CELEBRATING 20 YEARS

CAPT ACTP

Canadian Association for Population Therapeutics

National Pharmacare – Part Deux

Moderator: Dr. Judith Glennie

Toronto
Tuesday October 18, 2016

Objective

- Review developments in the Canadian National Pharmacare policy debate.
- Compare the benefits and risks of various National Pharmacare models.
- Obtain insights from key stakeholders on the various approaches under discussion.

Panelists

- Louise Binder
  - Health Policy Consultant, Canadian Cancer Survivor Network
- Glenn Monteith
  - VP - Innovation & Health Sustainability, Innovative Medicines Canada
- Neil Palmer
  - President & Principal Consultant at PDCI Market Access Inc.

Agenda

1. Objectives and introductions (5min)
2. Neil – What do the data tell us? (15min)
3. Louise – patient perspectives (5min)
4. Panel discussion (20min)
5. Audience Q&A (30min)
6. Wrap-up (5min)

CAPT ACTP

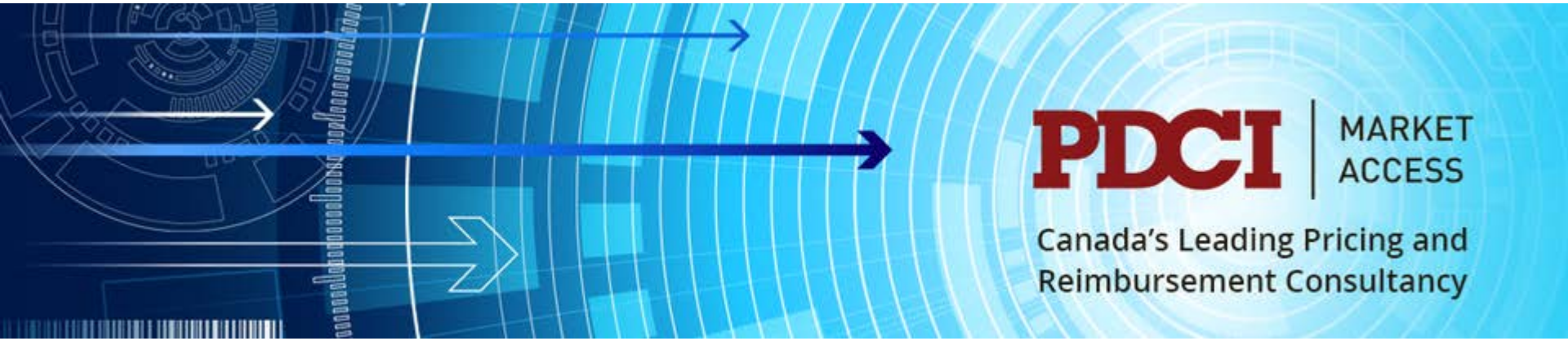
20th Anniversary Conference

Have we made any progress on Health Policy?

National Pharmacare Part Deux

W. Neil Palmer

Toronto October 18, 2016



Morgan *et al*, March 2015

CMAJ RESEARCH

Estimated cost of universal public coverage of prescription drugs in Canada

CMAJ 2015. DOI:10.1503/cmaj.141564

Steven G. Morgan PhD, Michael Law PhD, Jamie R. Daw BHSc MSc, Liza Abraham BSc, Danielle Martin MD MPubPol

- **Results:** Universal public drug coverage would (*worst case to best case*):
  - Reduce total spending on prescription drugs in Canada by $7.3 billion (*$4.2- $9.4 billion*).
  - The private sector would save $8.2 billion (*$6.6 billion - $9.6 billion*)
  - Costs to government would increase by about $1.0 billion (*$5.4 billion net increase -$2.9 billion net savings)*.
  - Most of the projected increase in government costs would arise from a small number of drug classes.

Table 2: Estimated total change in public and private retail spending on prescription drugs with universal public coverage, all provinces combined

Spending	Actual retail spending 2012/13, $ millions	Change in spending, $ millions (% change)					
		Base scenario		All model parameters set to worst-case scenario values*		All model parameters set to best-case scenario values*	
Public							
Direct public spending on public drug plans	9 725	3 383	(35)	7 813	(80)	–438	(–5)
Indirect public spending on private drug plans	2 425	–2 425	(–100)	–2 425	(–100)	–2 425	(–100)
Subtotal	12 151	958	(8)	5 388	(44)	–2 863	(–24)
Private							
Private-sector spending on private drug plans	5 659	–5 659	(–100)	–5 659	(–100)	–5 659	(–100)
Patient out-of-pocket spending	4 534	–2 556	(–56)	–3 911	(–86)	–896	(–20)
Subtotal	10 193	–8 215	(–81)	–9 569	(–94)	–6 555	(–64)
Total	22 344	–7 257	(–32)	–4 181	(–19)	–9 418	(–42)

*From the perspective of assessing the cost-impact to government.

Limitations of Morgan, *et al*

- Most of the "savings" rely on British prices as proxy for Canadian pharmacare prices but ignores:
  - British Pound and other currencies at historic low vs Canadian Dollar
    - Sensitivity analysis uses other currencies with same issue
  - PPPs are the better mechanism than PMPRB exchange rates

- Assumes (incorrectly) that Canada has a single health care system similar to other "single payer" countries:
  - Each province has its own health care system and health priorities into which it has integrated provincial funding for pharmaceuticals
    - Eg, Cancer drugs are funded / reimbursed differently across the country
  - Ignores the formulary decision making role of "fund holding" regions / local authorities in other "comparator" countries
    - UK: 211 local clinical commissioning groups (CCGs) each with their own formulary
    - Sweden: 21 "county councils" that establish when "reimbursable" drugs can be prescribed

- Estimated savings from increased generic use flawed due to:
  - Extrapolation from small sample PMPRB generic price study of broad therapeutic classes to more detailed classes
    - Some of the PMPRB broad classes had only one drug
  - Proposes generic savings where no generics exist
  - Calculation and tabulation errors (eg, best case scenarios worse that worst case)

Morgan, *et al*

Price Analysis relies heavily on PMPRB / NPDUIS - 2013

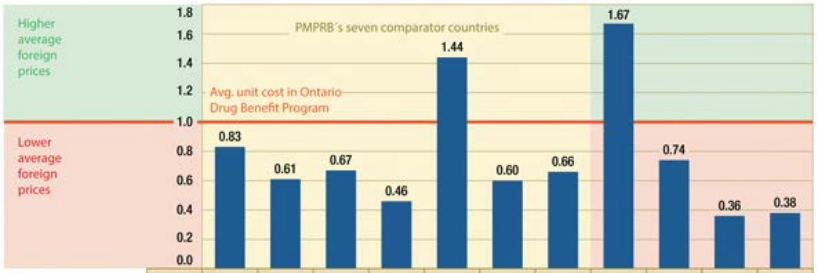
Figure 4.1 **Average multilateral foreign-to-Canadian price ratios**
Generic drugs, by major therapeutic class†, PMPRB-7*, Q1-2013

Drugs covered	Canadian generic sales covered ($million)	Therapeutic classification	Mean	Median
67	161.9	Cardiovascular system	0.48	0.38
85	151.6	Nervous system	0.81	0.70
25	100.8	Alimentary tract and metabolism	0.65	0.58
20	35.8	General antiinfectives for systemic use	0.93	0.70
15	17.8	Musculo-skeletal system	0.79	0.78
1	13.7	Blood and blood forming organs	0.66	0.60
5	10.0	Genito-urinary system and sex hormones	0.99	0.82
12	8.6	Antineoplastics and immunomodulating agents	0.86	0.74
1	0.3	Respiratory system	0.40	0.42

Overall median 0.58 | Overall mean 0.68

†Level-I of IMS Health Anatomical Therapeutic Classification (ATC).
*France, Germany, Italy, Sweden, Switzerland, the United Kingdom and the United States.

Figure 5.3 **Average bilateral foreign-to-Ontario generic price ratios**
Generic drugs, by comparator, Q2-2013



	CAN	FRA	GER	ITA	SWE	SWI	UK	US	AUS	ESP	NLD	NZL
Drugs covered	113	55	69	55	49	56	66	70	61	58	52	30
Canadian generic sales covered ($million)	556.3	302.2	396.6	394.9	299.6	389.7	423.4	401.5	390.6	350.8	291.5	141.4
Share of total Canadian generic sales covered (%)	100.0	54.3	71.3	71.0	53.8	70.1	76.1	72.2	70.2	63.0	52.4	25.4

Table A1: Drug-class-specific model parameters for our base scenario and for best-case and worst-case scenarios from the perspective of assessing the cost to government of a universal public drug plan

	Generic Prices (reference-to-Canadian ratio)			Generic Substitution Target (minimum rate)			Sole-source Brand Prescribing Target (maximum rate)		
	Base	Best-case	Worst-case	Base	Best-case	Worst-case	Base	Best-case	Worst-case
Antihypertensives	0.32	0.23	0.38	89%	93%	89%	7%	6%	8%
Cholesterol-lowering drugs	0.32	0.23	0.38	96%	97%	94%	3%	0%	4%
Antidepressants	0.59	0.42	0.70	98%	99%	98%	3%	2%	5%
Acid-reducing drugs	0.49	0.35	0.58	82%	89%	80%	0%	0%	0%
Drugs for diabetes: Non-insulins	0.49	0.35	0.58	96%	98%	94%	3%	1%	5%
Antibiotics	0.59	0.42	0.70	86%	94%	85%	6%	5%	8%
Antipsychotics	0.59	0.42	0.70	94%	98%	89%	9%	5%	11%
Non-steroidal anti-inflammatory drugs	0.66	0.47	0.78	99%	99%	99%	34%	7%	47%
Pregabalin and gabapentin	0.59	0.42	0.70	93%	96%	90%	0%	0%	0%
Drugs for ADHD	0.59	0.42	0.70	80%	96%	57%	21%	6%	38%
Benzodiazepines	0.59	0.42	0.70	98%	98%	97%	1%	0%	1%
Drugs for osteoporosis	0.66	0.47	0.78	98%	99%	98%	2%	0%	4%
Anticoagulants	0.51	0.36	0.60	99%	99%	99%	13%	2%	14%
Drugs for benign prostatic hypertrophy	0.69	0.49	0.82	99%	99%	99%	8%	3%	14%
Antiplatelets	0.51	0.36	0.60	37%	76%	31%	0%	0%	0%
Drugs for dementia	0.59	0.42	0.70	98%	99%	97%	62%	56%	70%
Hormone replacement therapy	0.69	0.49	0.82	44%	55%	32%	39%	33%	39%
Drugs for migraines	0.59	0.42	0.70	95%	99%	91%	15%	5%	16%
Drugs for respiratory conditions	0.44	0.31	0.52	86%	35%	58%	86%	65%	42%
Opioids	0.59	0.42	0.70	47%	47%	47%	29%	29%	29%
Drugs for diabetes: Insulins	0.49	0.35	0.58	86%	35%	58%	86%	65%	42%
Hormonal contraceptives	0.69	0.49	0.82	86%	35%	58%	86%	65%	42%
Drugs for hypothyroidism	0.49	0.35	0.58	49%	49%	49%	100%	100%	100%
Drugs for urinary frequency and incontinence	0.69	0.49	0.82	99%	99%	99%	54%	11%	64%
Androgens	0.69	0.49	0.82	86%	35%	58%	86%	65%	42%
Biologics for inflammatory conditions	0.63	0.45	0.74	N/A	N/A	N/A	N/A	N/A	N/A
Antineoplastics	0.63	0.45	0.74	N/A	N/A	N/A	N/A	N/A	N/A
Antiretrovirals for HIV	0.63	0.45	0.74	N/A	N/A	N/A	N/A	N/A	N/A
Drugs for multiple sclerosis	0.59	0.42	0.70	N/A	N/A	N/A	N/A	N/A	N/A
Drugs for glaucoma	0.49	0.35	0.58	N/A	N/A	N/A	N/A	N/A	N/A
Drugs for ocular vascular conditions	0.49	0.35	0.58	N/A	N/A	N/A	N/A	N/A	N/A
All other drugs not classified in study	0.49	0.35	0.58	86%	35%	58%	14%	35%	58%

Morgan *et al,* Model Parameters (selected drug classes extracted from Table A1,

	Generic Prices (reference-to-Canadian ratio)			Generic Substitution Target (minimum rate)			Sole-source Brand Prescribing Target (maximum rate)		
	Base	Best- case	Worst- case	Base	Best- case	Worst- case	Base	Best- case	Worst- case
Antihypertensives	0.32	0.23	0.38	89%	93%	89%	7%	6%	8%
Cholesterol-lowering drugs	0.32	0.23	0.38	96%	97%	94%	3%	0%	4%
Antidepressants	0.59	0.42	0.70	98%	99%	98%	3%	2%	5%
Acid-reducing drugs	0.49	0.35	0.58	82%	89%	80%	0%	0%	0%
Drugs for diabetes: Non-insulins	0.49	0.35	0.58	96%	98%	94%	3%	1%	5%
Drugs for diabetes: Insulins	0.49	0.35	0.58	86%	35%	58%	86%	65%	42%
Biologics for inflammatory conditions	0.63	0.45	0.74	N/A	N/A	N/A	N/A	N/A	N/A
Antineoplastics	0.63	0.45	0.74	N/A	N/A	N/A	N/A	N/A	N/A
Antiretrovirals for HIV	0.63	0.45	0.74	N/A	N/A	N/A	N/A	N/A	N/A
Drugs for multiple sclerosis	0.59	0.42	0.70	N/A	N/A	N/A	N/A	N/A	N/A
Drugs for glaucoma	0.49	0.35	0.58	N/A	N/A	N/A	N/A	N/A	N/A
Drugs for ocular vascular conditions	0.49	0.35	0.58	N/A	N/A	N/A	N/A	N/A	N/A
All other drugs not classified in study	0.49	0.35	0.58	86%	35%	58%	14%	35%	58%
	Lower is better			Higher is better			Lower is Better		

- There are no generic insulins!
  - No generic biologics, MS drugs either…
    - A couple of biosimilars now available as of 2015/16 – not included study analysis
- Several examples of “Worst case” better than “Best case”!

Palmer *et al*, Pharmacare Costing in Canada, 2016

Approach	Variation	Public Expenditures	Private Expenditures	Out-of-Pocket Contributions	Total
2015 Actual Expenditures		**$11,281**	**$10,235**	**$6,752**	**$28,268**
Public-Only Pharmacare Approaches	All Public, No Copay	**+$15,998**	**-$10,235**	**-$6,752**	**-$989**
	Public, $10 Co-Pay	**+$7,908**	**-$10,235**	**+$1,338**	**-$989**
	Public, 20% Co-Pay	**+$10,542**	**-$10,235**	**-$1,296**	**-$989**
	Public, Patient pays Rx fee	**+$9,526**	**-$10,235**	**-$280**	**-$989**
Pharmacare for the Uninsured Approaches	Public "Modified" Québec Model	**+$2,151**	**$0**	**-$2,045**	**+$106**
	Public PEI Generic Drug Plan Model	**+$93**	**$0**	**-$2,013**	**-$1,920**
	Private	**$0**	**+$2,349**	**-$1,999**	**+$350**

$ Millions - Source: Palmer et al, Pharmacare Costing in Canada, 2016

- Need to start with actual expenditures on prescription drugs
  - and then model for various scenarios….
- There are no correct answers – analysis is directional to inform policy decisions
- This analysis does not consider lower prices by international referencing
  - Potential for lower prices can be layered on top of scenarios
  - "National" Pharmacare not required for lower prices / costs
  - PMPRB, pCPA, payers are already lowering prices
    - See for example pCPA generic framework, pricing decisions for biosimilars

Canadian Pharmacare: *Evolution not Revolution*

- Provinces (including Quebec!) and Federal government already work together on pCPA to secure lower prices for prescription drugs
  - No evidence that a stand alone National Pharmacare would be more effective
    - Would lose the expertise that has grown through the evolution of pCPA
- CADTH (except Quebec) provides a national HTA process – greater collaboration and cooperation with INESSS/ Quebec on the horizon
- "Pan-Canadian" Pharmacare is evolving toward National Pharmacare while preserving the policy and decision making autonomy of the provinces
- *Caveat:* Pharmacare (whatever its form) will always have formulary and funding challenges – Drug plans will always have to make difficult choices
- *Issue:* What is the future role of private drug insurance ?

A Patient Vision for Pharmacare 2016

LOUISE BINDER

CELEBRATING 20 YEARS
CAPT ACTP
Canadian Association for Population Therapeutics

Our Vision

All people residing in Canada have timely, consistent, equal and equitable access to safe and effective therapies, including treatments and medications, as well as the information, diagnostics, care and support that they need, without conditions.

This is part of a broader vision for every person to have equal opportunity to access therapies regardless of barriers related to the social determinants of health.

Our Values

1. **Respect** for people who access the health system including their support team.
2. **Meaningful and ethical engagement** of people who access the health system, including engagement in health systems planning, decision making, implementation, knowledge transfer and exchange, monitoring and evaluation, and systems redesign.
3. **Accountability** as the framework for all health systems processes and health policy.
4. **Transparency** in sharing **information** about all health systems processes and health policy decisions.
5. **Timely access** to health innovations.
6. **Excellence** in health systems and health policy that recognizes the importance of integrating best practices in evidence based qualitative and quantitative medicine.
7. **Capacity building and mentorship** for all who engage with the health care system.
8. **Social Justice** as a principle to uphold equal opportunity to access and benefit from all social determinants of health.

Our Principles

The plan for pharmacare must:

- **Protect** or **improve** existing individual access to therapies at or above their current level.
- **Ensure universality and equality** that recognizes diversity in all its forms and accommodation for disability.
- **Safeguard access** to medically necessary therapies for uninsured and underinsured residents of Canada regardless of ability to pay or place of residency.
- **Recognize** the discrete needs of people with life threatening and serious debilitating illnesses that significantly impact quality of life.
- **Accept, assess and value** real world evidence in determining therapeutic value.

Our Principles (cont'd)

- **Reinvest** pharmaceutical system savings back into the Pharmacare budget in order to provide increased access to therapies.

- **Build** on the foundation of health care mechanisms and systems already in place.

- **Develop** value-based drug pricing contracts, including systems for sharing data and other relevant information.

- **Analyze** the value of a drug or treatment for a Pharmacare system to include savings in other parts of the health care budget and broader socio-economic impact.

- **Expand** health technology assessment processes to measure the value of all components of the health care budget

Signatories

- Supported by :
    - Canadian Cancer Survivor Network
    - CNETS Canada
    - The Canadian CML Network
    - The CML (chronic myelogenous leukemia) Society of Canada
    - GIST Sarcoma Life Raft Group Canada
    - Life-Saving Therapies Network
    - Lung Cancer Canada
    - Lymphoma Canada
    - Schizophrenia Society of Ontario
    - Sickle Cell Disease Association of Canada

AUDIENCE Q&A

CONCLUDING REMARKS