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PHARMACARE

Notes for Meeting with Your MP or MLA/MPP/MNA

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The Cameron Institute is a non-partisan, not-for-profit, public policy think tank specializing in the independent study of health, social, and economic issues. It is the goal of The Cameron Institute to provide decision makers with analyses that will better inform choices. The Institute is also dedicated to educating and better preparing patients, providers, and payors to make appropriate clinical decisions.

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This document is comprised of 3 parts for you to use when speaking with your political representatives re comprehensive drug coverage for all Canadians:

1. The **full 9-page paper** that dispels the myths about so-called pharmacare, as it is being proposed;
2. An appendix that includes our **principles for universal, comprehensive drug coverage**; and
3. **A one-page summary** for your political representatives and their staff as an introductory piece for meeting(s) and as a **"leave-behind"** afterwards which can be found in a separate PDF file on this website.

We hope that this helps you persuade others that pharmacare as proposed is NOT acceptable to Canadians and what we really need is universal, comprehensive drug coverage.

NOTES FOR MEETING WITH YOUR MP OR MLA RE PHARMACARE

BACKGROUND

Federal quiescence on the issue of universal, comprehensive drug coverage is a serious concern for all Canadians. After all the discussion at the House of Common' Standing Committee on Health (the Casey Committee) the outcome is that something should be done by someone, that it should be a voluntary system with first dollar coverage, but with a lack of clarity on who is to pay.

There is a lot of conventional wisdom that is not wisdom when it comes to so-called pharmacare, as it has been recently framed in the media by government academics. Below is a list of myths with respect to drug benefit programs. While there may be some truth in some of them, no definitive substantiation has been given for any of them. On the other hand there is a lot of evidence that they are in fact myths.

This note is for anyone planning to meet with their local MP or MLA/MPP/MNA to discuss the future of drug coverage in Canada. It helps to dispel myths in favour of the facts and offers insight into the real challenges facing us.

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A major issue is the misbelief that if we do national purchasing we will save so much money that it will support a national drug benefit program.

- A bulk purchase saving is a onetime saving, benefits paid out continue for years.
- Adding drugs to a benefit program increases the number of beneficiaries and the number of drugs prescribed. The impact is a rapid increase in

utilization. This was first evidenced back in 1975 with the Saskatchewan universal drug benefit program.

- More recently, the head of the Veterans Administration in the US stated that their biggest problem is drugs. As the biggest drug program in that country they get a 22% discount from list price for all drugs. (This is the goal of the Canadian program). They ship tons of drugs from VA hospitals to veterans by mail at no cost to the patients. This is the least expensive way of distributing drugs and has been in place for over 50 years (and has been contemplated by the Ontario government). The problem is that they have NO idea of how beneficial the medication has been to the patients. Some is used properly, some is misused, some is diverted or sold, some is saved but not used, some is discarded and some causes serious toxicity that is a major expense for VA hospitals. This is the model that Canada wishes to follow?

Conventional wisdom is that reducing drug prices is the key to reducing drug expenditures. Wrong.

- CIHI has shown that utilization is the major cost driver not price. Utilization is the measure of health care quality and drug safety. Why is it being ignored?

- Negotiations do not result in a saving every time. Failed negotiations result in a decision NOT to purchase a drug which means that some drugs will NOT be available to those who need it. The more you save in negotiations on one hand the more people do without medication on the other band.

- There is a relationship that has been ignored between the availability of new drugs and the prices of drugs in a country. While New Zealand is the poster child for cheap drugs the population have access to only 13% of new drugs compared to about 65% in Canadian public programs and over 90% in most European nations. Who do we want to be more like?

- The purpose of drug benefit programs is to reduce the financial barriers to care. Buying a lot of cheap drugs that the patient could afford to buy does not meet this objective. Reducing the price of new expensive drugs is not a

viable solution if government is not paying for them. A family that cannot afford $40,000 per year for a new drug cannot afford $35,000. The statement by government that they cannot afford to pay for the drug is misleading; it creates the false impression that patients can afford to pay for the drug. Use of a deductible where patients pay full price does not reduce financial barriers. Product Listing Agreements (kickbacks) do not reduce drug prices.

- Public programs exist to improve health by paying for health care. This concept appears to be lost in discussing pharmaceuticals. There is no discussion of health improvement.

- There is no evidence that a lot of cheap drugs provide better health care than newer drugs. There is evidence that new, expensive drugs do provide better care.

- The "wisdom" that drug prices are too high and that we cannot afford them misses the fact that the prices are set in competition with the cost of alternative care. Since hospital costs are a major factor for many diseases, pharmaceutical firms set their prices based on the hospital, medical and diagnostic alternative. If the drug is NOT purchased the cost of care remains the same but with the added disadvantage that the wait times are not reduced. (The wait time for a new drug coming to market is measured in years for most public programs.)

- The other disadvantage is that when the patent on a drug runs out the price drops substantially but the value remains. With a national program in place, if we do not buy a new product there will not be an established market in Canada and when the patent runs out it will be very difficult to create a market for generic versions.

- There is a belief that drug prices are increasing. This is occurring in the United States but not in Canada. The Patented Medicine Prices Review Board (PMPRB) and the provinces prohibit increases in price of pharmaceuticals. When a new drug comes to market its price has not increased as it did not have a price before coming to market.

- The higher price of new drugs compared to older drugs is a different story. They replace older drugs because they are better. They have a different value proposition and they need to be evaluated on the basis of their added

value in comparison with the added price. We must compare apples to apples to avoid the fuzzy thinking in this discussion.

Pharmaceutical expenditure takes place in isolation from the role of pharmaceuticals in the health system. Changes in the drug budget are not linked to resulting changes in other parts of the health system. This does not make sense and reflects poor planning and mismanagement.

- Canada's health care system ranks last amongst OECD nations. Reasons for this ranking are: we do not have a universal drug benefit system; we do not have an integrated health care system; and, we do not have an electronic medical record that allows us to evaluate care. To date there has been no discussion of integrating pharmaceuticals into the health care system because it is erroneously part of the conventional wisdom that changes in drug prices and programs will have NO impact on the rest of the health care system.

- Examining best practices involving pharmaceuticals illustrates the interconnected relationship of medication and other health services. With integrated care the use of comparative effectiveness enables the health organization to spend money on the type of care that gives the greatest health care for each dollar spent. We do not have an integrated system and there are few if any performance indicators for pharmaceutical programs.

- The nature of medication is changing. The continued reliance on generics (now 60 years) and bulk purchasing (40 years) is no longer tenable. We need to catch up with the rest of the world in using new approaches such as precision medicine using genomics. While there is talk of these new directions there is no action.

- The federal role in health care and pharmaceuticals is bizarre. Health Canada – charged with drug safety as is the FDA in the US - is showing more interest in drug prices than drug safety. Yes, the Constitution gives the provinces power over hospitals (not health care per se) but the residual

powers clause reserves to the federal government all powers NOT enumerated in the Constitution, such as health care and pharmaceuticals.

- The Patented Medicine Prices Review Board was established 30 years ago as rushed legislation to demonstrate a concern over consumer interests. After 30 years the conclusion was that the program was not effective so a review was conducted based on terms of reference that were linked to the current organization and procedures. The result was administrative changes to increase reporting requirements for firms and to shift the list of comparator countries to include countries that are less similar to Canada and that have poorer access to new medication. There was no attempt to assess the impact of shutting down the program or looking at less bureaucratic approaches. The whole exercise was to reduce expenditures by drug programs not to reduce prices to patient, the original purpose of the program.

- A review of 9 organizations reporting to Health Canada, charged with advising on health issues, revealed poor performance, lack of communication amongst them, and atrophy of imagination. Combining some functions was recommended. It is unclear what action is being taken or what public input is invited.

- A Federal /Provincial agreement on a National Pharmaceutical Strategy was signed in 2004. It set out reasonable objectives and included mechanisms for improving care as well as lower costs. That element of improved care seems to have been lost in the current discussion.

- Legislation for regulating drugs for rare diseases is now 14+ years in arrears and the issue of orphan drugs has been neglected for over a decade and has now been dropped from the Health Canada web site. Orphan drugs treat rare diseases such as Huntington's disease, myoclonus, ALS, Tourette syndrome and muscular dystrophy which devastatingly affect small numbers of individuals. Canada is 35 years behind the US in dealing with orphan drugs.

- Drugs for rare diseases is a rapidly growing sector with over 7,000 rare diseases that are genetic in nature, many of which can have treatments created, but at a high cost for each. Again, Canada is far behind the US in the number of products on the market, and for those on the market the

variance between provinces is growing. New specialty products that are increasingly specific for a narrow range of disease conditions are emerging but are complex and thus expensive. Double blind trials are not possible when there are only a handful of patients with a rare disease. Government must work with the firm developing the product and with other countries to establish the requirements for marketing.

- This is an area that will have a flood of new products in the next decade and there has been little planning for their incorporation into the health system. Health Canada is more interested in negotiating lower prices for medication, an area of marginal responsibility, while areas of health need are ignored.

The report from the Casey Committee is a rehash of conventional wisdom with a lot of misleading generalizations.

- The key element in the Report is the preparation of a national formulary. This is a major flaw as a formulary (a limited list of drug benefits) restricts the medication available to patients. The greater the restriction the greater the number of patients without benefits. There is no evidence that a short list of drugs provides better care than a long list, in fact the opposite is true.

- The determination of the products to be listed on a formulary is based on clinical trials on patient populations that are not representative of the populations using the medication. There is increasing research that real world evidence based on patients with several diseases and several drugs is more appropriate (in the United States the Institute for Clinical and Economic Review has prepared a framework to guide the use of real world evidence for formulary decisions; this has not been used by the committee).

- Overall the Report ignored improved health, integration of care and comprehensive coverage. The major focus is saving money through price reductions and even this is problematic. It is discouraging to see the bias in the report with respect to health systems, where Canada's health expenditures and outcomes are compared only with the United States' private system instead of with the other OECD countries with public systems

wherein Canada ranks near the bottom in outcomes, near the top in expenditures, and at the very bottom re value-for-money. In Europe there is universal coverage with virtually all drugs available, access to primary care, specialist, hospitals, lower health care costs and better outcomes; none of this was discussed in the report supposedly based on expert input.

CONCLUSION

The pharmacare report of the House of Commons' Standing Committee on Health provides no direction, does not clarify the role of the federal government, and discusses drug expenditure levels without linking them to the health care system or to improved health. The report does nothing to close the existing gap between drug benefits and patient needs – in fact, it may even widen it. The gap needs to be closed between drug benefit programs that provide treatment to most people most of the time and health care needs that require treatment for all the patients all of the time. Why is this not under discussion by the Advisory Committee?

The current direction of disease treatment is based on biological entities that are complex, targeted, and more effective and, yes, costly. Why is government so stuck in the past advocating generics (60 years) and bulk purchasing (40 years)?

APPENDIX

PRINCIPLES FOR A UNIVERSAL, COMPREHENSIVE DRUG COVERAGE PLAN

Preamble

Tax-funded, public drug reimbursement plans today are focused primarily on cost-containment. The Cameron Institute proposes that any comprehensive drug coverage plan not be centred on cost containment but rather the following people-focused principles.

1. Comprehensive

Comprehensive drug benefits should include all medication on the Canadian market approved by Health Canada as being safe and effective therapy. It is not appropriate to arbitrarily restrict the listing of drugs in order to reduce programme cost and/or attempt to influence prescribing. There already will be restrictions on prescribing guided by clinical guidelines and safety profiles. Other countries have much greater access to new drugs and this has been a benefit in controlling health care costs and improving health outcomes. A system that excludes drugs that may be required on the basis of cost is not a comprehensive system that puts people first.

2. Universal

A universal, comprehensive drug reimbursement programme would cover all Canadian citizens. Since many people have private insurance coverage there is an opportunity to co-ordinate the public and private systems (as in Quebec and Europe) to ensure universal coverage.

3. Accessible

Access combines two dimensions, geographic and financial. There is an excellent drug distribution system in Canada and all patients should be able to access their medication from a pharmacy of their choice. On the financial side there should not be any financial barriers to receiving medication. Expensive drugs are more affordable to government and employers than to the patient that needs them.

4. Efficient

An efficient system would enable patients to access new drugs coming on the Canadian market in weeks rather than months or even years in many cases. It is not efficient to have multiple clinical-economic assessments in the pharmaceutical system before placing drugs on a benefit list. With respect to administration of the drug programme, administrative costs should not rise more rapidly than the benefit costs.

5. Effective

Effective use of medication enables the health system to improve overall health status. With half the population using medication on a continuing basis there is a tremendous potential for health improvement. Medication is the most common form of care and is extremely important in the health system but little attention is paid to the collective outcome from prescription drug expenditures. Post-market pharmacovigilance could measure the value of comprehensive, universal and accessible catastrophic drug coverage as evidenced in other jurisdictions.

6. Safe

Patient response to medication is quite variable, and in older and paediatric patients even more varied. Since each patient has a different response there needs to be a large number of potential drugs for use and assessment. While a drug may be effective, it may also have side effects which reduce its usefulness as patients tend not to take a medication that interferes with their function and causes discomfort. To achieve effectiveness without side effects is to achieve appropriate therapy and this is an important goal. Increasingly, patients have two or more conditions for which a medication is prescribed. This accumulation of medication raises the risk of toxicity. In seniors the function of organs to handle drugs decreases with age at the same time more medication is being used causing serious health problems.