's actually one of the things that pushed me into this line of work.

Dr. Monika Dutt: Right.

Mr. Doug Eyolfson: My first question was asked by Ms. Harder. I was wondering the same thing as she, and I didn't quite understand your answer to it. In your previous incarnation as Canada's Research-Based Pharmaceutical Companies, your commitment was to 10% of profit to R and D, and it's now only 4%. Please explain again why it's now 4% when it was 10% before.

Mr. Glenn Monteith: The change from the 10% commitment in 1986—and we had to dig up the agreement letter with the federal government on it—

Mr. Doug Eyolfson: Okay.

Mr. Glenn Monteith: —was defined in a specific way so that the terms and conditions and the business practices would remain substantially the same. What has occurred over time is that drug development has evolved dramatically. It's much more international than it used to be and much more focused on international clinical trials.

The PMPRB still records R and D spending based on the same 1986 premise, but what has happened is that the tools for investment, infrastructure, etc., that were going forward have been reduced over the course of time. What has gone up significantly are investments in international clinical trials and, as I mentioned in my previous answer, we have over 9,000 trials going at any given time. If those trials are sourced out of Canada as the original research, even though Canadian sites are involved, none of the money spent, literally the hundreds of millions of dollars spent on that, gets counted or credited to our members for R and D that actually is occurring in Canada.

Mr. Doug Eyolfson: Yes.

Mr. Glenn Monteith: So it's an understatement of what's going on, really based on what has changed in drug development over time.

Mr. Doug Eyolfson: Sorry to cut you off, I have limited time here. So what you're saying is that this is money you are investing but isn't being counted.

Mr. Glenn Monteith: Correct, and it's significant.

Mr. Doug Eyolfson: All right.

There's been a lot of criticism, Mr. Skinner, of some of your writings, some done with the Canadian Health Policy Institute, and from other witnesses we've had, that really disputes the Morgan study. Now we've talked about how—and Dr. Dutt made references to it as well—this was peer reviewed research, quite rigorously studied and evaluated. What was the peer review process of the data that generated the numbers in what you've put forward?

Mr. Brett Skinner: I'm here to answer questions on behalf of the Innovative Medicines Canada organization—

Mr. Doug Eyolfson: Okay.

Mr. Brett Skinner: —not on behalf of my independent research. But I'm happy to address the question anyway.

The study was done by me and three colleagues through the think tank that I'm the CEO and founder of, the Canadian Health Policy Institute. All of the data sources are explicitly referenced in the study, and all the methodology is explicitly laid out in the study. We have an internal and an external review process, and then we publish our work and put it in the public domain ultimately for scrutiny by other academics and people in the policy community.

Mr. Doug Eyolfson: Okay.

Mr. Brett Skinner: We took a somewhat different perspective from the Morgan et al paper that was published in the CMAJ. We did not see that there would be, in fact, savings for taxpayers under the scenario of a national universal government-run monopoly approach to pharmacare. We saw that there would be substantial costs to absorbing current private sector expenditures on pharmaceutical-related costs, and that if those were absorbed under a federal plan, it would mean that $25 billion would added to the federal budget. If it were absorbed simply—

Mr. Doug Eyolfson: Okay, thank you. You answered that question, thank you.

The last question is for Mr. Monteith and it's on public versus private schemes. In public insurance schemes, what proportion of patients are turned down for coverage for pre-existing conditions? Do you know that?

● (1700)

Mr. Glenn Monteith: To my knowledge, none.

Mr. Doug Eyolfson: Thank you.

The Chair: Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): I'd like to ask a few questions of our celebrity panellist here, Mr. Romanow.

Mr. Roy Romanow: I thought you were referring to Marchildon.

Mr. Len Webber: No, I was referring to you. It's a pleasure to have you all here.

Mr. Roy Romanow: I take the easy questions; he takes the hard ones.

Mr. Len Webber: We had Dr. Abby Hoffman here a few weeks ago, and she was of celebrity status. I still rank her above you, Mr. Romanow, but you're a close second.

Mr. Roy Romanow: She certainly is. She can run; I can't.

Mr. Len Webber: You made a couple of comments. You said that the feds must take a strong leadership role with regard to looking into pharmacare and that Canadians want a strong national role. That was obvious from the Angus Reid poll as well.

You've experienced this in your days as the premier, and know that there are health care silos throughout the country. Trying to get provinces and territories to participate....

Dr. Marchildon, you mentioned that perhaps if provinces do opt out of a national pharmacare system, there should should be no financial contributions going to these provinces. I wasn't quite sure. That question is for Dr. Marchildon.

With regard to you, Mr. Romanow, how do you break down those silos? Obviously, we haven't been able to do that in the 14 years since your report. How do you get provinces on board?

Mr. Roy Romanow: First, I'd like to think that they didn't do it in the 14 years since my report because a pharmacare plan has not been initiated.

Secondly, I will make the point that it will not be easily implemented. There's no easy way in a federal system such as ours, in my experience. I do think that it is a divided jurisdiction between the federal and provincial governments. Ideally you'd like to have a co-operative set of negotiations and agreed-upon facts in public policy. What propels that kind of mechanism is a common agreement on what the values of Canadians are—and I'll spare you the talk about that.

However, what happens if there is an impasse?

The reason I cited Mr. Pearson is that at some stage or another, there simply has to be federal leadership. Then the question is whether or not it will stand if it is not effective. I think that any coercive policy federally is not going to stand if it doesn't, first, do the job, and second, resonate with the values of Canadians.

Medicare in Saskatchewan was introduced all by itself by little old Saskatchewan, in 1962. I was there as a young student on the side of the medicare battle, so I'm a little bit biased.

At a national level, for it to be taken as it was after the Hall commission report appointed by John Diefenbaker.... We're talking about a pan-political group of people based on science. There was opposition. There is always opposition. I suspect there will be opposition on this as well. I think that at this stage in the game, the federal government's obligation, and your obligation—with the greatest respect to this outstanding committee—is to weigh the facts, take a look at the values, and make some decisions as to what you recommend. If the recommendation is that we want a national pharmacare plan, the federal government's spending power, the rationalization, the cost-savings that will flow, and most importantly, the benefits to the Canadian public will lead everybody to come into it, as it was with medicare initially.

I don't think there's any way around that.

Mr. Len Webber: When you were doing this study back in 2002, did you look at other countries?

Mr. Roy Romanow: Yes, we did.

Mr. Len Webber: What other countries would you recommend we look at when it comes to our study here today as a good way to move forward with what we're doing?

Mr. Roy Romanow: First of all, the study is 14 years old, I'm sad to say. There has really been an explosion of pharmaceuticals since that time. I think it's safe to say—I'm not a medical person—that some of those work and some don't work, and so one has to be a little bit careful. In the years since that time, I would argue that the numbers—which are set out in one of the documents I presented to you as a model of what to follow—indicate in effect that 13 or 14 countries have followed a universal pharmacare program, which means that it has to have worked.

Why do I say that? Because it is accepted by the governments and by the public both on a cost basis and within a values structure.

The two outliers, strangely in my judgment of history, are Canada and the United States. What are the grounds for that? There don't seem to be sufficient grounds, at least there are none that I've seen. I've tried to keep up to date on the studies. I'm not as current on them as I was. There just seems to be a reluctance in terms of either federal-provincial co-operation or federal leadership.

I think the evidence, with some little discrepancies here and there, which are important to consider, overwhelmingly indicates that a single pharmacare plan complements our program. To me, it fits with our values, and it fits with the evidence that is there. Fourteen years ago, we didn't have nearly the numbers we have today.

● (1705)

The Chair: Your time is up.

Mr. Roy Romanow: I'm not answering your question quite fully, and I apologize for that.

Mr. Len Webber: The chair cut you off, so you weren't able to anyway.

The Chair: It is really a good question. If you were to pick a country or two or three, which ones would you say best reflect a successful system that delivers a viable process, a viable pharmacare program?

Mr. Roy Romanow: I'm using here some of the evidence of Dr. Marc-André Gagnon from Carleton University. I think the chart he has, which coincides with what we've been doing from time to time, indicates that the countries that seem to be the ones we would model are the U.K., Australia, and New Zealand, perhaps down the pike with regard to the arguments that have been set out in this particular brief.

To be honest with you, this is not my area. One would have to really plough into this in some detail to make sure that the broad statement I am making would coincide with the facts and outcomes.

The Chair: Thanks very much.

Mr. John Oliver: Can I raise a quick point of order?

The Chair: Sure.

Mr. John Oliver: Both Mr. Romanow and Dr. Dutt have referenced submissions to the committee. Just through you to the clerk, we didn't receive their submissions.

The Chair: They were just in English. They can't be presented unless they are in both languages.

Mr. John Oliver: So we won't have access to them? Dr. Dutt had some very significant points. For the first time, we had some estimate of the ongoing costs to the system of people who had not taken their medicines.

The Chair: They are being translated now, and we will have them.

Mr. John Oliver: Is there any way we could expedite these in the future so we could have them prior to committee meetings?

The Chair: I'm learning as we go. If they are in one language, we need unanimous consent to distribute them. In the future if we do have them, we'll seek unanimous consent at the beginning, because I miss them too.

Mr. John Oliver: Will these be made available to us once they are translated?

The Chair: Yes, they will.

Mr. Kang.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): My questions are for Dr. Dutt. You organize the professionals who work on the ground every day in the Canadian health care system. My first question is related to pharmacare. What are some of the myths that your organization has busted with regard to benefits from private insurance for medical necessities, such as hospitals and physician services?

Dr. Monika Dutt: The myths specific to pharmacare or to medicare in general?

Mr. Darshan Singh Kang: Relative to pharmacare.

Dr. Monika Dutt: Relative to pharmacare, I guess a myth that's come out through the discussion today is that our current plans are doing a good job.

First, it is clear that private insurance plans aren't covering what people need, that they aren't covering enough, and we don't get good value for our money from them. Second is the the myth that having these multitudes of public plans covers the people who should be covered. It's clear those plans are not covering the people who may need coverage the most, and they're not covering people in a comprehensive way.

The only way to address that is to have a comprehensive program that does cover everyone. That would benefit all Canadians, because as Angus Reid has shown, it isn't just low-income people who need some drug coverage, but that everyone who would benefit. Similar to medicare, it's a system that we all pay into, so that we can use it when we need to use it.

That's probably the biggest myth, that our system right now is working. The second myth is about cost, which has also been debated and discussed here today, that it's too costly to implement. It has been shown that it's too costly not to implement and that the cost savings would be significant.

● (1710)

Mr. Darshan Singh Kang: That was my next question, the cost. How significant will the cost savings be? Do you have a number?

Dr. Monika Dutt: We do use the CMAJ study as one of our main peer reviewed evidence-based studies showing the cost savings. It was published in the *Canadian Medical Association Journal*. It was peer reviewed. It was done by Steve Morgan, an economist at UBC, along with several other health policy experts.

It showed that there would be significant savings both to the private plans as well the public plans. I don't have the numbers. Overall, there would be a saving of $1 billion to government when you weigh out what the cost of the plan would be and who would be saving money. There would be savings both by government as well as private employers and private companies. Both of those areas would save money.

There would also be a cost to the program. If you are saving $7 billion overall, there would still be a cost of implementation. The overall savings would be about $1 billion in the most probable scenario.

Mr. Darshan Singh Kang: What kind of coverage would we be looking at under pharmacare? This is maybe a hypothetical question, but what will be covered?

When somebody gets Blue Cross, they have basic coverage of 70% and the rest they pay from their own pocket. When we have pharmacare, what kind of coverage do you think we should have in place?

Dr. Monika Dutt: Our organization has endorsed the Pharmacare 2020 plan. If you search Pharmacare 2020, you'll find that it's by some of the same people who put together the study that was in the *Canadian Medical Association Journal*. As has been said today, the actual implementation is a complicated process, but what that means is that conversations need to happen on how that would actually look in practice.

Pharmacare 2020 outlined a number of principles that need to be kept in mind when putting together this national pharmacare plan. That's an excellent starting point to go from. It looks at things like coverage of prescription medications at little or no direct cost to patients through pharmacare, because we know that having any kind of co-payment raises a barrier to people being able to access the medications.

I won't go over the whole list, but it does give some basic items that should be included in a national pharmacare program that you can then use to start that conversation of what a national plan would look like, because there are federal-provincial jurisdictions that need to be worked through.

Mr. Darshan Singh Kang: My concern is that when we come out with pharmacare, many people who are on medications may be left out of pharmacare coverage. We have to develop this so that we're going to cover everybody. That's my concern.

Dr. Monika Dutt: Your question is, how will we cover everybody?

Mr. Darshan Singh Kang: Yes. Say in Alberta, an existing condition isn't covered. How will we handle coverage for those people under pharmacare?

Dr. Monika Dutt: I'm not sure I understand the question.

Mr. Darshan Singh Kang: Say I have an existing condition and we all go over to pharmacare, will there be some coverage for people who have existing conditions? I'm keeping the costs in mind.

● (1715)

Dr. Monika Dutt: What needs to happen is that a national formulary needs to be developed, and that is definitely going to include the medications that Canadians need most. Then there needs to be a process by which other medications can be included or applied for. We know that the major lack in our health care system now is that it's not designed to deal with someone who has a chronic condition. Initially when medicare was created, people were dealing with more acute conditions. That's another reason pharmacare is so important, because more and more people are dealing with chronic conditions that require medication. Yet we don't have the medication coverage program in place to support those changes in health care needs across the country.

The Chair: Your time is up. Thanks very much.

The Angus Reid survey said that 26% of Atlantic Canadians have had an inherent problem maintaining their pharmaceuticals or prescriptions. You're in Sydney, Nova Scotia.

Dr. Monika Dutt: I am, yes.

The Chair: Does that sound right to you, that 26% of people aren't able to buy the prescriptions they are prescribed?

Dr. Monika Dutt: It sounds right. I don't have those numbers in front of me, but looking at the levels of poverty in our province and at what Mr. Romanow spoke to—or maybe it was Greg Marchildon—the fact is that Atlantic Canada is less able than other provinces to supply both public and private plans. That sounds reasonable to me, and it's what I see in my practice.

The Chair: Mr. Davies.

Mr. Don Davies: Dr. Marchildon, as Mr. Romanow said, Canada is the only country in the world that has a universal medicare system that does not include a universal pharmacare system of some type.

We're also heard from witnesses that we should be looking at a made-in-Canada solution, but certain concepts have emerged that, it has been suggested, would allow us both to save money and to afford universal coverage. Those include having a single formulary, perhaps a national one; having an efficient, evidence-based drug approval process to get on that formulary; having a streamlined, perhaps single, administration, perhaps a public one; bulk buying; perhaps giving certain manufacturers exclusive access to the Canadian market, as New Zealand does, for a period of time, which allows lowering of costs, and we've heard about the cost savings related to non-adherence.

You have proposed one such uniquely Canadian version, and that is to have a federally administered system. I'm just wondering if I could give you a minute or so to comment on that and to make the case for it.

Dr. Gregory Marchildon: I put that forward as an option because it's not generally thought of as an option in this country because of our history. I wanted to fully explore the advantages and disadvantages of that option, and to deal with some of the difficulties we've had with block funding over the last 30, 40 years. Block funding has done certain things well, but other things it has not done well, and I feel this option addresses those issues in a much more effective way.

It is very difficult to maintain a national formulary if you have 13 provincial and territorial single-payer plans. Even assuming they're single payers, it's going to be very difficult to have a single, national, pan-Canadian formulary that they will agree to at all times. Therefore, that allows for a lot of negotiating around the edges, lobbying etc. Interest groups can do a great deal to take advantage of that situation. Discipline can break down, and that's why I say that the federal option is one that will deliver a greater level of discipline. The potential of that discipline has to be exercised.

Mr. Don Davies: I haven't read what you may have submitted on that, but if you haven't, I would invite you to submit something on that to the committee. It takes more than a minute or two to explain the broad—

Dr. Gregory Marchildon: I'd be happy to submit something on both option one and option two if the committee desires.

Mr. Don Davies: On the other hand, Mr. Romanow, some witnesses and even some members of this committee have asserted that government is not capable of managing a streamlined, publicly administered system in a cost-effective manner, particularly with the private sector involved. As a former Premier of Saskatchewan, what's your comment on that?

● (1720)

Mr. Roy Romanow: This may sound a little too glib, but in 1962 in Saskatchewan when there was a province-wide doctors strike, the same argument was being advanced that some form of publicly funded system whereby the plan was delivered through doctors—basically that was the mechanism—wouldn't work, and of course it did.

When you say that it can't be done.... Not say, but when there's a hint that somehow there isn't a perfect consistency to it, I think that's probably true. Illness, treatment of illness, and drugs do vary a little bit in terms of what they deal with or don't deal with. It won't be perfect delivery of health care, and here I'd defer to the doctors who are in the room.

However, what we're trying to do here is to develop a social program, socio-economic program, health program that on balance acquires the drugs that scientists dealing with the most serious of illnesses tell us are generally effective. The doctors, knowing of this list, apply the medicines on the plan that are effective for their particular patients, and nowhere in the system is money a barrier to delivery of that program.

Will it be a completely perfect circle with no deviations and the like? Probably not, but it will certainly be one where we will remove this fast-rising component of health care costs, namely pharma costs, from the delivery of health care on the value that everybody, regardless of whether you are rich or poor or what your gender or background is, is entitled to the best possible care.

Mr. Don Davies: So is that a single-payer, first-dollar system like an extension of our medicare system into pharmacare, as Emmett Hall and Douglas envisioned?

Mr. Roy Romanow: I would go that way, subject to what further evidence needs to be looked at. My report, as I say, is 14 years old, and at one stage the report actually talked about a possible deductible in the first $1,100.... I forget what the number was. Greg, was it $1,100 or something?

Dr. Gregory Marchildon: For the catastrophic coverage.

Mr. Roy Romanow: Yes, for the catastrophic. We decided to move this in a very tiny step. We'd do catastrophic care and then we would have a bit of a deductible: the first $1,400 or $1,500 for that would be your responsibility, and then over that, if it were really catastrophic care required, you'd be covered. It wasn't a pure pharmacare plan as I always envisioned it, but I thought that if we could get the foot in the door through the catastrophic coverage.... But more importantly, at the time 14 years ago, that was basically how we were evolving and made sense.

I think we're at the stage today where we can, through science, determine what the drug formulary should be, pay for it through the contributions of all of society based on our ability to pay, as taxes are, and determined by the doctors, the professionals in concert with their patients.

I mean, how many different kinds of Lipitors do we need? There may be some differences, and I refer to the doctors who are here, but I think the stats are quite clear. Maybe it's true that Johnny out of step with the army is the correct person this time around, but I don't think so when it comes to the army dealing with the pharmacare plan.

Mr. Don Davies: Thank you.

The Chair: That completes our day.

I want to thank the presenters very much.

I think you'd all be interested to know that as a committee we considered 17 items for study when we came together in our first meetings. The decisions were made the committee members on all sides, and we decided that pharmacare was one we'd like to have a look at and analyze. I think it's a credit to the members of this committee on all sides for focusing on this. Certainly it's of great interest to a lot of people.

Again, I want to thank you all very much for your participation. We've learned a lot.

Thank you, Dr. Dutt, for being here on screen and taking our picture.

Dr. Monika Dutt: Any time.

Thank you.

The Chair: Okay.

Mr. Roy Romanow: Congratulations to the committee. You're right on the number one job or task.

The Chair: Thank you.

Mr. Roy Romanow: Good luck to you.

The Chair: Thank you.

This meeting is adjourned.