INNOVATIVE MEDICINES CANADA | MÉDICAMENTS NOVATEURS CANADA

President's Office | Bureau de la présidente

October 7, 2024

Senator Ratna Omidvar
Chair, Standing Senate Committee on Social Affairs, Science and Technology
Senate of Canada
Ottawa, ON K1A 0A6

Via email: ratna.omidvar@sen.parl.gc.ca

Dear Senator Omidvar:

On behalf of Innovative Medicines Canada (IMC), I am writing to thank you for the opportunity to present to the Standing Senate Committee on Social Affairs, Science and Technology (SOCI) as part of its study of Bill C-64, An Act respecting pharmacare. I am pleased to provide further data and information in response to several questions from Committee members.

Senator Osler asked, "Do you have data that shows that faster access to new medicines reduces health care system costs, or translates to better health outcomes for populations, especially Indigenous, Black, or racialized patients?" There is academic literature examining how access to new medicines reduces health care system costs and translates to better health outcomes. For example, Lichtenberg (2019) found new drugs reduced the number of disability-adjusted life years lost in 2016 by 2.31 million, and reduced length of hospital stays by 16%. Another example from a 2022 C.D. Howe Institute study estimates that COVID-19 vaccines were highly effective at reducing COVID-19 cases, hospitalizations and deaths, and that the estimated lives saved by vaccines (using the statistical value of life) are valued at $27.6 billion. These are just two examples of the positive impact that timely access to new treatment can offer to patients across the country, by providing physicians with options to treat a variety of conditions. In the case of rare diseases, some of these conditions have not had any effective treatment prior to the introduction of an innovative new treatment.

In Canada, Indigenous and racialized patients have been shown to have worse access to health care, receive poorer care and have worse outcomes than White people. Black people account for only 5% of clinical trial participants while White patients make up the vast majority. It is much more likely to have diverse patient participation in the development of newer treatments than in those of older, now generic drugs. Therefore, new treatments can provide more certainty of being efficacious in racialized communities

The second question posed by Senator Osler asked for ways in which the pharmaceutical industry could collaborate with governments to ensure the agreed upon list of essential medications is provided to a national pharmacare program at the lowest possible cost. As I stated during my testimony to the Committee, Canadian prices for patented medicines are already competitive with peer countries. Drug manufacturers engage with provincial drug plans through the pan-Canadian Pharmaceutical Alliance (pCPA) to negotiate pricing, supply, and listing agreements.

The most recent PMPRB annual report also noted Canadian prices are in line with comparative PMPRB11 countries, with 6 of the 11 countries having prices within +/-10% of Canadian prices. The report also noted:

- "Changes in the prices of patented medicines have played a minor role in the growth in patented medicine sales over the last several years, suggesting that, on average, the prices of existing patented medicines are fairly stable." (p. 31)
- "General price inflation, as measured by the CPI, has exceeded the average increase in the prices of patented medicines almost every year since 2003." (p. 46)

It is important to note that cost should not be the ONLY criteria used when selecting treatments for Canadians. As I specified during my testimony, treatments should be personalized to individual patients and innovation provides optionality to ensure physicians have a choice to select the appropriate treatment for their respective patients.

We maintain that a pharmacare program akin to the program implemented in Prince Edward Island in 2021 would allow for each province to have a tailored pharmacare program that would address their individual population needs, while costing the government less and ensuring access to more medicines. As I stated in my testimony, 97% of Canadians already have access to some form of drug coverage, and 10% of the population is not enrolled in a public or private plan that they are eligible to enrol in. The pilot project in PEI allowed them to use federal funding to improve access to 61 new drugs across a broad range of therapeutic areas, without disrupting the employer-sponsored drugs plans that some residents already had. By targeting the populations who were uninsured and/or underinsured, the government was able to ensure that more residents had access to more medicines in a timely and cost-effective way. The government stated in their release announcing this pilot project, "the Government of Canada will use early lessons from PEI's efforts to inform its ongoing work to advance national universal pharmacare. This agreement will also build on the ongoing work to develop a national strategy for drugs for rare diseases." We believe that the government should heed its own advice and pursue a similar approach at the national level would offer similar benefits to all Canadians, without impacting the existing employer-sponsored coverage that 27 million Canadians already benefit from.

In closing, allow me to reiterate our industry's support for a pharmacare program that would increase access to medicines for those who currently need it most, while protecting existing drug coverage. We remain open to opportunities to collaborate on such an effort and are available to provide additional information should you require it.

Sincerely,

Bettina Hamelin, PharmD, EMBA in Healthcare
President, Innovative Medicines Canada

cc: SOCI Committee, soci@sen.parl.gc.ca; Emily Barrette, Committee Clerk, emily.barrette@sen.parl.gc.ca