Evidence for Senate

Please accept this as evidence for the SOCI committee hearings on Bill C-64. I have written this submission in the form of a frequently asked questions document because there are a number of important matters related to national pharmacare about which the committee will hear conflicting testimony. Indeed, if recent hearings at the HESA committee are any indication, the SOCI committee may hear deliberately incomplete and/or misleading testimony from some witnesses. The questions and answers are meant to address that risk.

Respectfully,

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Q. Some think tanks and analysts argue strongly against a universal, public pharmacare system. Is this a matter about which there is serious debate among unbiased experts?

A. No, there is relatively little debate among unbiased experts concerning the benefits of a universal, public pharmacare system. When hearing dissenting voices, one should be very careful to scrutinize the evidence and potential conflicts of interest.

There will always be some level of disagreement over matters of public policy. That said, government must be aware of the subtle and not-so-subtle ways in which powerful interests in the pharmaceutical and insurance sectors can influence the narrative coming from think tanks, analysts, and even some patient groups.

One way to gauge the reliability of claims about pharmacare programs is to ask whether the evidence is peer-reviewed and published in reputable journals. (Be careful not to equate “journals” created by think tanks for reputable scholarly outlets.)

Another way to gauge the reliability of claims about pharmacare programs is to ask questions about conflicts of interest of those making the claims. The obvious conflicts are when individuals and organizations receive funding directly from insurers, pharmaceutical manufacturers, or pharmacy chains. Less obvious conflicts can also occur when individuals are paid to produce reports, give talks, or provide advice to think tanks or charities that, in turn, are funded by insurers, pharmaceutical manufacturers, or pharmacy chains. Some people don’t declare such conflicts but the conflict exists nevertheless.

Q. Are relatively few of the drugs on the world market currently available in Canada? And will a universal, public pharmacare system lead to fewer drugs being available to Canadians?

A. No, such claims are based on biased data and methods.

Industry associations and analysts and think tanks they support have claimed that Canada only receives a minority of new medications brought to the world market; however, those claims are based on data and methods that overstate international differences in product launches. According to the data and methods used in the studies on which such claims are based, even the best performing countries outside the USA (such as Germany, Japan, and the UK) only receive about half of the medications brought to the world market. (See, e.g., http://www.rand.org/t/RRA788-4)

These peculiar findings occur because ***nearly half of the drugs launched anywhere in the world are not launched truly globally.*** For example, about one in five drugs launched anywhere in the world is actually launched only in the USA and nowhere else; and about one in four drugs launched anywhere in the world is launched in either Europe or Japan but not in the USA.

The reason for this is that many new drugs with uncertain clinical or economic value are selectively launched in a test market (typically the USA, but also Japan, Germany, or other countries for a variety of strategic and logistical reasons). But many of those test launches end up failing – perhaps for good or perhaps only to be reformulated before being relaunched at a later date. This test launces of new products are of little clinical or economic significance, which is why they fail to be launched globally.

There are some studies that have done a better job of assessing drug availability and coverage in the scholarly literature. In 2020, peers and I published a systematic review and critical appraisal of the peer-reviewed literature on international variations in the availability and coverage of medicines. We found that international differences in the availability and coverage of medications are small. Studies assessing variations in coverage of all licensed medicines found lower rates of cross-national coverage variation than studies of coverage for selected specialty drugs and indications. ***That is because drugs with unequivocal evidence of comparative safety, efficacy, and value for money are available and covered in virtually all high-income countries, including Canada.*** That systematic review can be found here: https://pubmed.ncbi.nlm.nih.gov/31926652/

My own research suggests that a national formulary need not be a cause for concern in terms of drug access. On the request of the Advisory Council on the Implementation of National Pharmacare, I conducted a 2018 analysis to inform questions about the effects of a national formulary for Canada. In that analysis, I calculated the share all prescriptions written in Canada that would be covered if the national formularies of six comparator countries were adopted here. The countries in question were Australia, France, Germany, the Netherlands, New Zealand, the United Kingdom, and the USA (using the national formulary of the Veterans Health Administration as an example of a restricted national formulary in that country).

I calculated two ways of depicting coverage. The first was the share of all prescriptions written in Canada that would be covered if Canada adopted the national formulary from any one of those countries because the exact same medication is on the formulary of the comparator country. This is what I term as "identical coverage" on the foreign formulary. The second measure was the share of all prescriptions written in Canada for which a comparable treatment would be covered if Canada adopted the national formulary from any one of those countries because at least one drug from the same chemical subclass is on the formulary of the comparator country. This is what I term as "comparable coverage" on the foreign formulary.

Here are the findings:

	Share of Canadian prescriptions with identical coverage on the foreign national formulary	**Share of Canadian prescriptions with comparable coverage on the foreign national formulary**
Australia	91%	100%
France	92%	98%
Netherlands	96%	99%
New Zealand	81%	98%
US Veterans Administration	91%	99%

The table above shows that at least 81% of all prescriptions written in Canada would have identical coverage under national pharmacare if Canada adopted the national formulary from any one of these comparator countries. If we adopted any one of the formularies from Australia, France, Germany, the Netherlands, the United Kingdom, or the USA, more than 91% of prescriptions written in Canada would be covered.

Moreover, at least 97% of all prescriptions written in Canada would have comparable coverage under national pharmacare if Canada adopted the national formulary from any one of those countries. That is, at least one drug from the same chemical subclass would be on the comparator formulary even if the exact drug prescribed in Canada was not licensed or not covered in the comparator country.

That analysis of international formularies can requested from Health Canada. See here: https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/implementation-national-pharmacare.html

Q. Can a universal, public pharmacare system actually lower generic drug prices given the pan-Canadian Pharmaceutical Alliance (pCPA) is already functioning as a "bulk purchasing" system?

A. Yes, a national pharmacare system can lower prices – while better ensuring security of supply – because the pCPA does not engage in bulk purchasing. It "negotiates" a non-competitive, sector-wide generic pricing framework that results in high prices and no assurances of security of supply.

In 2017, the Auditor General of Ontario found that pCPA-approved generic drug prices at retail pharmacies were nearly double (85% higher than) prices for the same drugs in Ontario hospitals, where provincial law requires competitive bidding for supply contracts. That report can be found here: https://www.auditor.on.ca/en/content/news/17_summaries/2017AR%20summary%203.09.pdf

In 2017, colleagues and I published a peer-reviewed, Canadian Medical Association Journal (CMAJ) article in which we compared pCPA-approved prices for generic versions of essential medicines to the prices secured through competitive pricing processes run by the national purchasing authorities for the Veterans Administration in the US, Sweden's national health insurance scheme, and New Zealand's national pharmacare program. We found that pCPA-approved Canadian prices were 1.89 times higher than the prices achieved by the US Veterans Administration; 2.50 times higher than the prices achieved by Sweden's national health insurance scheme; and 6.25 times higher than the prices achieved by New Zealand's national pharmacare program. That article can be found here: https://www.cmaj.ca/content/189/8/E295

In preparation for this hearing, on 14 September 2024, I compared Canada's pCPA-approved generic drug prices (as listed on Ontario's provincial formulary) with prices in New Zealand (as listed on the PHARMAC Schedule). I did the comparison for the top 50 generic drugs in terms of public drug plan spending in 2022. The list of 50 drugs comes from Appendix F of this 2023 PMPRB report: https://www.canada.ca/en/patented-medicine-prices-review/services/npduis/analytical-studies/compassrx-9th-edition.html

To ensure accuracy of unit cost calculations, I focused on oral solids – e.g., drugs sold as tablets or capsules – available in a common dose in both countries. This resulted in a sample of 32 different types of generic drugs that public drug plans in Canada spent approximately $925-million on in 2022 (including estimated spending for Quebec). Prices were converted to Canadian dollars using exchange rates. Results do not include markups.

***As of Sept 2024, pCPA-approved prices for these generic drugs were 5.9 times higher than prices in New Zealand*.** Put another way, if the pCPA achieved prices equivalent to those achieved by New Zealand's national pharmacare program, public drug plans in Canada would save $770-million per year on these 32 generic drugs.

Interestingly, for 14 of the 32 generic drugs this sample, the manufacturer who won the competitive tender to supply New Zealand also sold the same drug and dosage form in Canada. The average price of these generic drugs sold by the same manufacturer in both countries was 5.2 times higher in Canada than in New Zealand.

Thus, because the non-competitive price negotiations between the pCPA and generic manufacturers do not come even close to the prices secured through competitive tenders in Canadian hospitals and in comparable countries, I would conclude that there is plenty of room for further price reductions on

generic drugs – without sacrificing security of supply – by way national procurement under a universal, public pharmacare program.

Q. Would it be a good idea to allow private insurers to receive the confidential price rebates negotiated by public drug plans in Canada?

A. No. Unless private insurers are willing to be bound by the public formularies used to negotiate these prices – that is to only offer coverage for drugs on the public formulary – doing so will increase the prices paid by public drug plans and give private insurers confidential rebates that government could not ensure would be passed onto plan sponsors.

Unless you bind private insurers to the public formularies used to negotiate prices, giving them the confidential prices negotiated by public drug plans make them a "most favoured nation" in terms of pricing – they get the best price deals even though they will purchase the product regardless of what prices are. This will increase drug prices under public drug plans because it effectively doubles the value of any rebate given to the public drug plans.

Canadians do not need to look elsewhere to find evidence of this. In 1993, Quebec passed a most favoured nation law requiring that the price charged for any drug in Quebec be no higher than the best available price anywhere else in Canada. This didn't lower prices in Quebec – as one might naively hope it would do. Instead, it increased prices in other provinces that were actively negotiating drug prices at the time, such as Saskatchewan, where prices increased by 10 percent. The same will happen to public plans if private insurers get publicly-negotiated price rebates without being bound to the public formulary. See here for a discussion of the Quebec policy: https://unbscholar.lib.unb.ca/bitstreams/45cf14b4-ae9b-422c-bdee-57586bd05219/download

Q. Why should provinces go along with a national program? Why can't they do this on their own?

A national strategy for financing and procuring important medications for all Canadians will improve Canada's purchasing power and capacity to ensure security of supply.

Around the world, countries are finding it increasingly difficult to assess the value, negotiate pricing, and secure a stable supply of medicines on their own. This is because the pharmaceutical sector has grown more complex over recent years, with growing market power of manufactures, less transparency of pricing information, less robust pre-market clinical trial data (owing to regulatory pathways that expedite market authorization for many new drugs), and list prices that defy conventional logic concerning reasonable thresholds of value-for-money in health care systems. Countries are therefore binding together to help with pharmaceutical assessment and even pricing policy.

BeNeLuxA – involving Belgium, the Netherlands, Luxemburg, and Austria – and the Nordic Pharmaceutical Forum – involving Finland, Iceland, Norway, Sweden and Denmark – are examples of countries working together to better manage pharmaceuticals in their health care systems. They do this because they can better manage pharmaceutical pricing and better assure their countries of a secure supply of necessary medicines if the work together. In the language of BeNeLuxA, they are working together to "provide sustainable access to innovative medicine at affordable cost for [their] patients."

Canadian provinces can do the same – for their entire populations – through a universal, public pharmacare system. Federal funding – whole or in part – for medications on a national formulary would help bind the federation together against pressures from industries that benefit from pharmaceutical policies that leave our provinces and territories divided and our purchasing power fragmented.