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Chair

Mr. Bill Casey

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● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): It being 3:30, I call the meeting to order.

I'd like to welcome our four distinguished guests from four distinguished organizations. I'm sure they'll provide us with a lot of information to help us with our study on a national pharmacare program.

The rules are that you each have 10 minutes to introduce yourselves and your organization and to state your thoughts on this matter. Then we will have questions for you. You can start in whatever order you want.

Mr. Kang.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Mr. Chair, I have a suggestion. We can get answers for our questions, but the depth and breadth of all the knowledge might be lost, so could we get written submissions so the witnesses could elaborate a little more on the questions we are asking? That would be helpful.

The Chair: All right. As a follow-up?

Mr. Darshan Singh Kang: Yes.

The Chair: Okay.

The member has asked for written submissions to follow up on your presentations, if you could.

Mr. Darshan Singh Kang: On the questions we are asking, so you could—

The Chair: We're getting a lot of information, and a lot of it is new to some of us.

Mr. Darshan Singh Kang: Thank you, Mr. Chair.

The Chair: Okay. Go ahead.

Dr. Steven Morgan (Professor, School of Population and Public Health, University of British Columbia, As an Individual):

Good afternoon. Thank you for having me here today.

By way of introduction, I am Steve Morgan. I am a tenured full professor at the University of British Columbia. Over the past 20 years, I have published 105 peer-reviewed pharmaceutical policy research studies and 43 reports on pharmaceutical policy for governments, research centres, and think tanks in Canada and abroad.

My remarks today draw on that research and on the years of research and consultations that went into the production of the report "Pharmacare 2020: The Future of Drug Coverage in Canada", which was published last summer. That report provides a clear, principled, and evidence-based vision of what pharmacare should be for Canada.

Specifically, it recommends that federal, provincial, and territorial governments work together to implement a universal public pharmacare program that has a predefined and transparent budget with which prescription drugs of proven value for money, from a public health care system perspective, are made available to all Canadians at little or no direct cost to patients.

The "Pharmacare 2020" recommendations have been reviewed and endorsed by 281 of Canada's leading university-affiliated experts in health care policy and clinical practice, including 12 members of the Order of Canada. I say this to assure the members of this committee that those recommendations are rigorous, credible, and widely respected by disinterested experts from across Canada.

The first point I'd like to make in my remarks today is that such a model of pharmacare is an essential yet missing component of Canada's universal health care system.

The United Nations and the World Health Organization have declared that health is a fundamental right and, as a consequence, that all governments are responsible to ensure their citizens have access to necessary health care, including medically necessary prescription drugs. All member states of the United Nations, including Canada, have effectively ratified several declarations to that effect over the past 30 years.

Consistent with those recommendations, nearly every developed country has achieved universal health coverage, and every developed country with such coverage also provides universal coverage for prescription drugs, all such countries with the exception of Canada, that is.

Canadian medicare, our public system that provides universal equitable access to medically necessary hospital and physician services, effectively ends as soon as a patient is handed a prescription to fill. From there, the drug coverage in Canada is an uncoordinated and incomplete patchwork of private and public drug plans. Approximately 10% of Canadians have no drug coverage at all. A further 11% have ineffective drug coverage involving high deductibles and co-insurance that imposes ongoing financial burdens and creates known barriers to accessing necessary medicines.

A 2015 survey by the Angus Reid Institute found that more than one in five Canadians report that they or members of their households have not taken medicines as prescribed because of costs. Almost one-third of working-age Canadians report such barriers for themselves and for their family members.

This was not supposed to be the case. On clinical, ethical, and economic grounds, comprehensive public drug coverage has been recommended by national commissions on the health care system in Canada dating as far back as the 1960s. Twenty years ago, the National Forum on Health recommended that Canada establish a universal public pharmacare system just like medicare.

Government did not act on this recommendation. At a 1998 national conference on pharmacare, the then health minister, Allan Rock, summarized his government's thinking by saying:

> In an ideal world, were the slate clean and money not a factor, few would doubt that a first dollar publicly-funded, single payer...system would be the best outcome. It would be the least expensive to society as a whole. And it would be the most fair. It would also follow through on the original recommendation of Emmett Hall's 1964 Commission on Health Care: namely, that the national plan be expanded, over time, to include, among other things, prescription drugs. But, we do not, of course, live in an ideal world, with that clean slate and unlimited money.

Thus, despite the government's acknowledgement that a public pharmacare system would be better, fairer, and less costly overall, Canadians were told that a private-public mix of insurance would have to suffice. Things did not get better. Just five years later, the 2002 Romanow commission called once again for pharmacare.

● (1535)

Romanow specifically recommended that the federal, provincial, and territorial governments begin work immediately to specifically bring carefully selected medicines into Canada's universal first-dollar public health care system. But once again, policy-makers argued that government couldn't or shouldn't act on those recommendations. Over the years that followed, we were told that the private and public mix of drug plans would be fine, because governments would offer catastrophic coverage for all Canadians. Yet, contrary to those assurances, access barriers have remained and drug costs have increased substantially, despite having catastrophic coverage in almost all Canadian provinces.

Our lack of action on comprehensive public pharmacare is unacceptable and, to be perfectly clear, Canadians are literally dying as a result. A 2012 study by researchers at the University of Toronto estimated that in Ontario alone, over 700 diabetic patients under the age of 65 died prematurely each year between 2002 and 2008 because of inequitable access to essential prescription drugs. If those numbers are correct, that is like a plane full of Canadians crashing every year, perhaps every month, while governments refuse to take action because of concerns about costs and politics.

This brings me to my second message today. Universal public pharmacare is the economically responsible thing to do on behalf of Canadians. The existing private-public mix of pharmaceutical insurance in Canada fails because it is neither universal nor integrated with the rest of our public health care system.

No country with a universal public health care system finances its system of universal drug coverage through a separate private insurance system. The reason is simple. In countries with publicly managed health care, including Canada, universal public drug coverage allows for prudent expenditure management at a societal and health system level. Such integration of systems consolidates purchasing power and best aligns the incentives of providers and managers of health care by integrating the management of pharmaceuticals with the management of other components of the health care system. Countries that do this achieve far better access to medicines than any province in Canada does today, and they do so at considerably lower costs.

Canada spends 30% to 50% more on pharmaceuticals than 24 of the OECD countries, including many with health care systems comparable to ours. These other systems achieve pharmaceutical savings through more cost-effective medicine use and greater purchasing power, which translates to lower prices.

Though provinces have done well to coordinate their pharmaceutical price negotiations in recent years, provincial drug plans are far from having the power of a single-payer system. A universal public pharmacare program would dramatically increase Canada's purchasing power in the global market for pharmaceuticals and enable careful evidence-based selection of medicines by system managers, prescribers, and patients. Credible estimates based on conservative assumptions about policy outcomes indicate that this would save Canada approximately $7 billion per year.

This brings me to my third and final message for you today, and that is that the transformative change that is required in Canadian pharmacare depends on federal involvement and financial contributions. This is a familiar story in Canadian health care policy. Every major stage of Canada's universal medicare system was brought about through federal cost-sharing that helped provinces to afford the changes needed and helped provinces to overcome political opposition that stood in the way of progress. Pharmacare will be no different.

On their own, provinces may not have the resources or purchasing power needed to implement the prudent pharmacare system. Regardless of size, all provinces will certainly need help to overcome the predictable opposition that comes from select industries that profit from the private-public mix of drug plans in our system and the resulting high prices for medicines in this country. As they have repeatedly done in the past, pharmaceutical sector interests will oppose a universal public pharmacare program, because such a system will almost certainly achieve better outcomes at, importantly, lower costs.

The pharmacare reforms that Canada needs, therefore, require the truest test of political leadership: ability to champion the legitimate but diffuse interests of ordinary Canadians, dare I say middle-class Canadians, over the concentrated and thus powerful interests of specific actors. This is not to say that governments that take action won't find support from the Canadian public. On the contrary, the 2015 Angus Reid Institute survey mentioned earlier found that 87% of Canadians support adding prescription medicines to our publicly funded Canadian medicare system.

● (1540)

I will conclude by noting that it is important for this committee, indeed this government right up to the Prime Minister, to realize that now is the time for pharmacare reform. Canadians have been waiting for pharmacare since it was first recommended in the 1960s. Evidence suggests that decisions not to implement universal public pharmacare is costing us billions of dollars, and worst of all, hundreds of lives every year.

Unlike past eras when pharmacare was on the policy agenda, there is currently political alignment of a majority of governments across Canada that would support the broad goals and objectives of pharmacare reform. Such policy alignment is a once-in-a-generation opportunity for Canadians, and it may not be present by the next time a federal election comes around. Thus, now is the time for action. Now is a once-in-a-lifetime opportunity for political leaders wishing to leave a lasting positive legacy in the Canadian health care system.

With that, I would note that I wish your committee well as you study this issue and contribute to such a positive legacy for all Canadians.

Thank you.

The Chair: Thank you very much for that information. It is very helpful. Certainly, you are not on the fence on this debate; that's for sure.

Next up.

Dr. Danielle Martin (Vice-President, Medical Affairs & Health System Solutions, Women's College Hospital): Good afternoon and thank you so much for inviting me to join you.

My name is Danielle Martin. I am a practising family physician and I'm also a hospital administrator. I'm the vice-president of medical affairs and health systems solutions at Women's College Hospital in Toronto. I'm also an assistant professor at the University of Toronto.

I want to speak to you today mostly as a practising family doctor, but also as someone who is trying to help run a hospital and organization in the Canadian health care system, someone who is working to try to make care better for patients on the ground every day. I'd like to share with you what I see from my own vantage point about what the problem is that needs to be fixed with respect to pharmaceutical policy in Canada. It is that our current patchwork system is letting many groups, not just a single group, but many groups of Canadians fall through the cracks. It encourages and provides incentives to make bad prescribing choices. It is forcing doctors and other health care workers to engage in what can only be described as crazy workarounds to try to get our patients the basic health care that they need.

As the committee now knows—and I know you're up to date on these basic statistics—more than 50%, probably somewhere around 60%, of Canadians are covered by private drug insurance, usually through their employers or the employers of their spouses or parents. In those private plans, by and large, whatever a physician prescribes or another provider prescribes to a patient with private coverage will be covered. This is what's known as an open formulary drug plan. The majority of private drug plans function in this fashion. They make absolutely no attempt to base their coverage on medical evidence until an individual's spending on drugs gets into the many thousands of dollars annually. As a physician, if I write a prescription for a patient, their private plan will nearly always cover it.

Now that might sound good to you. I know it sounds good and you will probably hear people present to your committee over the coming days who will try to convince you that it is good, but in fact, it's not. It's not good for health, and it's not good for the economy. Why? Such open formulary plans give licence to doctors and other providers to prescribe more expensive medicines when less expensive ones are just as good or even better. This results in high costs for no reason and is one of the many drivers for the high costs that you've heard described by Steve and others.

Eventually, of course, those costs are passed on to Canadians, either directly or indirectly. Open formulary plans also encourage what's known as off-label prescribing, which leads to doctors writing prescriptions for cases where the drugs are not medically proven to work, and they fail to provide any guidance to patients or to prescribers about what the most appropriate drug choice is for a given condition.

This leads to a culture of over-prescribing and inappropriate prescribing that has real effects on the health of Canadians every day and leads to statistics of the kind we know. For example, one in five Canadian seniors today takes a drug on the Beers list, which is a list of medications that should almost never be prescribed to people over the age of 65 because the risks outweigh the benefits.

Indeed, private insurance plans have no incentive to reduce inappropriate prescribing. In fact, the incentive is just the opposite, because the more prescriptions we write, the more money they make.

Now the fact that many people depend on those employer-based drug plans also causes problems in the job market. A parent whose child has diabetes or whose spouse has cancer cannot afford to lose his or her employer-based insurance, and that traps people in jobs that may not be right for them.

Importantly, many Canadians who are working—the self-employed, people who work on contract, people who work part-time, and people who work in small businesses—do not have private coverage. It isn't only the working poor. The changing nature of work in Canada means that the issue now extends well beyond the nannies and taxi drivers of the nation, although we should of course be concerned about the nannies and the taxi drivers of the nation. In my own practice, I see lots of self-employed consultants and others with medium to high incomes who don't have drug coverage. As you will know from interactions with your own constituents, precarious work is on the rise in the Canadian economy. More and more people are working on serial contracts and in more than one job, and there are fewer long-term jobs with a single large employer.

As our economy shifts into an age where old models of employment become increasingly rare, old models of benefits are also disappearing. It's important to understand that many middle-class Canadians either don't have good drug coverage or are at risk of losing their drug coverage in the modern Canadian economy.

That's the private drug plans. They're not working well for Canadians.

● (1545)

Now let's talk about our public insurance plans. Every province, and also the federal government, runs at least one public drug plan, but most Canadians with jobs are excluded from public plans, despite the fact that they may not receive coverage through their employer, unless their costs become what is known as “catastrophic”. As you know, those catastrophic plans are supposed to kick in to save people from having to mortgage their homes in order to pay for their drugs. It is really important to understand how unhelpful catastrophic drug coverage is for the patients in my practice and practices across the country: people living with diabetes, high blood pressure, asthma, chronic heart disease, and chronic lung disease. To give you an example, in Ontario, where I live, on an income of $20,000 annually, a patient would need to spend $800 out of pocket before her coverage would kick in. This requires an upfront cash outlay that a person living on $20,000 a year simply can't afford, so what happens is that people just don't fill their prescriptions. For people who can't afford those catastrophic deductibles of 3%, 5%, 10%, or 12% of their income, having access to catastrophic drug coverage is equivalent to not having any drug coverage at all. In that context, it should not surprise any of us that one in five Canadian households now reports that someone in the household does not fill a prescription due to concerns about costs.

The impact is not only on patients, but it is also on the practice of medicine and on clinical practice across the nation. The reality is that every day in your communities doctors are doing things they shouldn't have to do in order to get medicine for their patients. We are allowing ourselves to be lobbied by pharmaceutical reps in order to get a few boxes of drug samples. We are prescribing an alternative to the drug that is actually needed by our patient, so that he can afford to fill the prescription. We are admitting people to hospital so we can give them treatments that they can't afford to take at home. We are wasting time begging companies to give our patients compassionate access to a drug they can't afford. Sometimes we just buy our patients' medicine ourselves, and sometimes the pharmacists do the same. Sometimes we just advise them that they should go on social assistance so that they can get the drug card they need.

It is abundantly clear to those of us who work in it that our current system, one in which private insurance drives unnecessarily expensive prescribing and huge numbers of Canadians go without their medications, is fundamentally flawed. Given the importance of medicine in modern-day clinical practice, the ongoing exclusion of prescription medicines from our publicly funded health care system makes no logical sense. Instead, we need a national pharmacare program with five key elements.

First, every single Canadian must be covered by a public plan. Just as we have done for doctors and hospitals, essential prescription medicines must be accessible to everyone.

Second, not every medication should be covered for every person. We need to devise an open, transparent, and evidence-based process, one that is at arm's length from government and free of industry influence and political interference, to make our decisions about what to cover.

Third, copayments should be extremely low or zero, especially for low-income people, because there is very strong evidence that even very small copayments can prevent low-income people from filling their prescriptions.

Fourth, governments must band together to purchase all drugs for the nation. Even the pCPA, with its limited success thus far, has failed to get the kinds of savings on drug prices that other countries get, because even with the federal government participating, public plans represent only 40% of the market for drugs in Canada.

The fifth and final element of a well-designed pharmacare program is an emphasis on reducing over-prescribing and improving quality and safety. This critical job cannot be left to private insurance companies or to pharmaceutical companies, which neither are accountable to the public nor have any kind of incentive to decrease rather than increase prescribing.

As I close, I would like to say that a national pharmacare program does not need to involve a full uploading of all provincial jurisdiction over drug plans in order to be successful. A co-operative effort, convened by the federal government, could be achieved without any constitutional hassle and without sticking the federal government with the whole bill. The tasks involved in pharmacare are discrete and could be shared between the federal government, the provinces, and the territories to achieve the five elements I have just outlined.

Canadians are rightly proud of the principle that our universal public health care system should base access to care on need rather than ability to pay. Until we deal with the lack of national pharmacare in this country, I am sorry to say that I don't believe we are living up to that principle.

● (1550)

The Chair: Thank you very much. That's quite a report.

Who is next?

[*Translation*]

Dr. Marie-Claude Prémont (Professor, École nationale d'administration publique, As an Individual): I will continue, Mr. Chair.

My name is Marie-Claude Prémont. I am a full professor at the École nationale d'administration publique in Montreal, where I teach health and social services law, among other things.

I would like to thank the committee for inviting me to appear. I am pleased to tell you about Quebec's pharmacare system.

As the federal government is analyzing, through your great services, the issue of drug coverage across Canada, it might be tempting to follow the example of a province. That is what the federal government did in the late 1950s. It followed Saskatchewan's example and implemented the hospital insurance plan. Quebec has set an example that might appear innovative and inspiring to people.

Let me tell you right away that my primary goal today is to explain why I don't think Quebec's system is an example that should be followed. On the contrary, I would like to warn you about Quebec's type of system, which has been in force since 1997. Next year, it will have been in place for 20 years. Let's start by understanding the principles of the system.

First, it is important to understand that, when pharmacare was introduced in Quebec, a fundamental paradigm shift took place. Canada and all the provinces operate according to the logic of a universal hospital insurance and medical insurance system, whereas Quebec's pharmacare is a general, not universal, system, although everyone is covered. This is not a marginal distinction, but rather a fundamental one.

Let me explain. With a universal system, the primary insurance is public and everyone is covered in the same way. With a universal health care system such as the one in place right now, private insurance is prohibited. That is the case in Canada for 90% of people, who are covered under provincial legislation that provides for a plan forbidding private insurance.

With Quebec's pharmacare, unlike health insurance, private insurance has privileged markets, while public insurance is stuck with the least profitable and most challenging markets. So, in Quebec's system, it is private insurance that gets the first pick in terms of pharmacare.

Steven told us about the patchwork concept. Danielle reiterated that, right now, we are dealing with a patchwork system across Canada. Actually, Quebec's system is just setting in stone this patchwork of plans. That's the best description for Quebec's system: it is a patchwork of plans.

On the one side, there is a public system for the most vulnerable—seniors and the unemployed—and on the other hand, there is a multitude of private group plans that are provided by employers or associations. Let me repeat: Quebec's system has only further set in stone what was there before. It has then tried to plug the holes to ensure that the entire population is covered.

I will not dwell on the basic principles and terms and conditions, but I will instead draw your attention to the fact that, in Quebec's system, the premiums of private insurance companies are not regulated. In the past 20 years, we have seen a gradual increase in private sector premiums to the extent that more and more people are leaving the private plans to seek refuge in the public system, which is heavily subsidized.

● (1555)

Only the public part of the system is regulated, because people could not afford what the system truly costs without substantial subsidies.

Quebec's system has four major features.

The first feature is that the system operates on a systemic triage of risks. This means that good risks go to the private companies, which represent those who work. Those private plans cover 57% of Quebec's people. Conversely, the bad risks go to the public sector. We are talking about seniors or the disadvantaged, meaning 3.5 million people. This logic recognizes a role for the public sector in terms of social assistance. This is a residual logic in the sense that the public sector is there just to take care of the most disadvantaged. That is truly the fundamental feature of Quebec's system.

The second feature has to do with funding. We are seeing the funding being moved away from the tax system. This means that, instead of being funded by taxes, as is the case for medicare, the funding structure basically emulates the way the private insurance industry does things. There is a premium, a deductible and co-insurance. Furthermore, this mimicking of private insurance funding is a complete illusion.

When the public portion was put in place, we were told that the plan was going to be self-funded. However, as we can see—I checked the latest numbers from RAMQ—the contributions, made up of deductibles and co-insurance for the public portion, don't even cover 20% of the plan. That's why huge subsidies must be invested for the system to work. In terms of the private portion of the system, there is no relationship between the contribution made to the private plan and people's income. So the plan operates completely removed from the tax system.

The third feature is that tax tools that normally belong to public authorities have been made available to the private insurance sector. We are talking about mandatory insurance for clients and patients whose employer provides the service. We are talking about source deductions, like income tax, which are then forwarded to the insurance sector. Then, private insurers have the advantage of covering only group plans. As soon as an individual does not have access to a group plan, they must obtain insurance from RAMQ, the public system.

The fourth feature of the system—the last but not the least—is that the role of public authorities is completely overlooked, because the social solidarity between segments of the population has been completely dismantled. The system is not forward-looking, contrary to what people may think and contrary to what a public insurance system should be. People who contribute to a private system their entire lives receive no warning when they are removed from the system and are insured by public insurance as soon as they turn 65 years old. There is no inter-funding between the private and public portions of the system, and the coverage terms and conditions vary a great deal between the public and the private portions.

● (1600)

Quebec's general system is therefore a dead end, and this blocks any reforms, even if the costs have been pointed out on a number of occasions in Quebec.

Thank you.

[*English*]

The Chair: Thank you very much for that different perspective. It was enlightening.

[*Translation*]

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

My thanks also to all the members of the committee for this invitation.

My name is Marc-André Gagnon. I am an associate professor at the School of Public Policy and Administration, Carleton University, Ottawa. Today, I will talk to you about the problem, the solutions and the way in which a public system could be funded.

My colleagues have already talked about the Canadian anomaly. Canada is the only country in the OECD with a universal public health insurance system that does not include prescription drugs, as if drugs were not an essential element of health care in Canada. Our system is fragmented and it relies first and foremost on the primacy of private plans, as the public sector must look after those who have no access to private plans.

This system is becoming very costly. In 2012, prescription drug expenditures in Canada were $771 per capita. The average of OECD countries is $498. In Canada, we pay 55% more than the OECD average. Not only do we pay more, but there is also a more pronounced increase in costs in the long term. Between 2000 and 2012, the costs per capita in Canada have increased by 96%. They have almost doubled, whereas in countries like the U.K. and France, which have universal public drug insurance plans, the growth was around 55%.

Some countries have spent a lot of time on the issue of appropriate usage. For instance, Denmark's growth was 36%. In the U.S., which remains the model of waste and inefficiency, the increase was 87%, which is still lower than what was observed in Canada. To give you an idea of the scope, if Canada had been able to limit the increase in expenses, the way the U.K. and France had done, right now there would be savings of $5.8 billion per year. If we could measure up to Denmark, we would be saving $8.3 billion annually. For that, we would have had to equip ourselves with the institutional capacity needed to better contain costs, while ensuring that the prescriptions were more appropriate and the health results better.

Other systems are more effective because they are public systems structured in such a way to maximize the therapeutic value for the people, which is clearly lacking in Canada. The cost growth in Canada is not sustainable in the long term, meaning that major reforms will have to take place one way or another. The issue is determining what types of reforms will be put in place. A possibility would be to transfer the risks to patients, by increasing premiums, co-insurances and deductibles. The other possibility would be to start preparing reforms by drawing on the best practices of other countries.

The problem with the current system is that it is fragmented. When you have a fragmented system, it is always easier to shovel the costs to other parts of the system instead of trying to set up a way of containing them. In Canada, private plans have priority. By definition, those plans are far less effective in containing costs. That is normal because private plans are built on the logic of benefits negotiated under collective agreements that seek to have conditions that basically please employees. Our logic is one based on privileges provided by employers to employees. We are not using a logic that strives for the best results in terms of public health care.

The result is this sort of culture in Canada where a good drug insurance plan covers everything at any cost, which leads to a huge waste in many respects. Let me quote Express Scripts Canada, the largest provider of private health benefits management services in the country. Keep in mind that private plans reimburse about $10 billion per year. Express Scripts Canada tells us that the amount wasted in private plans is estimated at $5.1 billion. That is money spent without obtaining any additional therapeutic benefits compared to what we might have paid had there been less costly alternatives.

In 2013, the Canadian Life and Health Insurance Association published a very interesting report.

● (1605)

The report indicates that there are problems of fairness and that the plans are not sustainable in the long term. We need government intervention. Private plans alone do not have the tools for self-reform. We need government intervention. Unfortunately, the proposed solutions go in directions that are sometimes problematic.

If we are trying to think of solutions based on the current fragmented system, we end up thinking that the public system is some sort of trash can for bad risks. This means that, if private plans are not able to handle something, the public system will get it. The Canadian government should therefore look after those without coverage and perhaps provide coverage for expensive treatments or for some more problematic drugs that private systems are not able to cover, such as those related to oncology.

If we do that, the public system is based on the commercial needs of private plans, not on the health needs of Canadians. The typical example is the Quebec model, which is sometimes held up as a model. That should not be the case because the Quebec model simply makes the ineffective structure of private plans mandatory for everyone. It institutionalizes a system that is defined by its ineffectiveness in containing costs. When all is said and done, it is not surprising that, if we compare the costs per capita in Quebec to the costs per capita in the rest of Canada, Quebec spends on average 20% more per capita than in the rest of Canada.

What do the employers have to say about that?

They say some interesting things. Last December, *Benefits Canada*, the largest publication on private benefit plans, published a survey for its members, over 200 managers of private benefit plans. Employers were asked what had to be done to ensure greater sustainability of drug insurance plans. Respondents were asked whether they would support the idea of establishing a universal public prescription drug insurance plan. Thirteen percent of respondents were opposed to the measure, 33% were undecided or unsure and 53% were in favour. We can therefore see that employers feel that a universal public prescription drug insurance plan would be an interesting solution for businesses as well.

The respondents who were in favour were also asked whether they would support the idea of universal public prescription drug insurance even if that meant additional fees for companies to fund the plan, such as an increase in taxes for companies. Seventy per cent of them were in favour of that measure, since the increase in fees would still be lower than what they are paying now for ineffective plans.

We need a public solution based on best practices. What form should a universal public system take? We must pay attention to that. We must not think of a universal public system solely in terms of transfers of funds. A public system must not be an open bar. If the idea is to reimburse everything at any cost, I am opposed to that type of system. We need to set up a system that is structurally built around evidence-based data in order to maximize the therapeutic value of each dollar spent.

Take blood services, for example. The Canadian Blood Services is an independent agency funded both by the provinces and by the feds. With its budget, it must coordinate blood services across the country by maximizing the therapeutic benefits of each dollar spent. A universal public prescription drug system could be built on the same basis. We could have a depoliticized independent agency that would rely on evidence. For instance, we could merge the Canadian Agency for Drugs and Technologies in Health and the pan-Canadian Pharmaceutical Alliance. This agency could manage the national formulary, meaning the list of covered drugs, but always with a view to maximizing the therapeutic value of each dollar spent.

People might think that a national formulary of this kind would reduce the choices for patients, but that is not at all the case, because waste would be reduced. If patients still wanted treatment that is not based on evidence in terms of its effectiveness or if they wanted more expensive treatments when a less expensive alternative was available, they could do so by paying out of their own pockets.

● (1610)

They would not rely on the solidarity of other taxpayers or work colleagues.

I would like to address how a program like this can be financed. I'd be happy to talk to you about that if you like. If you ask me for my opinion as an expert, I will tell you that a universal public program is not only the best way to improve access to medical treatment at a lower cost for Canadians, but would also help significantly reduce the labour costs in Canada, which would in turn increase the competitiveness of Canadian businesses.

As for financing, I would like to speak a little more on that, but let's say that there is no real economic obstacle to putting a program like this in place. All we need is a little political will.

Thank you very much.

● (1615)

[*English*]

The Chair: Than you, all, for your presentations. They give us a lot to think about.

We'll start the questions. The first round of questions is for seven minutes, but I believe, Ms. Sidhu, you're going to split your time with Mr. Oliphant, so you have three and a half minutes.

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

Thank you to all the witnesses for being here with us and for your great knowledge.

As the chair said, I'm sharing my time with Rob.

My first question is on the funding.

In your study the estimated cost of universal public coverage of prescription drugs in Canada, for establishing a universal drug plan, would reduce government expenses by $2.9 billion in the best-case scenario, or would increase them by $5.4 billion in the worst-case scenario. In order to better understand the large differences between these two possibilities, could you elaborate on the elements that would guide this implementation of the best-case scenario reducing government expenses, and on those that could lead to an increase in costs?

Dr. Steven Morgan: Thank you for that question.

It is important for committee members and other people to get the full manuscript from the *Canadian Medical Association Journal*, including the technical appendices that provide detailed sensitivity analyses to show you what kind of parameters have the biggest impact on the cost to government.

To be clear about how you can direct a pharmacare system toward the best-case scenario, our model held the conservative assumption that the public program would fund virtually every medicine in virtually every drug class, which no comparable health system in the world does. We decided we'd throw it all in as a public benefit under this plan. The truth is the public plan would make judicious choices as to which medicines would be covered. The starting point might be the common formulary, or at least the common drugs that are on formularies across Canada. If you did that, you would immediately reduce the incremental cost to government of running a national plan and of expanding coverage to all citizens.

The other thing we did in this model, particularly in the worst-case scenario for government, is we assumed there would be virtually no copayments in the worst-case scenario, which again is something that no province in Canada currently does for general beneficiaries, and in fact, only a few countries around the world do, notably Scotland and Wales, which provide universal coverage at no copayments. If you wanted to limit the public expenditure on a universal public pharmacare program, you would devise a carefully chosen formulary and you would have patients make some contribution toward their prescription costs with notable exceptions for low-income individuals or people with chronic disease. For those of us who have moderate to middle incomes, we might pay $15 or $25 per prescription under the universal drug plan, and indeed, we might continue to have a parallel private insurance benefit to cover the costs of those prescriptions. So it would also be an opportunity to keep costs down under the public plan while still having some viable market for the private insurers either to cover the $15 or $20 copayments or to cover medicines that just didn't make the mark because they weren't proven value for money.

Ms. Sonia Sidhu: Can you elaborate more on the pharmacare programs that you believe are working best elsewhere in the world? What are some of the best practices regarding the maintaining of those programs?

You mentioned Denmark and France. Do they have any challenges with the models they have come up with for pharmacare?

Dr. Marc-André Gagnon: In different countries, there are different practices. We need to be careful because sometimes you need to embrace the whole thing at once.

What is interesting is that having no copayments in some countries is something that's absolutely great in terms of better access. Some countries, like Australia and the Netherlands, emphasize a lot the more appropriate use of medicine. Denmark is maybe pushing this idea to the extreme of more appropriate use of medicine by having a specific agency take care of that in terms of trying to influence the prescribing habits of doctors.

What I like as well is the New Zealand system, the idea of having a depoliticized national agency. Based on the budget they receive, their mandate is very simple and very clear: maximize the therapeutic benefits for every dollar spent by the agency.

Then you have a whole system that uses every trick in the book, but for every dollar you spend, you want to get the most out of it, so you reduce opportunity costs and you reduce waste with that.

In terms of these different practices, these can be interesting examples.

● (1620)

Dr. Steven Morgan: Very quickly, I'll add that there are several things we can learn from several high-performing systems around the world. The key ingredient is that your drug plan has to have a budget.

In fact, some of the best performing drug plans in the world are in every Canadian hospital that Canadians use on a regular basis. Our hospitals have drug budgets from which they carefully manage expenditures. They have formulary committees that make tough decisions about what drugs are on formulary for hospitals and which ones are not. They buy all of their medicines in bulk because the budget forces them to do so. That also forces manufacturers to give them better prices; otherwise, there will be no sales to a particular hospital or to a particular province.

Look to Canadian hospitals. Look to the U.S. Department of Veterans Affairs' health administration, one of the best run drug programs in the world. It happens in the United States, one of the fiercest markets in terms of pharmaceutical cost pressures, and yet they've had virtually flat expenditures per beneficiary for the last couple of decades.

Look to Australia, New Zealand, Sweden, and the United Kingdom. All of these countries have lessons we can learn. We'd be happy, I'm sure, to provide more details if you have questions following these committee hearings about what it is that you can learn from each of those examples.

The Chair: Mr. Oliphant, we only have about two minutes.

Mr. Robert Oliphant (Don Valley West, Lib.): Thank you, Mr. Chair.

Thank you. It's very much the A-team who are with us.

I just want to make sure, Mr. Chair, that the report, “Pharmacare 2020” is entered into evidence. I'd formally request that so that we have the report for consideration by the committee.

I am just an alternate here. I'm happy to substitute any time for both sides, if you would like me to substitute.

Voices: Oh, oh!

Mr. Robert Oliphant: This is an issue I care a lot about.

I want to dig down a little bit and start with a case. A nurse in Vancouver called me a year and a half ago. She was on a drug called Xolair, which is a biologic medication for asthma. BC PharmaCare decided to, I call it, bureaucratically substitute. It took the drug off the formulary. She was forced to actually move to Alberta, as a nurse, because the nurses' plan mirrored the B.C. pharmacare plan. There was a cost saving which BC PharmaCare was required to do, but she was actually forced to move.

On the good side of your report is a national patchwork-free kind of pharmacare system where every Canadian would have the same. On the downside, how do we ensure that Canadians have the drugs they need and that they are provided in an affordable way?

I'm not sure who wants to answer that.

Dr. Danielle Martin: Maybe I'll start from a clinical perspective. Of course, I can't speak to the specifics of that individual's case.

One important thing that we always have to ask ourselves is whether the prescribing that's going on is actually based on the best available evidence and whether the formularies are based on the best available evidence. Nobody wants a situation in Canada in which we make decisions purely based on cost. You're not going to hear anybody advocating for that from any realm.

What we do want is to make sure when we are paying for a drug that it is the right drug, and it is a drug that has been shown to be maximally effective.

Mr. Robert Oliphant: So it's not cost. I was just a little concerned. In your presentation, it sounded like it was mostly about cost.

Can a pharmacare system give Canadians the best health care?

Dr. Danielle Martin: I really appreciate the question.

Not only can a pharmacare system give Canadians the best health possible, but a pharmacare system could give them much better health care than they currently get.

To me it's incredibly important that this message come across clearly in this afternoon's discussion, that giving everybody access to every drug all the time is not good health care. It leads to inappropriate prescribing, which causes real harm to people's health. What we need is to push ourselves and to push Canadians to understand that what they need access to, what they deserve access to, are drugs for which there is good, solid medical evidence.

This is why I think the notion of depoliticizing the formulary compiling process, moving those decisions out of the reach of industry, out of the reach of politicians—with the greatest of respect—and into an area that is entirely based on the best medical evidence.... You're still going to have really difficult conversations about cost-effectiveness, about clinical effectiveness, about how many of the me-too drugs within a given class. There are going to be lots of important conversations to have about what goes on the formulary.

What goes on the formulary should be the drugs for which there is solid evidence, and then there should be a transparent and fair appeals process. If this nurse has been through 14 different drugs that are covered on the formulary, and she has some unusual variant of asthma that responds only to this specific drug, and there is a process by which she can make her case and her physicians can make her case, then there needs to be a method for us to assess that. But we shouldn't be paying for the fifth-line therapy that costs ten times the price of the first-line therapy for every single person. It makes no economic sense, and it makes no sense from a health perspective as well.

● (1625)

The Chair: Thanks very much.

Dr. Carrie, you're up.

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

First of all, I want to thank the witnesses today. When we started this study, I think all of us thought that where the system was.... After hearing from witnesses, we're starting to paint a bit of a picture out there. At first, I thought Canadians weren't getting access to pharmaceuticals and that was the biggest problem. But in hearing the witnesses who were here last week, and then using Mr. Google, I've found out that Canadians are the number two consumers of pharmaceuticals in the world.

I like what Dr. Martin said. We rank in the top 10% of countries that use benzodiazepines, opioids, and stimulants. We're number four with respect to antidepressants, number two with respect to opioids. That in itself is costing taxpayers a lot of money. And with all due respect, Dr. Martin, it's not just which drugs you choose, but at the end of the day, somebody is writing prescriptions for these things.

I know we're trying to get our heads around what the role of the federal government is. I know that different governments have taken different approaches, and I remember a controversial one for the opioids. I remember Deb Matthews in Ontario a few years ago, the frustration.... She was out there urging all provinces and territories to band together to convince Health Canada to block generic forms of opioids. She's on the ground as a politician. She's a lot closer than we are. She said that Ontario had the highest rate of prescription narcotic abuse in the country, two to four times higher than any other province. She mentioned the challenge with first nations communities, where the federal government does cover prescriptions. She said it has devastated many first nations communities, including one small northern reserve where 85% of residents are addicted to opioids. When we hear stuff like that, it just tears our hearts out, because you want to do the best. All Canadians want to have access to the pharmaceuticals and treatments that they need. She was quoted as saying that we simply don't need easily abused long-acting oxycodone drugs to achieve better care.

My question would be, how far do governments go? Dr. Martin, you're on the ground. Do you agree with Deb Matthews and her analysis with certain segments of the pharmaceutical prescriptions?

Dr. Danielle Martin: Thank you for the question.

A have a couple of observations. The first is that you're absolutely right. It's not government that's writing prescriptions for patients primarily in our country; it's doctors. As I'm sure the committee can appreciate, the decision to pick up one's pen and write that prescription is the culmination of a whole lot of complex factors.

What do we know works with respect to improving the appropriateness of prescribing? There's no single silver bullet.

What you want is a system in which, first of all, you can provide the best possible guidance based on evidence. We know that having an evidence-based formulary does work. Physicians are going to write prescriptions by and large for drugs that are covered for our patients. Patients are going to demand that we write prescriptions for the drugs that are covered for them. The use of an evidence-based formulary.... There are examples of formularies even in Canada that are tiered so you know that if your patient has failed the first-line therapy, for example, then you can move to the next therapy, which is more expensive, etc. Using the formulary to shape prescribing is an important way that governments—whether at the provincial level or at the pan-Canadian level, or because we collectively decide to hand those decisions over to an arm's-length agency—can shape prescribing among providers.

● (1630)

Mr. Colin Carrie: Should governments go as far as banning certain drugs, do you think?

Dr. Danielle Martin: It's interesting. One thing that government can do...I certainly don't think it's the role of government to make the individual decisions. I would rather have the government get out of the business of making decisions, because we've seen there can be influences on those decisions that can go either way.

What I do think government should do is to abide by the decisions made by an arm's-length entity or agency where the best evidence is used and there's a transparent process for making those decisions.

Mr. Colin Carrie: I thought we had a system in place where there was some oversight in that. These statistics that we're seeing here—

Dr. Danielle Martin: We have a system in place where among our private plans pretty much anything that is prescribed is covered. That's the open formulary plan. If you think about what the incentives are for a private insurance plan—the more I prescribe, the more prescriptions churn through the industry, the more money gets made—it's the reverse incentive of the incentive one would want or hope for. There's no incentive for appropriateness in that way.

Mr. Colin Carrie: Maybe I should move on to another question, because I have a few here, but thank you for those answers.

Mr. Morgan, with your ideas moving forward you talk about this agency, or this one government plan, negotiating with pharmaceutical companies. If you look at the pan-Canadian Pharmaceutical Alliance and they've been functioning, it would probably take years for the government to negotiate thousands of contracts with drug companies. Have you estimated what you expect the initial cost would be that the government would have to absorb on day one if the government were to undertake a national pharmacare program? What would those costs be on day one?

Dr. Steven Morgan: We haven't estimated the specific administrative costs of ramping up, in part because Canada, probably to the surprise of this committee, has dozens of public drug plans across the country in each province, territory, and at the federal level. All of them manage their own formularies; all of them make their own decisions, and all of them, should they participate with the pCPA, have to sign their own contracts. We have a tremendous amount of redundant infrastructure in the contract negotiations with drug manufacturers. Every drug listed on any provincial formulary in this country has to go through the formal listing process and increasingly requires a product listing agreement, or a utilization management agreement as they're known in Manitoba.

We are already doing this in large scale, but we are not doing it on behalf of the entire population. We are doing it on behalf of the select segments of the population that are beneficiaries of the existing public drug plans.

I think the pCPA is a tremendous example of the provinces voluntarily coming together to work together in order to increase their purchasing power. They are hindered by a couple of things, one of which is that the provincial drug plans fund less than 40% of drug costs in each province. That makes them a minority payer in the market place. That means that if they say yes to a drug, about 40% of the market is covered under that pCPA negotiated deal.

Mr. Colin Carrie: If you had a negotiator, couldn't you, with the system we have now, allow the private companies to take benefit of negotiated prices as well? We had some witnesses here last week, and I think they said private payers take up, I think it's $10 billion, and then the copay is another $5 billion. So you're looking at $15 billion that the public systems don't pay now—

Dr. Steven Morgan: Yes. Overwhelmingly, there's—

Mr. Colin Carrie: —and if you ramp something up, that's obviously going to go on to a public payer, wouldn't it?

Dr. Steven Morgan: Two things hinder the provincial negotiation power. One is that it's a minority payer. The other thing is that no does not necessarily mean no, and yes does not necessarily mean yes. When a province actually says yes to a drug, then that's great; it's signed a deal if it's taken up the manufacturer's offer. When a province says no to a drug because the price isn't suitable for Canadian value-for-money expectations, private insurers often still fund the drug. So, in essence, they actually weaken the negotiation power of the pCPA process because, by default, the presumption by private insurers is that they'll cover it.

Now, if you had a system in Canada where you legally bound all insurers to say yes when the government says yes and to say no when the government says no, then you would have a system by which you could probably leverage universal purchasing power. Of course, under that situation, you've basically reduced the private insurers to claims-processing agencies, which they are in some provinces like Alberta and Nova Scotia. Private insurers run the claims-processing function of the public programs, and the government manages what's on formulary and what's not, and what the prices are.

If private insurers want to be claims processors under a universal pharmacare program that's publicly managed, that's great. But the deal is that you have to be all in or all out if you're going to get—

● (1635)

Mr. Colin Carrie: What about the drugs that aren't going to be covered? You could have some bureaucrat in Ottawa decide that, for example, they're only going to fund the generics. I brought up the OxyContin thing because it is kind of a political, controversial thing. You have one type of drug that is tamper-resistant anyway, and the other one is not and is easily diverted. That's just an example.

If you have a monopoly where patients can't get covered, you're going to need some type of private insurance, aren't you? Aren't there going to be shortages and stuff, if that occurs?

Dr. Steven Morgan: Well, no. I mean shortages are not a function of coverage decisions, per se. In markets that we would compare ourselves to, governments do make decisions about what will and what will not be covered under the universal drug plans. In a few of them, you can buy supplementary private insurance to cover those sorts of things. The United Kingdom has supplementary private insurance for health care. Very little of that actually goes to prescription drugs because, on the whole, people in the United Kingdom understand that they get access to the medicines they truly need, and the exceptions are rare where the medicines that they really need aren't available in some way on formulary.

You could have a supplementary or parallel private insurance system essentially, as I said earlier, for things like the copayments, which will likely happen in public pharmacare in Canada, and for things like the medicines that just don't make the list. Opioid drugs, for instance, may not be the first thing that public pharmacare would go for universal coverage for, in part because we are desperately trying to manage an epidemic of overuse of those medicines. Coverage decisions alone aren't going to solve that problem. That problem's root cause is about addiction and mental health, and it's going to require complex interventions. So it's not a reason not to move forward with pharmacare, but it certainly wouldn't necessarily be the priority one drug class for a pharmacare program.

The Chair: The time's up. I let you go a little longer because we went a little longer on this side, too.

Go ahead, Madame Sansoucy.

[*Translation*]

Ms. Brigitte Sansoucy (Saint-Hyacinthe—Bagot, NDP): Thank you, Mr. Chair.

I'd like to thank the witnesses appearing before us today. This information is very helpful.

Dr. Prémont, your explanation of Quebec's experience over the last 20 years and the reasons why the program is so costly compared to regimes in other OECD countries were very clear. It was also clear that, in the case of a program like Quebec's, some shortcomings might be countered by a universal public program intended for all of Canada.

Dr. Gagnon, you said that there was no economic obstacle to implementing this program. Yet, in the context of this committee's work, the minister said last week that she thought a pharmacare program would be too expensive. So you can understand why cost is a concern for our committee.

I don't know if one of you could tell me how much the Government of Canada is already spending annually on tax credits to companies that offer their employees a drug coverage plan.

Dr. Marc-André Gagnon: That's a very interesting question.

It's important to understand that current private plans are in fact already generously funded in part by the government, by public budgets. For the Government of Canada, it is estimated that federal tax subsidies are 13% of overall spending for private plans. As for the provinces, although they don't all offer them, it's 7% or 8%. Overall, it is estimated that close to 20% of what private plans pay out are covered through tax subsidies by the various governments.

However, I would add one important thing. Keep in mind that 30% of spending by private plans is for coverage of public servants. So it's already being covered through public budgets, to maintain plans that are not very cost-effective.

So almost half of spending by private plans is funded by public budgets one way or another. In fact, private plans reimburse some $10 billion. Furthermore, an estimated $5.1 billion of private plans are directed toward what we call waste and toward establishing a universal public plan to ensure proper use and maximize therapeutic benefits in order to minimize waste.

It's important to understand something about the issue of economic costs. The population can be divided in two: the employed and the unemployed. For the moment, the provinces are already setting aside funds for people who don't work, including seniors and social assistance recipients. Every province provides public funding to cover those individuals. What about people who are working, so those who are covered by private plans? So when we look at the numbers and dig a little, we can see that public funding is essential for these private plans. I think we simply need to take this public money and use it more effectively to better serve the population's needs.

● (1640)

Ms. Brigitte Sansoucy: Thank you.

Would you like to add anything, Dr. Prémont?

Dr. Marie-Claude Prémont: Yes, I could add something, Ms. Sansoucy.

So, without getting into the numbers, there's something you need to understand. If a universal drug plan was set up, it wouldn't necessarily cost the government more. The public portion, as Marc-Andrée explained, is already largely subsidized or funded by the public. And for the private portion, as my two colleagues also explained, insured individuals make significant contributions, which isn't effective.

Before Quebec introduced pharmacare generally, a report was submitted to the government that stated that introducing a public plan would not cost a penny more if the premiums being paid to private insurance were collected and used not to generate benefits for drug or insurance companies, but to finance a plan for the entire country.

So it's wrong to say that setting up a universal public plan would cost anything. The huge amount of money that is currently being wasted in an open-format plan simply needs to be better used, as Ms. Martin explained.

Ms. Brigitte Sansoucy: Thank you.

My next question is for Mr. Morgan.

To what extent do coinsurance, co-payment or deductibles create barriers for people trying to access the drugs they need? Would you recommend coverage from the very first dollar spent?

[*English*]

Dr. Steven Morgan: We know from repeated studies, literally dozens of studies conducted in Canada, the United States, and elsewhere in the world, that even relatively small costs borne by patients can be a barrier to filling prescriptions. It's important that we understand that patients don't act the way that we as managers of a health care system might wish them to act.

If you put a $10 charge on a prescription drug for a patient, many will look at that drug and think that it's a preventative thing, that it's for their cholesterol, or for their hypertension, or for managing their blood sugars because they're a type 2 diabetic. They'll say, “I don't think I will fill that prescription. I'll just get by without it, because I don't feel there's a benefit.”

That personal choice by the individual, which is quite rational to an individual, ends up costing our health care system money in the long run. It's those very drugs, those preventative drugs, that patients stop taking and then end up in the hospital, where it costs us far more money than we will have saved in the long run by asking them to pay the copayment.

I've often argued that we need to have some form of first-dollar coverage for prescription drugs. I tend not to necessarily call it first dollar, because in the Canadian context, this idea of giving away medicines with no copayments whatsoever is currently politically untenable. It is not something that I think any province or the federal government will accept. Canadians fill so many prescriptions that even a $2 to $5 prescription charge to patients will raise billions of dollars of costs to the program.

As a consequence, I refer to coverage in an ideal pharmacare model as being first-prescription coverage. There should be no deductibles, because deductibles are the worst barrier to filling prescriptions that patients need. From the very first prescription, depending on the drug type, it might be a very low copayment, maybe free if it's a preventative treatment that we know patients should have, or it might be a modest to a high copayment if it's something that we know is more of a private benefit, such as a painkiller that patients could have substituted an over-the-counter drug for. One could imagine a pharmacare system with something of a blended copayment that actually took the copayments based on evidence, not just a flat copayment across all prescriptions.

● (1645)

The Chair: The time is up.

Mr. Ayoub, I understand you're going to split your time.

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Yes, maybe.

The Chair: Okay. Maybe, because time flies.

Mr. Ramez Ayoub: It depends on the answer to the question.

The Chair: All right.

Mr. Ramez Ayoub: Maybe I'll share with Rob.

[*Translation*]

Dr. Gagnon, your testimony was fascinating, especially since I already find the topic very interesting. I have a number of questions I'd like to ask you. My first one is this.

I understand that, given costs and time, there should be a hierarchy of treatment. What are your solutions? You seem to be criticizing the fact that individuals who are insured can obtain any drug at any price. You spoke about this as the choice of doctors. What do you think this hierarchy should be? If I've understood correctly, this is the kind of solution that should be chosen. What is the link between treatment, price and time?

Dr. Marc-André Gagnon: I can give you a partial answer at least.

It's estimated that about 80% of new drugs that arrive on the market have no therapeutic benefit over existing drugs. Yet if our system agrees to cover everything at any price, companies would end up engaging in major promotional campaigns to convince doctors to always prescribe the newest, more expensive, patent-protected drug. So we end up with marketing-based medicine, not evidence-based medicine.

Ultimately, it's the newest drug on the market that is prescribed, and it's more expensive but there are often generic drugs that are much less expensive with side effects that have become well known over time. We haven't developed this culture.

With regard to the hierarchy, there are what we call reference prices. Take the case of proton pump inhibitors for gastric reflux: there are 13 different ones on the market. For one of them, each pill costs $2.50, while all the others cost 40¢ or less. Under this system, the ceiling is set at 40¢ or less per pill, and the one that costs $2.50 can only be prescribed to individuals who can show that they need it for specific therapeutic reasons.

Mr. Ramez Ayoub: We know that generic drugs are available. You said that there should be a regulation for doctors or, better yet, they should be trained so that their first consideration is the hierarchy of treatment. If a patient ever disagrees with it or wants to try another drug—obviously the doctor has to agree because the doctor prescribes it—does the patient have the choice?

Dr. Marc-André Gagnon: There are two ways of proceeding. If there is a medical reason to use a more expensive drug, there is currently an override system so that it can be refunded.

Suppose there is a generic version of the drug, but the patient wants to continue using the brand-name drug because of the colour, taste or something like that. If it isn't demonstrated that, medically, the brand-name drug provides additional therapeutic benefits, the person should still be able to get it, but that person, not taxpayers, should assume the difference in cost.

● (1650)

Mr. Ramez Ayoub: We talked about the situation in Quebec and in other countries, such as New Zealand. In the course of your studies and research, have you been able to establish costs based on the options open to Canada? What might the costs be if depending on the model we choose?

Your opinion is that the decision should not be political. What are your comments on that?

[*English*]

Dr. Marc-André Gagnon: Do you want to start?

Dr. Steven Morgan: Yes, if I may.

I have a couple of things to highlight in terms of the probability or possibility of moving forward. We can learn a bit from countries that have reorganized the way they cover medicines in their countries in recent years.

New Zealand created this purchasing agency referred to as PHARMAC in 1993. It didn't exist for decades prior to that.

There's no other country in the world that doesn't have universal drug coverage as part of their health insurance in the postwar era. All countries that developed their systems developed drugs and health care together. Canada is the only outlier in that regard.

We can look to New Zealand's purchasing agency. We can look to the United States Department of Veterans Affairs' health administration. They reorganized how they purchase their medicines also about two decades ago. We can look to Sweden which more recently reorganized how they purchase their medicines.

To give you an idea of how important it is to defray the political tension that comes from having manufacturers demanding prices for medicines that may not be justified, there are a growing number of countries around the world that are coming together and buying their medicines together across national boarders. We can't even do this in Canada across provinces, and yet the Scandinavian countries have developed a purchasing consortium that will be rolling out this coming year and will buy medicines on behalf of multiple Nordic countries.

A number of Russian-speaking nations are now creating a single market for pharmaceuticals, including single regulatory processes and single coverage decision-making processes.

Even the Dutch and the Belgians are joining together in purchasing medicines, that is, in making these difficult decisions as two countries coming together and binding themselves to the same formulary. It's precisely because they do not want the political tension, the political pressure, to fund the drug just because their neighbour does. They want to fund drugs based on value for money, not peer pressure.

The Chair: Mr. Oliphant, you have time for a quick question.

Mr. Robert Oliphant: If I could then ask quickly, have you had a chance to formally respond to the CPA's, the Canadian Pharmacists Association's response that they did in the CMAJ?

If you haven't had a chance to respond to it and would like to, particularly on underestimating costs, and concern about slow drug approvals and lowering patient choice.... If we don't have time, you may want to send something in writing to respond to them. They always like responses.

Dr. Steven Morgan: Thanks.

I actually chose not to respond to their work, in part because it wasn't peer reviewed. It's not credible research.

Mr. Robert Oliphant: It's an opinion piece, really.

Dr. Steven Morgan: Our paper is a peer-reviewed research paper in the *Canadian Medical Association Journal*. It's been out for over a year now, so other academics have had plenty of time to try to replicate, critique, or tear it apart in a formal and disciplined way, and no one has. That paper has recently won a national prize for its scholarship and its importance in helping policy in the country. I am positive that the paper is robust.

The critique that the Canadian Pharmacists Association commissioned from a pharmaceutical industry consulting firm makes a number of false assumptions about the paper. It included the assumption that we were solely basing our costing estimates on Canada versus U.K. prices, which is not the case. We looked at a wide window of prices, and recent Patented Medicine Prices Review Board data show that approximately 26 OECD countries fall within the range we used in our analysis.

They argued that we didn't take advantage of, or account for, the $490 million in negotiated rebates that our provinces get through negotiated contracts with drug manufacturers. We discussed in the paper that we deliberately did not do that because the rebates in Canada are smaller and apply to a smaller proportion of our market than comparable countries like the United Kingdom, New Zealand, Sweden, or Australia. If we were to have done what they suggested we should do, we would have added $1.5 billion in savings that we left out of our study.

● (1655)

Mr. Robert Oliphant: If you have a sleepless night, and I don't think you are, you can always....

Dr. Danielle Martin: I would like to add something to that.

A thoughtful question was asked about the political role here. I would implore this committee to consider that what you're doing right now is a tremendously important politically. You are thinking not only about what the end state should look like, but also about the hurdles involved in the transition .

One thing that those of you who work every day in both capital “P” and small “p” politics will understand is how to smell the interests in this conversation. We should not be afraid to have a conversation in Canada about where those interests reside and why some groups will be coming before your committee to present you with things that are not science but are dressed up as science in an attempt to serve their own interests.

I know many pharmacists understand the evidence, and I know many pharmacists go to work every day to try to defend health for Canadian patients. As a regulated health professional, however, I can tell you that had my association put forward a critique that flew so blatantly in the face of scientific inquiry, they would have heard from me as a member. I suspect that if you were to ask the Canadian Pharmacists Association whether they have heard from their members on this paper, you might hear some interesting answers.

I think it is important for us all to be grownups about this. We have to understand that there's a lot of money in the drug industry in Canada and that there are always going to be winners and losers in every transition.

We need to look to you as political leaders to show leadership in the politics of the transition. No one is better placed to do that than our elected political officials. That is something that is difficult for those of us who are at the front line of the health care system and in academia to do, but that's where you can really excel.

The Chair: Thank you.

Ms. Harder.

Ms. Rachael Harder (Lethbridge, CPC): Mr. Morgan, in your presentation you referred to an Angus Reid study, which says that 91% of Canadians support the concept of a national pharmacare program in Canada.

Now, the second part of that, which was left out of your presentation, was the fact that the next question asked of people was whether they would be in support of the GST increasing from 5% to 6% in order to pay for a program like this. Seventy per cent said that they were absolutely against this increase in taxation.

If this is not done by an increase in taxation, where would you suggest that we would find the money for such a program?

Dr. Steven Morgan: Actually, the Angus Reid survey asked a number of questions about support for the system and then asked people what their support would be with different instruments, not just the GST.

Canadians want a universal public program.

I will be clear: I helped Angus Reid design that survey and was responsible for some of the analysis. They asked a number of questions about fundraising instruments or tax increases that would have been between $5 billion and $10 billion in additional revenues raised to support a program, which is much more than you need to run the program. GST increases were the least popular, if I remember the responses.

Canadians generally preferred the idea of having corporate taxes returned to the rates that they were in 2012 as a mechanism for raising sufficient revenue to run a pharmacare program. I suppose in the minds of the Canadians who responded to that survey, the employers are going to benefit from reduced costs of employment-related health insurance, so maybe they could make that cost up by contributing more through corporate taxes.

Ms. Rachael Harder: Thank you.

I think the point remains that it's one thing for Canadians to be in support of something. I think we can all be in support of free pharmaceuticals—it sounds great—but at the end of the day, it's not free. It does have to come from the pockets of the taxpayer. If the broad band of the Canadian public isn't in support of that, I don't know how we can move forward with a program like this.

That's a statement, not a question. I do have another statement to make.

Mr. Morgan, when we asked what role politicians have to play in this, you mentioned the veterans program. It concerns me that you would bring this up as a model to follow, because there are a couple of things that have happened with the veterans program. One is that there's an extremely long waiting list, to the point at which there are actually people who are passing away before they can access the pharmaceuticals they need. If that's a model we're going to replicate here in Canada, that seems problematic to me. The other reason this is concerning to me is that there are managers who, it has been proved, actually falsify information in order to cover themselves very well and prevent themselves from being fired. That's another reason that I feel that this, perhaps, is not the program we need to be modelling after.

That said, my question is for Ms. Martin or, I suppose, Mr. Morgan. When we're saying politicians need to get out of the way, where are we suggesting the accountability for such a program would come from?

● (1700)

Dr. Steven Morgan: I'll respond to the developments there.

First of all, if you've got a citation for the patients in the veterans administration dying on wait-lists for particular medications, I'd appreciate seeing that. It would be nice to look at it.

On the issue with respect to accountability, we do want publicly accountable bodies that are making coverage decisions. They need to be accountable through fair and transparent processes. I think Canada actually is an exemplar on the world stage. I give a lot of credit to the Canadian Agency for Drugs and Technologies in Health and to the federal-provincial collaboration on the common drug review. It is a reasonably robust and reasonably transparent process that they have under way right now. A similar process, with some new elements to its mandate, could be conducted. Again, it's conducted by an agency that's at arm's length from political influence.

This would not be unique to Canada. Other countries around the world have similar infrastructure in place. Countries like Germany, Sweden, the Netherlands, Australia, New Zealand, the United Kingdom, all have agencies that are at some level arm's length from politicians. It's specifically to protect you from being lobbied by the manufacturers of a particular medicine that want their medicine on the formulary at a cost that isn't justified vis-à-vis other ways of improving the health of the population.

The Chair: You can ask a really short one.

Ms. Rachael Harder: Okay.

I guess I'm simply looking for some help with regard to understanding. Right now health care is, of course, given to the provinces, so I am looking for help in terms of understanding how the federal government can impose a one-payer system on the provinces. In terms of respecting the system that's been set up in our nation, how do we move forward toward a pharmacare system, if that's what we choose to do?

Dr. Marc-André Gagnon: When it comes to jurisdiction, pharmaceuticals are a bit of a problem because health care establishment is a provincial jurisdiction. When it comes to drugs, there's nothing in the Constitution, except that legal substances or illegal substances are to be decided by the federal government. It is the role of Health Canada to approve new medications. When it comes to pricing of the drugs as well, it's with intellectual property, the patent system, which is also with the federal government. So like it or not, the federal government already has two feet in the jurisdiction of pharmaceuticals. But yes, absolutely, in terms of moving forward, we need to have the collaboration of the provinces. Right now we have some great steps with the pan-Canadian Pharmaceutical Alliance, basically a creation of the provinces, wanting to move forward. Right now there's an open hand, basically, from the provinces, and I think the context is just great to build this collaboration to move forward with the provinces.

Ms. Rachael Harder: Thank you.

The Chair: The time is up.

Mr. Kang.

Mr. Darshan Singh Kang: Thank you, Mr. Chair.

Thanks to all the witnesses for coming here today to enlighten us on the things that we probably don't know.

Dr. Martin, you were talking about patients demanding drugs from doctors. I have a family doctor, and whenever a patient walked in and said “I need this medication, Doctor”, he used to say, “I'm the doctor. You're not the doctor, so you don't tell me what to give you.”

I believe there is some abuse in prescribing medications. What kind of abuse is there in the system, when doctors are caving in to the demands of the patient and writing something the patient may not even need, or may end up writing a prescription for an expensive drug the patient may request? What kind of abuse do you think could be there in the system?

● (1705)

Dr. Danielle Martin: Thanks for the question.

There has been quite a lot of study done on what influences the prescribing decisions made by physicians, and also what influences the demands patients make. In fact, one of the most powerful forces in prescribing in present-day North America is the influence of industry.

Some of you who have been following the news recently may be aware that there's quite a lot of controversy about the relationships between the pharmaceutical industry and physicians, and the ways in which industry can influence the prescribing decisions of physicians, such that as a medical community—and certainly as a medical educator I know that this is the case with our educational programs—we are increasingly trying to move away from allowing industry to have a big influence on the way we educate physicians about how to prescribe. Again, we want those decisions to be made based on medical evidence as opposed to marketing. Some of the marketing that goes on can be linked to education, or the education can be linked to marketing, in ways that I think are increasingly making the medical profession uncomfortable.

Similarly, there's quite a lot of evidence with respect to direct-to-consumer advertising. As you probably know, it's not legal currently in Canada for pharmaceutical companies to advertise their products directly to Canadian patients, but Canadian patients tend to consume a lot of that advertising through American television and other sources, and that can also have an influence.

But actually, one of the many things that influence prescribing decisions among physicians is habit. There are many thousands of drugs on the market today, and most of us get comfortable with a number of them. We really understand the side effects and the mechanisms and how they interact with other drugs or whatever. Most physicians tend to prescribe the same small number of drugs over and over again. That's why we need to make sure that the education we get from the outset is based on sound evidence, and use the formulary to make sure that those initial decisions we make are good ones, and then educate patients. I actually think that some interchange between physicians and patients about prescribing is good. I welcome my patients questioning me and pushing me about what they want to have, but those conversations need to be based on the best medical evidence as opposed to marketing from industry, and I think that's where some improvements need to be made.

Mr. Darshan Singh Kang: I could go on and on about this.

My next question is for Mr. Morgan.

Say we bring in pharmacare. Everybody should be covered. There should be no deductibles. You were saying something about people being allowed to have private insurance on the side in case the medication they need is not covered under pharmacare. Here we're trying to come up with one universal coverage, but at the same time, we are opening the door a crack for a little private coverage on the side, too.

Should we have that little private coverage on the side? That's my first question.

My second question is, should there be any means test to stop abuse? If it's free, people will think they should be able to get any medication.

I just finished talking with Dr. Martin about doctors caving in to the pressure of the patients, right? There will be some abuse of the system. Don't you think there should be some means test?

Dr. Steven Morgan: I strongly disagree with means testing of a universal drug benefit.

If a drug is deemed to be safe and effective at addressing legitimate health care needs and it represents value for money from a public health care system perspective in how we address those health needs for a Canadian, it shouldn't matter where they live, where they work, and what their income is in terms of their accessibility for that medicine.

There have been a number of provinces in recent years that have implemented income-based drug plans, otherwise known as catastrophic drug coverage, under the idea that we shouldn't be giving medicines away for free to people with higher income.

There are two problems with that. One, as I mentioned earlier, it means that everyone faces charges, or people with a higher income face charges that may dissuade them from taking the very medicines we really want them to take, preventative medicines that keep them out of hospital. The second problem is it breaks down the willingness of those with middle and upper incomes to support a universal drug benefit: they pay higher taxes, so shouldn't they also get essentially equal benefit? There are clinical, economic, and perhaps ethical grounds to avoid means testing of a drug benefit.

I think on those grounds what we want to think about is that it's a paradigm shift for Canada. It's changing our dialogue about pharmacare from which particular Canadians are going to have access to virtually every drug to which particular drugs are so deserving that every Canadian should have access to them.

Under that latter model—and I know Danielle has written about these sorts of options—we could envision building pharmacare in planned stages, probably using a planned budget increment, starting maybe at $10 billion for the national program, perhaps as much as $2 billion of which would come from the federal government and the remaining money from provinces and through other contributions, like copayments, and moving towards the $20-billion or $25-billion program down the road that we would need for truly comprehensive coverage.

As you rolled it out in that kind of planned fashion, of course there would be room for the private insurance industry to continue to offer drug coverage for things that aren't in the first phases.

If all of the evidence that we've gathered from other countries is correct, I believe that Canadians will actually see that a program can demonstrate value as it's rolling out. As a consequence, I think you will find that Canadians will continue to support the program and support its expansion.

● (1710)

The Chair: Mr. Webber.

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

Thank you, all, for coming today. I appreciate it, particularly Mr. Gagnon, and your summary sheet that you distributed to all of us before this meeting today.

I appreciate that, Chair, and I just want to perhaps suggest that for any one of our future guests who come here, is there any possible way we can get documents from them, their reports?

Robert mentioned the “Pharmacare 2020” report by Mr. Morgan. That will be released to us. It certainly would have been nice to get that beforehand.

My suggestion is that at any future meeting, if we can get as much literature as we can, I would certainly appreciate that.

The Chair: I don't know. I'd like to have copies of all their presentations if that's possible, because they were really.... That's a start.

Mr. Len Webber: Yes, exactly.

Again, thank you all for coming.

Mr. Morgan, I was interested in hearing your comments about the number of diabetics who are dying because they choose not to purchase medication. Perhaps because of low income, they can't afford the medication.

I don't know too much about catastrophic drug plans and how they work, but each province is responsible for catastrophic drug plans. Could you talk a bit about how the catastrophic drug plans kick in?

Dr. Steven Morgan: Yes, every province is responsible for its own drug benefits. We have no binding commitments between the federal and provincial governments around national standards, and so provinces run their own programs, which are very different.

Ontario, which is where that study was conducted, offers relatively comprehensive—in fact, "Pharmacare 2020"-like—coverage for persons age 65 and older. Under the age of 65 people in Ontario fall into the mix of private and public coverage that has been standard in Canada for so many years: voluntary private insurance for people who work in occupations that offer that as an extended health benefit, and then catastrophic coverage from the province for people who don't have private insurance.

That catastrophic plan which Danielle described has a 4% of household income deductible, which is thousands of dollars. It was an interesting study scientifically. In that Ontario study they compared people younger than 65 with diabetes with people just over 65 with diabetes and used the change in benefit structure that comes with that age of being entitled to public coverage as the mechanism of demonstrating the value or the increased access that comes with coverage. It is on that basis they were able to infer the number of diabetics who are skipping their medicines because of the costs when they are under 65 versus those over 65 who don't face those barriers. It is from that they were also able to infer the premature deaths.

I have similar work coming out later this summer from British Columbia looking at a similar study design based on our income-based drug plan, which has an accident of history. People born in 1939 or older got better coverage than people who were born after that date, and it's because in some sense they literally grandfathered the more comprehensive coverage that B.C. used to provide for seniors.

● (1715)

Mr. Len Webber: Interesting. Please finish that report and let us have it.

Dr. Steven Morgan: I'm sure we all have probably a half dozen we can send you over the course of the coming months.

Mr. Len Webber: Yes, exactly.

I want to talk about our provinces and the silos in which we tend to work within our health care system, and the fact that a universal pharmacare purchasing power, by bringing all the provinces and territories together, would certainly be beneficial.

Mr. Gagnon, on your statistics with regard to how Canada ranks very poorly when it comes to drug costs and such, it just makes sense that we come together as a country to purchase our drugs.

I'm going to mention organ and tissue donation. There is clear evidence that our provinces and territories work in silos with respect to sharing organs and tissues, and I find it very frustrating. We, as the federal government, should work toward having an overarching system as well when it comes to organ and tissue donation. I know we are talking about pharmacare here, but it's just the attitude. Mr. Gagnon, you said it is constitutional, that the provinces have their jurisdictions and that the feds should not step into their jurisdictional areas, but I think this is something that all provinces and territories need to discuss and they need to move forward with bulk purchase power buying.

I think about Quebec, for example, who run their own—I'm back to organ and tissue again. There is very much a silo in Quebec when it comes to organ and tissue donation. I just don't understand it.

Ms. Prémont, with your experience in Quebec, maybe you could talk about why there are silos throughout the country, in particular in Quebec.

Dr. Marie-Claude Prémont: This is a very important question that you're asking. I think this is one that we did tackle historically as a country. Don't forget that the Constitution says hospitals are under the jurisdiction of the provinces. It's specifically written, yet we did manage to implement a public health care system across the country, respecting the Constitution and the jurisdiction of the provinces.

I don't know what should stop us from doing the same thing with drugs. We just need to have a bit—maybe a lot—of the political will to go ahead, I think, in facing the difficulties that every single province is facing now with this, and which Canadians are facing with the current situation. I include Quebec in that, because people recognize more and more that the system is not sustainable. The cost has been increasing steadily since its implementation. The portion that was supposed to be self-funded is really obviously not self-funded, far lower than 30%.

I agree with Steven that now is the time to get our act together, including Quebec. I don't speak for Quebec, of course. I only speak on my own here, but I think the time is right to revisit that and see how all the provinces and territories should get together to improve the situation of every province.

Mr. Len Webber: Yes, absolutely.

The Chair: The time is up.

Dr. Eyolfson.

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

Thank you all. These were amazing presentations. They gave data to things that I had thought intuitively were the case from my medical practice. I've had anecdotes, and Dr. Martin, you could probably share many of these with me as well, of treating a patient with diabetic ketoacidosis in the emergency department when they couldn't afford their insulin. If that patient ends up in the intensive care unit, the cost for that one hospital visit probably exceeds a lifetime of that patient's insulin. That being said, we also know that the plural of anecdote does not equal data.

It's believed by many practitioners that the initial investment of a pharmacare program would eventually be offset by savings to the system, by just improved health and decreased hospital costs. In any of your reports, is there any data or any numbers that could say what the upfront costs, the ongoing costs, and the long-term savings would be to the public purse for such a program?

● (1720)

Dr. Steven Morgan: I'll take that on because of the study that we published in the *Canadian Medical Association Journal* about how much it would cost to provide a reasonably comprehensive drug benefit for the community in Canada. That's not including hospitals and long-term care, but in retail pharmacy we estimated that the direct increased cost to governments was $3.4 billion, if I recall correctly, $2.4 billion of which would be recouped in some sense by reduced cost of the taxpayer-financed extended heath benefits for public sector employees, including, likely, all of you and myself. It's about $3.4 billion to expand the program and to generate about $8 billion in savings to the private sector by way of reduced need for them to be paying either out of pocket for their medicines or a reduced demand on private insurance for drugs.

In and of itself, the program paid for itself. But we didn't—and we make note of this in the *Canadian Medical Association Journal* article—take on the second argument that you are raising, which is a very important one, the argument about the incremental effect on our health care system. There are very good trials that have demonstrated that lowering the copayments for even relatively wealthy insured beneficiaries of private insurance in the United States improves access to preventative treatments and reduces the demands on medical and hospital care sufficiently so that, in the U.S. market, that's revenue neutral, not accounting for the savings in prices that one gets for it.

It's almost certain that this program would pay for itself, in some sense twice, once by way of increased purchasing power, and twice by way of better health for patients and therefore a reduced demand on the health care system.

Do I think we're going to see savings actually realized in health care? No. But I think we'll see health care resources being able to address other unmet needs in health care, and that would be a great thing for Canadians.

Mr. Doug Eyolfson: All right, thank you. As I say, it's nice to know my assumption actually had some basis to it.

Dr. Martin, one of the things I've noticed, and again, I have noticed it in my individual practice, is that doctors very often when they write prescriptions know that patients are going to have trouble affording medications. I practised emergency medicine in the core of Winnipeg where there are a lot of poor patients.

Would you say doctors are spending a significant amount of time on workarounds to try to make sure their patients can afford the medications they need?

Dr. Danielle Martin: Thanks for the question.

In fact, we've just completed a study on this that is under peer review and we hope will be published relatively soon. In that study we looked only at family physicians, including family physicians who practise emergency medicine, but I suspect that the data for specialists will not be all that different. We did find, unsurprisingly, that physicians report quite a lot of time spent, and quite complex—what I think of as unnecessary—workarounds to try to get medicines for their patients.

The kinds of examples that I referred to in my presentation are not just anecdotal from my own practice, but come from qualitative research and from speaking to family physicians across the country who talk about the kinds of things that they have to do. They talk about giving patients samples and interacting with drug reps in order to get samples, changing the prescription that they're writing from the medicine that they think their patient actually needs to the one that they think their patient is actually going to be able to afford, applying on behalf of their patients for compassionate access through a pharmaceutical company for a medication that their patient can't afford, and just purchasing the medicine for the patients themselves. It's amazing how many physicians will report that at some point in their career they've done exactly that, just bought the medicine for the patient. Pharmacists, I know, report the same thing. You know the old story: "Don't worry, I'll just tell my boss that I dropped it on the floor and had to throw it out. Don't worry about it. Just take the pills home."

There are all kinds of workarounds that are going on that well-meaning health care providers are engaging in across the country in order to try to get access to medicine for Canadians who need it. When you think about the wasted—never mind the wasted money—energy that it entails, that energy would be much better spent directed at patient care. I think it just adds to the importance of this conversation.

● (1725)

Mr. Doug Eyolfson: Thank you very much.

Thank you, Mr. Chair.

The Chair: Madame Sansoucy, again, you have three minutes.

[*Translation*]

Ms. Brigitte Sansoucy: Thank you, Mr. Chair.

My question is for Dr. Gagnon.

We know that some people do not fill their prescriptions because the drugs are too costly. This leads to other health problems for them. Do we know what the cost of this is to the system itself?

Dr. Marc-André Gagnon: That is something that hasn't been studied much. There are estimates, but so far the results differ greatly.

For example, some studies in the United States show that if more drugs were covered by the plan, there would be fewer hospitalizations. In fact, this argument is being used to state that more and more new drugs should be covered. However, the reality is something very different. The number of hospitalizations is significantly lower when there is greater access to drugs, particularly for lower-income individuals.

It is clear that the costs will drop when patients better follow their treatment. We see it fairly systematically, even though it sometimes means fewer choices when it comes to drugs. A new study—and I can send you a copy—was recently published by CVS, an American chain of pharmacies. It shows that, in terms of health outcomes, using a more restrictive formulary to reduce costs can make access to some drugs more difficult for certain patients. That creates a problem. Moreover, health outcomes are improved through better adherence to treatment than for other patients.

So a more limited formulary does not have an impact on the overall population, but can make a difference in specific cases.

Ms. Brigitte Sansoucy: Some people are against setting up a pharmacare plan—

[*English*]

Dr. Steven Morgan: Could I just add, just so you know, in 2013 the British Columbia Pharmacy Association reviewed literature on the financial impact of access barriers because of cost in the Canadian health care system, and as Marc-André suggested, there's not a great deal of literature, but they found estimates that range between $1 billion per year and $9 billion per year. Even if you just take the low end, that's a significant burden on our health care system. At the high end, it may still be realistic, given the numbers of diabetic deaths that the Ontario research study suggests have happened as a function of access barriers. It could really be as much as $9 billion a year.

[*Translation*]

Dr. Marie-Claude Prémont: I would like to add that a study was done in Quebec when the plan was introduced in 1997. In its first version, the plan provided that people entitled to free access to drugs, including social assistance recipients, would now have to pay the required deductible and co-insurance.

Professor Robyn Tamblyn from McGill University and others have conducted studies to measure the impact on the number of hospitalizations caused by the fact that people could not pay for the drugs they needed. So specific studies have been done on this.

Ms. Brigitte Sansoucy: Some people who are opposed to the pharmacare program believe that it will lead to drug shortages. Could that happen?

Dr. Marc-André Gagnon: I would like to answer that question.

I provided my opinion to the Government of Quebec, which put in place a bidding system for manufacturers of generic drugs. I should point out that this is where there are the most shortages.

It's true that some people feel that if prices are lowered, there would be more shortages. You need to be careful with that kind of statement. When it comes to generic drugs, how the supply system is organized is important. For example, if you launch a call for tenders for generic drugs and provide specific provisions to ensure the safety of the supply, that will help reduce costs while improving the safety of the supply. That's the case in Sweden and New Zealand. The cost of generics is a third of what we pay in Canada. Despite that, there are far fewer drug shortages there.

As for drug access, people think that if you pay more for a drug, it will be easier to access. That isn't the case at all. Standards are used, such as that of quality-adjusted life years.

● (1730)

Let me give you an example.

A government agrees to pay $50,000 for a drug because of the quality-adjusted life years. The manufacturer of a new drug decides to make the rate $100,000 instead. If the government in question agrees to pay that amount, every company will then ask $100,000. Indeed, agreeing to pay more won't solve the access problem. It will only push back the problem, which will come up again later.

If you continue to accept the increases, you'll only encourage people like Martin Shkreli, who is selling a drug for 50 times more than he should because he says that people are crazy enough to pay it. So that creates more problems with drug access and shortages. The large pharmaceutical company Valeant pretty much follows the same business model. These are predatory dynamics in the system in Canada, and we have no protection against it.

[*English*]

The Chair: The time is up.

We are done.

I really want to thank the panel, because you have given us a lot of incredible information. As we go forward, we would welcome anything you have, because we are serious about this. The information that comes from this committee will help determine the future of this possibility. We really would appreciate anything you have, either now or as you finish it. We would like to have any information you could provide to us.

I want to thank the committee, too, for the great questions and the way this has gone.

Everybody went over-schedule, and everybody broke the rules, but it was well worth it.