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Chair

Mr. Bill Casey

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● (1110)

[*English*]

The Vice-Chair (Mr. Len Webber (Calgary Confederation, CPC)): I call the meeting to order.

Because we have a tight timeline, we'd better get moving here. I'd like to welcome Mr. Matthew Brougham, who is a consultant economist with Brougham Consulting Inc. He is a former vice-president of products and services at the Canadian Agency for Drugs and Technologies in Health, and he's a former chief executive at Pharmac.

We welcome you here, Mr. Brougham. Thank you so much. We're going to give you 10 minutes for a presentation, and then we will question you after that. Please start whenever you're ready.

Mr. Matthew Brougham (As an Individual): Thank you for the opportunity to speak to you today. I hope I can help you in your deliberations on this important issue for Canada. More importantly, I hope that all of you here today have a very happy Valentine's Day.

New Zealand has universal access to pharmaceuticals. It has this at an affordable cost. More importantly, it can fully control the costs of its universal pharmacare program with a somewhat unrivalled precision.

New Zealand has a broad formulary. It has 2,000-plus line items. It has very low copayments by comparison with other countries, in the region of $0 to $5 per item a month. It has very low copayment maxima by comparative standards. No family spends more than $100 a year out-of-pocket on medicines. There are no annual maxima, and there are no lifetime maxima. Costs have grown at a manageable rate over the last 20-plus years, and that's between, on average, about 1% to 3%. During this modest growth in expenditure, the volume of medicines subsidized has grown, sometimes in excess of 8%. Along with all of that, new on-patent medicines and expansion to on-patent medicines have been added to the formulary.

It's clear from the testimony given to this committee, and indeed from the sentiments expressed by its members, that Canada wants universal access to pharmaceuticals for its citizens. The problem, of course, is how to get there.

I've read some of the testimony that you've heard over the last 12 months, and I'm struck by the complexity of the situation. Canada is a vast country and is united as a country under a loose federalism. That makes moving to universal access to pharmaceuticals all the more challenging. New Zealand, by contrast, has a unitary government, and most of its social services are supplied by central government. It's a small land mass and a small population, around the same size as British Columbia.

What does the New Zealand experience of management of pharmacare possibly have to offer Canada? Well, no matter how Canada decides to get there, one key element that it'll need to master to make it feasible is the ability to control the costs of such a scheme or schemes. New Zealand has costs under control, and thus, I believe, there are lessons that can be learned from its approach to gaining this control.

Here are what I believe are the key takeaways from the New Zealand experience.

First, within a jurisdiction, however that jurisdiction is defined, there needs to be a single purchaser. What does this actually mean? It means that the purchaser has to have the power to negotiate. To put it more bluntly, when it says no to a proposal to buy a pharmaceutical, no means no. If a seller can go to another purchaser within the same jurisdiction, the ability to negotiate is diminished. Likewise, if the seller can go to a politician and get a no overturned, the ability to negotiate is lost.

This leads to the second takeaway: the specific decisions about what pharmaceuticals to fund and what not to fund need to be distanced from political decision-making. It's not possible for the drug plan manager to negotiate and manage the costs if his or her day-to-day decisions are at significant risk of being changed. Clearly, drug plan management needs general oversight by our elected representatives and needs to be held accountable for individual decisions. However, this oversight, I believe, is better effected through other levers, rather than by undermining the ability to negotiate. In short, the power of veto should be used judiciously and rarely.

The third lesson is a little technical, but is nevertheless vital: drug plans are better managed by setting an explicit budget and demanding that managers gain the most health benefit possible from within this budget, rather than by setting decision thresholds. I suspect many of you have heard of NICE, the model we look at in the U.K. In NICE, typically decisions are made on the basis of a threshold, usually at cost per QALY, taking into account other things. They may set that threshold at, let's say, 40,000 quid per QALY. That's what I mean by a decision threshold. I don't believe that's a sensible way to approach management in this area, and there are several reasons for this.

First, obviously the funder knows what they're going to face when they set a budget, but more important are the incentives that setting a budget with an explicit objective create for managers and the lever it subsequently offers to politicians. Briefly, the important outcomes that arise from gaining the most health benefit from a fixed budget are as follows.

First, purchasers are given the strongest incentives possible to minimize opportunity costs in their decision-making. Then sellers, faced with purchasers attempting to minimize opportunity costs, are given incentives to offer prices nearer their minimum willingness to sell. By contrast, when thresholds are used, sellers are effectively saying this is the price at which they'll purchase this product. Clearly, this is not a good way to be negotiating prices in any market.

More importantly, the public, when given information, understand rational decision-making in the face of a budget constraint. This has been my learning through my period managing the Pharmaceutical Management Agency in New Zealand. People who have faced the consequences of these decisions, somewhat to their detriment, understand this notion of having to maximize benefit to society within a budget constraint.

Finally, once you have organizational mastery of an explicit objective within an explicit budget, this gives politicians a very powerful lever. It's a lever that allows them to deliberately and consciously reallocate funding between pharmacare and other health care in the manner that they perceive provides the most benefit.

We are all used to the idea of having budgets and being able to reallocate money across different budgets, but frequently those budgets are not stuck to. The difference I'm trying to get at here is organizational mastery of managing the pharmaceutical budget within the budget as set.

All these lessons are structural in nature, which is why I presented them here. If there's one comment I hope you remember from my testimony today, it is this: structure matters in this arena if you want to control costs.

Finally, I have a comment on the key criticism of the New Zealand approach, which I'm sure you're going to hear from my colleagues after the hour. It's often most heavily criticized for its apparent limiting of the range of medicines to which New Zealanders have funding access. In particular, some argue that the rate of adoption of new technology—that is, new chemical entities in this area—is too restrained.

While I might argue about what the word “too” means in “too restrained”, the adoption of new technology in New Zealand is in fact restrained. Creating a fixed budget and requiring its managers to stay within it creates a competitive tension in the marketplace only if the budget cannot fund everything.

I ask simply that you put this criticism in context. All New Zealanders, and I mean every last one of them, have publicly funded access to a very wide range of drugs. This stands in stark contrast to the situation that Canada finds itself in, where some Canadians have access to an even wider range of drugs, while others, most often the working poor, have nothing but out-of-pocket access to this generous array of generously priced pharmaceuticals. This difference is most starkly highlighted by the research you were alerted to earlier last year in the research of Dr. Booth, which pointed out that working-age Ontarians with insulin-dependent diabetes die at a higher rate than 65-plus-year-old insulin-dependent diabetics simply because the older folks have funded access to insulin. Needless to say, this is not an outcome witnessed under the New Zealand approach, and I would certainly hope that this is an outcome that can be dispatched in Canada before too long.

● (1115)

The Vice-Chair (Mr. Len Webber): That's great. Thank you, Mr. Brougham. We appreciate your presentation.

We'll start with questions from Mr. Darshan Kang, in a first round of seven minutes.

Mr. Darshan Singh Kang (Calgary Skyview, Lib.): Thank you, Chair.

Mr. Brougham, thanks for shedding some light on New Zealand pharmacare.

Since you have worked on both sides, can you explain some of the strengths and weaknesses of the Canadian Agency for Drugs and Technologies in Health compared with the therapeutics advisory committee? How could Canada move forward to ensure we are making the most informed decisions for a national pharmacare formulary? You were talking about Ontario, but how could we move forward so everybody could benefit?

Mr. Matthew Brougham: Health technology assessment, which is what the Canadian Agency for Drugs and Technologies in Health —or its acronym, CADTH—engages in, assesses pharmaceuticals in a manner very similar to that of other agencies around the world, including New Zealand. I would say, in actual fact, that the Canadian approach is very precise and very meticulous, probably at a higher quality than I experienced when I was in New Zealand.

Canada has at its disposal, right at the heart of its decision-making, extremely good information on which to make decisions about what to put into a formulary and what the costs and benefits of those options are, etc. It has that ability and it has the technology, if you like—the institution in place—to make that happen.

What it has is a large number of different purchasers around the country that take advantage of that information and use it in different ways. As yet, it doesn't have the ability to fully utilize that information for the purposes of creating a national pharmacare program, and that's not the fault of the HTA body, the health technology assessment body. That's the fault, if you want to call it a fault, of the structures we have in place in order to achieve some form of national consistency in our access to pharmaceuticals, and indeed to achieve universal access. All of the abilities are there in Canada. It's just a matter, in my view, of structuring them in a way that enables Canada to take advantage of them.

● (1120)

Mr. Darshan Singh Kang: In your opinion, what is needed, or can we lump all the approaches together? How much work do you think is already done in order to bring in pharmacare?

Mr. Matthew Brougham: I've read the testimony and I work in this area, so I talk to a lot of people in this area. I think partly the question that you're driving at has to do with this broad tension that comes about through Canada's political environment, this federalism that essentially gives the role of making drugs available to Canadians to the provinces. As a result, you have this provincial-federal dynamic that one has to deal with, and let me be clear that this is nowhere near my forte. I have no particular strengths in this area, and in fact the testimony I read that was interesting was from Roy Romanow, basically saying that you have to practise the darker arts of federalism in order to make these things happen.

I think what it boils down to is essentially two options. Typically, Canada has achieved national programs by virtue of the federal government following the provincial governments' lead, and that seems to be an approach that Canada has been comfortable with over the years. As a result, you have one set of advisers saying to you that the way to move forward is to allow the provinces to provide universal access under their own steam, and then you have another set basically saying that this approach will result in a bunch of differences—not only differences in access, but differences in skill levels across the country, differences in prices, and that you'd be better off going for what you might describe as a big bang approach and trying to do it from the federal level down.

I can see a way to do it with the big bang approach because that's what I've grown up with, that's what I've lived with, and that's what I can understand. The dark arts of federal politics and the provincial-federal split that you have to practise here in Canada are not things I'm expert in, and I'm unable therefore to tell you which way to go.

Mr. Darshan Singh Kang: Thank you.

I understand that New Zealand has a copay of $5 per prescription. Have you studied whether the subsidies for low-income New Zealanders have been successful in ensuring that no one is prevented from accessing pharmacare?

Mr. Matthew Brougham: Look—

Mr. Darshan Singh Kang: Also, are there any further difficulties with this model that would be useful for us to know about?

Mr. Matthew Brougham: As I said, the copayments are low by international standards. They range from zero for under 13-year-olds to $5 per item on a scrip per month. As I said, once a household reaches $100 in any given annual period, it then has no copayments.

I would say that even with copayments at these levels, there are people who still struggle to fill a scrip. There are people who go get a scrip, walk out of the door, go to the pharmacy, and balk at the idea of paying $5. Some people are very poor.

● (1125)

Mr. Darshan Singh Kang: Sorry, was that $5 per item, per drug? Let's say if I had—

Mr. Matthew Brougham: If they had five items, it would be $25.

Mr. Darshan Singh Kang: It would be $25. Okay. You think that would be enough to make poor people not want to fill their prescriptions?

Mr. Matthew Brougham: I would say even $5 in some instances is $5 too much. I just wanted to be clear that even with those levels of copayments, you still create barriers for some people, and that's something you have to live with. It was at $3 until about two or three years ago, and it was at $5 before that.

Copayments act as a barrier. They're put in place to try to deal with problems of moral hazard. In this area, you really have to ask yourself a very hard question, and you have to ask it of economists: is there really moral hazard here? Is it something you really need in order to control overuse of prescribed medicines? I'm not sure that you do.

After that, I'm not sure if I'm out of time.

The Vice-Chair (Mr. Len Webber): You've run out of time, but perhaps the next time the Liberal caucus is up for questioning, you can answer that question.

We'll move on to the Conservative caucus now, with Rachael Harder. You have seven minutes.

Ms. Rachael Harder (Lethbridge, CPC): I'm actually giving my time to Colin Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, and I want to thank the witness for being here.

Unfortunately I missed your opening because I had to give a speech in the House, but my colleague raised something I'd like to return to. I think it was a 2013 survey by the Commonwealth Fund that indicated that 8% of Canadians with below-average incomes did not fill a prescription or skipped doses because of cost.

This system is being held up as a kind of poster child for our country to replicate, but my understanding is that in New Zealand it was 18% of people who skipped their doses because of cost. Can you comment on that?

Mr. Matthew Brougham: My answer is broadly the same as the answer I just gave to the previous committee member, which is that copayments—

Mr. Colin Carrie: That's a problem we're trying to fix. What I'm trying to figure out is whether going to something like this will really solve it, and I guess what you're saying is not necessarily so, right?

Mr. Matthew Brougham: I'd be very careful with making comparisons across the different countries. First I'd want to have a look at the data and understand whether those differences are truly real. The other thing you'd want is to equate for general wealth across the two countries in order to understand if you're going to have those sorts of similar differences.

I don't think anyone here is really saying this is a model you should replicate holus-bolus here in Canada. If you missed my introductory remarks, they were about what New Zealand has to offer. What its experience teaches is essentially some of the structures you might need in place in order to get control of costs.

If you have a very careful look at moral hazard and whether or not it's really an issue with copayments here in Canada, you might find you don't need a copayment system.

Mr. Colin Carrie: Out of curiosity, I think the population of New Zealand is about 4.6 million. The population of one of our biggest areas—where I live, in the Durham region in the GTA—is about six million people.

In New Zealand, is it one central government body that makes decisions on health care, or do you hand that responsibility down to regional bodies? Is it one central authority?

Mr. Matthew Brougham: Well, it's a mixed model, so when it comes to pharmaceuticals, it's essentially one central agency that's making the decisions about what to put on the formulary and what not to put on the formulary. In fact, it's now been given the role of doing that across the hospital sector as well.

When you go outside of pharmaceuticals, it's a more complex system. You have 20...well, I think two or three of them have combined, so I think there are now about 19 different districts that are involved in the management of their health system, but by having a central agency control the pharmaceuticals, they're handing the responsibility to that central agency to do that within their districts.

Mr. Colin Carrie: Does the health care system in New Zealand have copayment as well for having a visit to your doctor, going to a clinic, or anything along those lines?

Mr. Matthew Brougham: Again, it depends on whether you're in a PHO—a primary health organization—or your socio-economic level.

However, no, when it comes to access to physician services, Canada enjoys better access to physician services than New Zealand.

● (1130)

Mr. Colin Carrie: It's difficult when you're looking at the whole system to compare apples to apples, so I did want to dig in a little further on that as well.

What's the world of private insurance like in New Zealand? I know that in my community of Oshawa, a lot of union members have really great coverage. One of the criticisms I've heard of New Zealand, for example, is if a brand name drug or an innovative drug were desired by a patient, perhaps it would not be covered. I've heard of people going to Australia, for example, for treatment for certain things.

Can you comment on the role of the private system in New Zealand, please?

Mr. Matthew Brougham: Private insurance is not as deep. The market is not as deep as here. It's not as significant in the provision of health care in New Zealand, and most people are privately insured to cover, essentially, surgery and surgical procedures. That's largely what's covered.

When it comes to pharmaceuticals, you're right when it comes to being able to pick up a supplementary package of pharmaceuticals. When I left New Zealand, there was one insurer offering that kind of coverage, primarily because all the other insurers would just say, "Look, we'll just use the national coverage, thank you very much."

Yes, there are situations of drug coverage not being provided for a particular drug. It's considered to offer less health benefit to the country than other options that might be in front of the decision-makers, and as a consequence patients are left with two options: they either pay for it themselves out of pocket or, if they're able to, they take advantage of the Australian system, but few people actually have that opportunity.

Mr. Colin Carrie: I think at the end of the day everybody would appreciate staying in their own country or community for their health care.

Looking at this, we see there are so many complications. With the private sector insurance in Canada, I believe, it's over half of the pharmaceuticals when you're looking at the dollar value, so if we went to this monopoly from, say, a government system, some people said you'd have to come up with $17 billion from day one, or something along those lines. Also there's the option of choice, and again I'd say a lot of Canadians do have that choice.

One of the criticisms I've heard of New Zealand as well is that it takes a significant amount of time to get a drug on a formulary. Is that something you could comment on?

Mr. Matthew Brougham: Yes, it does take time. It can take a long time here as well. You have products that are sitting inside the pCPA currently that are essentially stonewalled, not moving forward and not moving backwards. You're asking managers to essentially try to drive a hard bargain or get a good deal out of a manufacturer. If they don't have a product that is very high value and they're not prepared to adjust their price, then, yes, that can hold things up.

However, by the same token, as I mentioned in my opening address, when managers are given a fairly clear set of instructions—i.e., get the most health benefit you can from the budget available—it provides them with incentives to work in both directions, so things that don't look like they're a good value tend to languish until prices adjust. Things that look like very good value go through very quickly. In my experience in the past, New Zealand was, in some instances, among the first countries to fund new technologies because it considered them to be very good value.

The Vice-Chair (Mr. Len Webber): Great. I'll have to cut you off there. We have to move on with our questioning.

I'd like to welcome Monsieur Pierre-Luc Dusseault here today. Welcome to our health committee. You are in the room with the best committee in the House of Commons.

Mr. Pierre-Luc Dusseault (Sherbrooke, NDP): I'm seeing that. Thank you.

The Vice-Chair (Mr. Len Webber): You have seven minutes of questioning, Mr. Dusseault.

Mr. Pierre-Luc Dusseault: Thank you.

Thanks to our witness.

I will speak in French, so you may want to use your earpiece. Sorry about that.

● (1135)

[*Translation*]

I hope that will work.

I thank the witnesses for being here with us today.

First of all, I would like to know the main reason why medication prices are much lower in New Zealand than in Canada. What is the main reason that explains that, in your opinion? Is it bulk purchases? Are there other factors at play? As my colleague said earlier, there are four to five million inhabitants in New Zealand, and there are 35, soon to be 36, million in Canada. Is the fact that you buy medication in large quantities and through centralized procurement by the government really the only reason that explains the lower cost of medications there? Are there other factors that explain the lower costs?

[*English*]

Mr. Matthew Brougham: Yes, there are other factors. Bulk purchasing gets you part of the way, gets some price reductions essentially, but as anyone who is involved in business knows, the way to maintain a high price is to identify your product as unique. The alternative to that—in other words, if you're on the buyer's side—is to understand what products are substitutable for one another. It's understanding the substitutability of products that actually drives the competitive process. This is what introduces strong incentives for price competition in the marketplace.

You can do that in several different ways. In New Zealand, for example, when things go off patent, New Zealand runs tenders for sole supplier of the product. Clearly there are many suppliers of the product, and these products are very substitutable for one another, if not perfectly substitutable for one another.

When it comes to on-patent medicines, you will frequently come across a situation where a competitor...and let's be clear, the competitor has produced a “me too” in order to make it into the market and get a slice of the action. These me toos are frequently substitutable for one another, so suddenly, even in the on-patent market, you'll have the ability to leverage price competition from competing suppliers, and that is one of the key areas where benefits derive.

Therefore it's not just bulk purchasing, and in fact these things tend to combine together in many different ways to enter into what you might call “clever contracting”, essentially.

[*Translation*]

Mr. Pierre-Luc Dusseault: If memory serves, medication covered by insurance in New Zealand is listed in a schedule to the law. I would like to hear about the process through which people determine which medications are in that schedule of covered medications, and I'd like to know how much that list can vary over time. You said that there was fierce competition among the companies. Certain medications are interchangeable and have the same effect, but are marketed under different names.

Also, over time, how can you adjust your list of covered medications and provide the best medication that is on the market?

[*English*]

Mr. Matthew Brougham: New Zealand engages in the same sorts of processes that we engage with here in Canada. You do a form of health technology appraisal of the technology, essentially to try to determine what health benefits this product is likely to give relative to how much you need to spend on it. The “relative to how much you need to spend on it” is really important, only from the point of view of knowing how much you can spend within a given budget. More importantly, once you rank all of these options it tells you which one is the most valuable down to which one is the least valuable within the budget that you have available.

The usefulness of doing these sorts of analyses is in understanding which one provides the most benefit and which one provides the least. That what's we refer to in trying to provide incentives to minimize the opportunity costs of these decisions.

That process is no different from the way it's done here; it's just that the results are used differently. One goes through the same use of technical expertise to try to arrive at an understanding of the product's benefits and the product's costs, and ultimately the budget impact of that. Those options are then compared with other options that are on the table and various recommendations are made, in the case of New Zealand, to a board of directors of the Pharmaceutical Management Agency to list a product or not list a product.

It evolves over time through the addition...and, as I mentioned, you have the substitutability of products. As opportunities come up to substitute from one product to another, those opportunities are taken and patients are asked to switch. Essentially doctors are asked to manage that process of switching the patients from one product to another product.

● (1140)

[*Translation*]

Mr. Pierre-Luc Dusseault: So there is a certain flexibility.

I also have a question on access to the medications listed in that schedule.

In Canada, we have sometimes in the past had problems with medication shortages, and access to some medications. Have you experienced similar situations regarding the covered medications that are recommended by the New Zealand government? Have you had problems with access and shortages, and if so, what did you do to resolve them?

[*English*]

Mr. Matthew Brougham: The shorter answer is, yes, in any system that uses pharmaceuticals.

Ultimately, the pharmaceutical supply chain is quite fragile. It's a very precise engineering process. When it goes wrong, it goes wrong for very large volumes of products. It affects large parts of the world when this happens. I don't think there would be any system in the world that can avoid shortages of pharmaceuticals because of that.

The truth of the matter is that, from what I've seen over the last five or six years in Canada, New Zealand's supply shortages have been less problematic, and there have been fewer of them than I've seen here in Canada. Part of the reason is the different supply chains that the two countries use. There are really two or three blocks of supply chains around the world, and countries tend to be engaged with one or the other, but not both of them.

The other reasons for the difference, despite the fact that New Zealand uses sole-supply purchasing for off-patent pharmaceuticals, are the contracting arrangements. The contracts are very specific about continuity of supply.

For example—

The Vice-Chair (Mr. Len Webber): I will have to cut you off there, Mr. Brougham. We've got to move on to the next round of questioning. Perhaps next time, Mr. Dusseault, you can continue on with the answer there.

We're going to move back to the Liberal members. Dr. Eyolfson, you have seven minutes. Go right ahead.

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

Thank you for coming.

I'm a physician. I practised medicine for almost 20 years here. I'm very interested in this subject. I've seen the costs in the emergency department of non-compliance.

This is a very hard number to track down. It may be very difficult to answer. When people don't adhere to medications, of course this causes illness, and this costs the system. Is there any estimate of what the cost of patient non-compliance and non-adherence would be to the medical system?

Mr. Matthew Brougham: Occasionally there are estimates that are specific to a particular intervention. In terms of a general estimate, you have just reminded me that there have been one or two studies out of the U.S. that have looked at this and tried to generalize it. Generally, though, they attracted a great deal of criticism from academics for poor methodology.

You're right. It's very difficult to argue that non-compliance of X does not lead to additional costs on the system of Y. I would say that it's next to impossible.

● (1145)

Mr. Doug Eyolfson: All right.

I understand that this Pharmac program started in 1993. Is that correct?

Mr. Matthew Brougham: Correct.

Mr. Doug Eyolfson: Okay.

What percentage of New Zealanders had limited or no coverage prior to 1993?

Mr. Matthew Brougham: New Zealand has had universal access to pharmaceuticals since about 1956, I believe. In 1993, it went from being a program run by the Ministry of Health to a separate arm's-length program run by a government agency. There were a few other changes that I remember. This fellow who spoke before was talking about a schedule at the back of the legislation. That no longer exists. The schedule is actually published separately by the management agency.

That's what changed in 1993. As a result of that, some of the management practices changed as well. I referred briefly to the idea of substitutability of products and thus creating price competition in the marketplace. Some of those efforts were being undertaken by the Ministry of Health prior to the establishment of Pharmac.

Mr. Doug Eyolfson: All right.

I think I know the answer to this, but I'd like to get it on the record. Are people ever refused drug coverage because they have a pre-existing condition?

Mr. Matthew Brougham: No.

Mr. Doug Eyolfson: I thought the answer would be that, but as I said, I wanted it on the record, for obvious reasons. With private insurance plans, particularly in the United States, that does cause a significant problem.

Mr. Matthew Brougham: That's correct.

Mr. Doug Eyolfson: It's something we'd like to avoid.

In regard to how physicians are prescribing, is there any surveillance of prescribing practices within the national network that might show that physicians in one region or even individual physicians are preferentially prescribing more expensive drugs, when you find that generic, equally effective, cheaper drugs are available? Is there any surveillance of the physician prescribing practices like this?

Mr. Matthew Brougham: In short, yes.

What I have focused on and tried to talk about in terms of the structural change that fosters price competition in the marketplace is what you would refer to as supply-side management. What you are referring to is what an economist would refer to as demand-side management. You want to manage the demand for pharmaceuticals—in other words, the writing out of the prescription.

Yes, there are national agencies. There is the Best Practice Advocacy Centre, run out of the University of Otago in New Zealand, which essentially does what is technically referred to as academic detailing of physicians. Fundamentally, they use their own practice and compare it with what they might consider to be comparable practices and ask them why they're out of line or what they think they might do differently, etc.

Yes, those demand-side management activities are well utilized.

Mr. Doug Eyolfson: All right.

Mr. Matthew Brougham: That's just the tip of the iceberg.

Mr. Doug Eyolfson: Yes, for sure.

Mr. Matthew Brougham: There are other answers to that question.

Mr. Doug Eyolfson: Certainly.

We talk about a formulary. Of course there are different formularies available, and we are looking at which formulary we would use if we were to establish one. There is one from the World Health Organization, and there are others, different ones.

How would you say New Zealand's formulary compares to the World Health Organization formulary? Is it comparable, more inclusive, less inclusive?

Mr. Matthew Brougham: I would say it is significantly wider.

Mr. Doug Eyolfson: Okay. Thank you.

Would you recommend that scale of formulary for Canada, or do you think the World Health Organization one to be sufficient as a starting point?

● (1150)

Mr. Matthew Brougham: To be frank, I think anything would be sufficient as a starting point to gain universal access, if the provinces were all in alignment and in agreement to see it funded. Over time you would manage it, adjust it, and add more to it. You might leave opportunity for those very high-cost, supplementary kinds of medicines to be dealt with, with the deep insurance market that you have in North America. In fact, I think that Canada, in a sense, has greater opportunity here than New Zealand did to have universal access to a good range of products and at the same time keep access to some of these very specialized and high-cost treatments.

The Vice-Chair (Mr. Len Webber): All right. Thank you, Doctor.

We'll move on to our second round of questioning. It's a five-minute question-and-answer session, and we'll start with Ms. Harder for the Conservatives.

Ms. Rachael Harder: Thank you, Mr. Chair.

Thank you, Matthew, for coming in and spending some time with us today and helping us better understand the New Zealand system.

I am going to issue an apology, because I'm going to take us away into a different topic at this point in time. It's a topic that is of the essence in terms of time, and it's a motion that has been tabled since the beginning of December. Unfortunately, this is my opportunity to do so.

At this time, I would like to resume debate on the motion that was adjourned at the meeting of December 13. The motion calls on this committee to review the effectiveness of the 2015 thalidomide survivors contribution program.

The committee will recall that a lengthy history of thalidomide and a detailed overview of the problems facing thalidomide survivors in their efforts to obtain compensation were presented at the meeting on December 13, as stated. That presentation outlined that survivors' medical records from the 1960s have been lost or destroyed, witnesses have passed away, and there is no medical or physical screening undertaken and no in-person interview conducted to determine whether survivors qualify for compensation.

The motion calls for a review of the current qualification procedures and how the procedures to qualify for compensation should be changed to ensure that Crawford's victim services are inclusive rather than exclusive.

These survivors, who have all been denied compensation under the current rules, have now gone through another Christmas without the assistance that the government offered to other survivors. As such, I respectfully request that the members limit debate and that we proceed to a vote on this motion at this time so that the committee can undertake this very important review as we go forward in 2017.

The Vice-Chair (Mr. Len Webber): Thank you, Ms. Harder, for that.

I apologize, Mr. Brougham, for having to put you through this debate or this motion here, but hopefully we can get back to you right away.

I do have someone on the list here who would like to say something.

Go ahead, Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): I would move that the debate be adjourned on this motion.

The Vice-Chair (Mr. Len Webber): Mr. Oliver, Ms. Harder has tabled a motion that has precedence and we have to vote on her motion—oh, I apologize; we have to vote on Mr. Oliver's motion to adjourn debate.

Mr. Colin Carrie: I'd like a recorded vote, please.

The Vice-Chair (Mr. Len Webber): We'll have a recorded vote, then, not on the motion that Ms. Harder has put forward but on Mr. Oliver's motion to adjourn the debate on this particular motion.

(Motion agreed to: yeas 5; nays 3)

Mr. Oliver, your motion to adjourn this debate has succeeded.

Ms. Harder, we will have to continue your questioning. You have close to three minutes left.

● (1155)

Ms. Rachael Harder: Thank you very much.

My first question here, then, has to do with wait times.

According to New Zealand Medicines, the wait time in New Zealand is actually 2.4 years on average from the time that a drug comes to market until it can actually be approved for this schedule. That's a lot of time. I looked on online and compared other countries, and it's actually the greatest wait time of any nation. In Canada, in comparison, the average wait time is 464 days. That's about half the amount of time that it takes New Zealand to approve a drug and get it out to patients.

That is a very significant difference and appears to be very detrimental to the health of patients and their access to the medicines they need. When we're talking about increasing patients' access to medicines and making sure that patients have what they need to take care of their health, this seems to be very detrimental.

I'd like your comments on that. Do you feel that it is beneficial to patients to have such a long wait time?

Mr. Matthew Brougham: Well, as usual there's a trade-off, isn't there? The trade-off here is that some Canadians don't have access to anything.

Ms. Rachael Harder: Do you feel that this is beneficial, then?

Mr. Matthew Brougham: A two-and-a-half-year wait time for a new drug versus no access to some people is.... Is that a reasonable...?

Ms. Rachael Harder: Let's be reminded that up to 18% of people in New Zealand are still not accessing medicines because of cost, while here in Canada, the number is only 10%, so I don't know that your argument holds weight.

Mr. Matthew Brougham: I don't know where those figures come from. I'd dispute them to some extent, but—

Ms. Rachael Harder: Well, they came from New Zealand Medicines—

Mr. Matthew Brougham: It's Medicines New Zealand.

Ms. Rachael Harder: —which happens to be the company you work for, is it not?

Mr. Matthew Brougham: No, it's not. Is it Medicines New Zealand you're talking about?

Ms. Rachael Harder: Yes.

Mr. Matthew Brougham: They are the representatives of the patented pharmaceuticals companies.

Ms. Rachael Harder: Would you disagree with those figures, then? Would you say that the wait time is not 2.4 years in New Zealand?

Mr. Matthew Brougham: As I said before, I'd like to know what their source is, because the comparisons don't stand up, in my mind.

Ms. Rachael Harder: This is not causing you concern, then?

Mr. Matthew Brougham: What is more concerning to me is the vast number of people in this country—the figure I hear is somewhere between 10% and 20% of people—who don't fill a scrip because they can't afford to. They don't have access.

Ms. Rachael Harder: Is it 18% in New Zealand?

Mr. Matthew Brougham: That I don't know. I don't know those numbers.

Ms. Rachael Harder: You don't know what percentage of the population in New Zealand isn't able to fulfill their prescription?

Mr. Matthew Brougham: No, I do not.

Ms. Rachael Harder: Okay. All right.

Can you comment on why there is the increase in—?

The Vice-Chair (Mr. Len Webber): I'll have to cut you off there. Your time is up, and we have to move on. We have a presentation also from two individuals from New Zealand via teleconference, and it's important that we get them on here right away, Mr. Brougham, because it's 5:55 in the morning for them and it was very kind of them to come to present to us.

Mr. Clerk, are we ready to have the presentation from...?

It will take about 30 seconds to get the teleconference TVs up and running; then we'll get the presentation going through them.

Mr. Brougham, if you would like to stay and perhaps take some questions afterward in questioning by individuals, that would fantastic.

Mr. Matthew Brougham: Sure.

The Vice-Chair (Mr. Len Webber): We'll suspend for about 30 seconds in order to get the teleconferencing going.

Thank you.

● (1155)

(Pause)

● (1200)

The Vice-Chair (Mr. Len Webber): I'd like to resume the meeting, please. If everyone would please be seated, I'd like to welcome our friends from New Zealand, all the way from...where exactly in New Zealand are you from?

Ms. Heather Roy (Chair of Board, Head Office, Medicines New Zealand): We're in Wellington.

The Vice-Chair (Mr. Len Webber): Well, welcome.

I'd like to welcome here Ms. Heather Roy. Heather is the chair of the board in the head office at Medicines New Zealand. It is an industry association representing companies engaged in research, development, manufacture, and marketing of prescription medicines.

We also have here Graeme Jarvis, who is the general manager, also at Medicines New Zealand.

I understand it's 5:55 in the morning in New Zealand—

Ms. Heather Roy: That's right.

The Vice-Chair (Mr. Len Webber): We really appreciate your being here today and presenting to us here in Canada. We are undertaking a study on pharmacare, and your testimony here today will be listened to with deep thought. We will hopefully gain something from your knowledge in New Zealand.

I would like to start the presentation now. You have about 10 minutes to present to us, and then you'll get some questioning from our panel here, from all three parties in the House of Commons in Canada. I would ask that you start your presentation, and we'll question you after that.

Thank you.

Ms. Heather Roy: Thank you very much for inviting us to come and to give our view about our Pharmac model here in New Zealand.

I've been chair of Medicines New Zealand for five years, and prior to that I was a member of Parliament in the New Zealand Parliament for 10 years. For much more of my career, then, I was actually sitting on your side of the table, so it's interesting to be at this end.

I'll just have Graeme briefly introduce himself, and then we'll start our presentation.

Dr. Graeme Jarvis (General Manager, Medicines New Zealand): Good morning. It is quite early morning for us, and almost lunchtime for you, I guess.

I've been the general manager here at Medicines New Zealand for a little over two years. Before that I worked in a variety of industries, where I was mainly involved with innovation, export development, and product development. That's it's my background.

Ms. Heather Roy: Thank you.

I'm not sure how much you know about the New Zealand medical system, but it is a largely socialized medical system. It has many similarities to the Canadian system. You might want to ask some more questions about that later on, but we thought we would go straight to the way in which pharmaceuticals in New Zealand are registered and funded so that you would have a good basic understanding of that.

In a nutshell, we have a regulatory agency called Medsafe, which in United States terms is the FDA equivalent. This body makes decisions about which medicines may be marketed on the basis of their safety and effectiveness. That process in New Zealand works well on the whole. Registration occurs quite quickly, particularly when we compare it to the way in which it happens elsewhere in the world.

Then we have the medicines funding agency, Pharmac, which I think we've not heard much of in Matthew's presentation, but which he will be talking to you about. It's responsible for funding the vast majority of medicines in New Zealand. The private market of New Zealand is tiny and insurers generally fund only what Pharmac approves. Pharmac comprises a secretariat and a clinical committee called PTAC, which is short for the pharmaceutical technical advisory committee, which also has various speciality clinical subcommittees.

Although Pharmac bases its operations on a health technology assessment, or HTA, framework, specifically using cost-utility analysis, there are a number of elements of HTA best practices that are not applied.

For example, the clinical committee that I spoke of, PTAC, is not independent of the secretariat. These problematic aspects have led to a system that has been criticized by patients and clinicians for being unresponsive to patients' needs, inconsistent in its decisions, and responsible for major delays in accessing new treatments. In this, New Zealand sits well behind other OECD nations.

One of Medicines New Zealand's recommendations for greater transparency is that the clinical committee be independent of the secretariat as a way of putting in place normal checks and balances needed in a funding system of this type.

The other point I would make, just at a high level, is that Pharmac is exempt from key elements of the New Zealand Commerce Act. Because of this, it can negotiate very aggressively. It does deals, and it trades by bundling contracts. For example, we'll fund this drug for X if you'll sell us this other drug for Y, and it can and does pursue sole-supply relationships. Sole supply means that Pharmac can contract a company to supply 100% of the market, for three years normally, and it often changes the entire patient population to the next cheapest option once that contract ends. Doing that brings some issues with it.

That, I hope, sort of sets the scene for you.

I'm going to hand over to Graeme now to talk briefly about the strengths and the weaknesses, as we see them, of the New Zealand Pharmac setting.

● (1205)

Dr. Graeme Jarvis: Thank you very much.

I'll limit my discussion points to innovative or patented medicines. Obviously, as the industry association for patented medicines, we don't represent generics and over-the-counter products, so bear that in mind.

For anyone, the biggest strength—and I'm sure Matthew spoke at length about it—is the cost containment or the kept budget that Pharmac has. From a health perspective, it's the one component of our health care budget that has remained relatively stable, at around 5% of the total federal health care budget over the past decade or so. You have to give Pharmac credit for that. Ironically, health care costs are going up in New Zealand, as with the rest of the world, with trends such as a chronic disease boom in the aging or older population.

Often one of the highlights that's pointed out to us is that Pharmac is doing a great job because the life expectancy is above the OECD average. Basically, it's above the OECD average as a result of health and medicine standards in New Zealand. It's about 80.3 years of life expectancy. However, even the New Zealand treasury has noted that life expectancy measures are not a particularly useful indicator for a health system's efficiency, obviously because it's influenced by a lot of other factors, be they the living conditions, socio-economic status, or lifestyle choices. That's often the example given to us about the strength of the Pharmac system

From the weakness side, we do have some issues from a new or innovative medicines perspective. There have been a lot of studies, comparative or otherwise, showing that New Zealand lags behind the rest of the world in terms of accessing new or innovative medicines. We're 20th out of 20 comparable OECD countries. In fact, only 13% of a list of 247 innovative medicines were actually funded in New Zealand over a five-year period. For reference, there was a three times greater rate of access in Canada, despite the different systems that I understand you run.

The other thing is that the actual process for registration is quite slow. A published study, not by us, in 2011 highlighted that the lag time between the listing of a medicine by Pharmac on the schedule and its actual registration was 3.6 years. We've done an updated internal study because that study is quite old. We've shown for the newer medicines that it's over four and a half years, so that lag time seems to have been increasing over the past five or so years.

As Heather Roy also mentioned, at times the Pharmac approval process is not transparent. We've seen this from publicly released information from PTAC, the technical advisory committee. There have been 91 cost-effective medicines that they have recommended, which Pharmac funds, but the average waiting time for these medicines—because remember, they're recommended but they've not been funded—is now over three years for these 91 medicines, and that's not just in one therapeutic area. There are things like mental health and depression medicines, cancer medicines, medicines for diabetes, medicines that I understand people in Canada can get access to but New Zealanders simply can't. Type 2 diabetics don't have access at the moment through public schemes. It is the same with asthma and arthritis.

There have even been what have been termed high-priority medicines, so they were recommended by the committee with a high priority, and these have been waiting for up to six years and are still not funded. They're not available to the health care system and they're not available to patients.

You may say, “Well, what does this mean?” “There's only a certain amount of money” is often the thing that's used.

● (1210)

Well, there are studies that have been done on pharmaceutical innovation, and we think they have an effect on patient outcomes and the broader health care system, and, in fact, on society. These are based on what we term real-world data, so it's not clinical trial information, which is often used for health technology assessments, but actual real-world data.

One particularly good study done in Australia in 2015 showed that in 2011 alone, the investment in innovative medicines led to a net savings upstream in the health care system of $1 billion New Zealand.

We've also had a study done in 2016 that was talked about in the New Zealand Parliament. It is currently going through the review process. It showed that just in cancer alone, for every $1 spent and invested in cancer medicines in New Zealand, $1 was saved in terms of the hospitalization costs. That's reduced hospitalization costs, reduced time for patients to be in there, as well as things like improving survival rates and reducing life-years lost, and hence mortality, by over 5%. In fact, for every new cancer medicine that was introduced in New Zealand, the cancer mortality rate dropped by 5%.

That's quite important from a monetary perspective, a budget perspective, and a patient outcome perspective. The study was done repeatedly when we funded it, but then data was collected from public sources away from us. Sadly, the study concluded that had New Zealand invested more in these new cancer medicines, the impacts that I've talked about and noted above may have been far greater, both for patients in the New Zealand health care system and in fact for the clinicians, who would have had access to even more tools to treat the patients.

Finally and most importantly, it's not just us stating these sorts of views. In 2010, the then Minister of Health commissioned a report looking at the role of Pharmac, with the potential to expand it. It was referred to as the Sage report. It requested that some operational corrections be made to Pharmac's procedures around the lack of transparency on the scientific processes for making decisions, the time frames for funding decisions to be made, the lack of direct stakeholder access to the clinical committee, to PTAC, and the lack of ability to challenge a funding decision or the presence of any appeals process.

As well, questions were asked over the practice of bundling. It was felt that bundling led to decision-making processes that focused on cheap prices or good deals but not necessarily the best solution for the patients or the health care system in general. Regrettably, none of those steps have really been implemented, despite the way that Pharmac is now changing its model and is now, in fact, looking after medical device procurement for the public health system.

The other thing to note, I think, is that it's not just us saying these things—

● (1215)

The Vice-Chair (Mr. Len Webber): Please finish your last comment, Mr. Jarvis. We are going to start our questioning soon.

Dr. Graeme Jarvis: Yes. We've seen, I think, over the past five years quite a bit more awareness in the public and health care professionals and in general media debates over a lack of access to medicines in New Zealand. Out of interest, an online survey completed last year showed that of the over 1,000 people who responded, 89% thought the New Zealand government should invest more in new medicines.

Specialists and doctors in oncology and their patients have become far more vocal. There was a big one last year around innovative medicines for skin cancer, melanoma. We have the highest rate globally for melanoma. Australia had five innovative medicines that were funded; we had none, absolutely none, and these are shown to make quite a big impact.

It's not just cancers; it's rare diseases, diabetes, and arthritis. There is a lot more public debate on access to these medicines. Even in the case of general practitioners, such as community-based doctors, a survey last year showed that 71% of them thought that the range of medicines reimbursed through Pharmac may compromise patient health outcomes, and 72% also felt the range of medicines available affected their prescribing practices.

These are not good things from a New Zealand patient perspective or a health care system perspective, and yet we are cognizant of the fact that there is only a certain amount of money to go around. It means investing the best you can with the best return on investment. For us, and from the evidence, we believe that innovative medicines are a very good return on investment for any health care system to consider.

Thank you.

The Vice-Chair (Mr. Len Webber): Thank you for your presentation, Dr. Jarvis and Ms. Roy.

We have to move quickly into the questioning. We're on tight timelines here.

We will start with our Liberal colleagues, with Ms. Sidhu. You have seven minutes of questions.

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

Thank you, Medicines New Zealand.

In your view, what types of pharmaceutical pricing and/or reimbursement strategies are necessary to promote innovation in the development of new medicines while ensuring the financial sustainability of prescription drug coverage programs?

Dr. Graeme Jarvis: I think it's a matter of hitting the right level of funding. As we've stated, Pharmac has done a good job with what the agreement is, but it's a matter of funding it at the right level. I'm not sure whether Matthew touched on this, but Pharmac received a very large increase in funding last year, a record new investment in funding. I remember that was based on the business cases built around innovative medicines, such as the melanoma medicines, the hepatitis C medicines. These are medicines that are curing people of disease in some cases, and they are reducing the bills upstream, which is a point I touched on.

I think it's a matter of having a good balance among things, and it shouldn't be done on a cost containment model. It should be based on the best return on investment, looking beyond the medical budget to the impact it will have more broadly on society and the health care system itself. It is a way of looking at as an ambulance at the top of the cliff versus an ambulance at the bottom. The ambulance at the bottom will often cost more money.

Ms. Sonia Sidhu: According to Medicines New Zealand, the wait time for medicines listed on the pharmaceutical schedule is too long, with an average wait time of approximately two and half years. What is the impact of long wait times for formulary listing decisions? Additionally, in your view, what steps could Pharmac take to improve the timelines of its approval process?

Ms. Heather Roy: Our view is that wait times are too long, and there's no guarantee any medication that is put before Pharmac will be funded. The clinical committee considers applications and makes recommendations to the Pharmac board, which says yes or no to the funding and gives it a priority of low, medium, or high.

Medicines New Zealand has done a project we call “the waiting list” to look at how many of those products that have been give a priority are actually funded. At the moment, an increasing number of medicines are waiting for funding. They have been recommended for funding, but haven't been given funding. Often it's the low-priority medicines that come recommended from the public board committee that receive funding first, not the high-priority ones.

There's a lot of work to do here to get priorities right. There are some issues around transparency as well.

That only answers your question in part, but those are some issues we'd like to highlight for you. They're things that are problematic with this type of model that do need to be looked at if they're going to make best practice on other HTAs.

● (1220)

Ms. Sonia Sidhu: Do you think copayments have created a barrier for some citizens in New Zealand?

Ms. Heather Roy: Some people here would say it's a very low copayment in New Zealand. It's a maximum of $5, depending on what the cost of the medicine is, and no family is asked to pay for more than 20 prescriptions every year. It's not as huge a barrier as one might anticipate. Frequently, for families or individuals who do need medicines, pharmacists are very generous in forgoing that copayment. I don't believe it's a huge barrier, no.

Ms. Sonia Sidhu: In your experience, what is the cost-benefit comparison between taking on the cost of pharmacare and the savings to the overall health system?

Dr. Graeme Jarvis: Although I'm quite happy to send the committee the papers, if they so I wish, there have been studies that actually quantitfy this, and these are those real-world studies that I was referring to.

The Australian study I referred to talked about a range of chronic and acute conditions—cancers, diabetes, arthritis—and actually showed that you are saving money, so there's a return on investment for the health care system. Other studies have also shown that in terms of productivity, meaning economic impact, access to a number of medicines provides you with enhanced productivity, as I mentioned, because there's less absenteeism from work, and less presenteeism, which is a term meaning you're not optimal at work. You're half asleep, as I am this morning.

There are studies that have actually quantified that based on real-world analysis. These are economic studies. Therefore, I think there is a place for medicines, and for innovative medicines in particular, in the health care system; and it's a matter of getting the balance right.

I think that is our fundamental discussion here today. If you don't get the balance right in terms of funding, if you only have costing payment on what is allowed you and don't deal with the real return on investment from innovative medicines as part of the health care system, that creates problems in your health care system.

If everything was great and we had the right medicines, I wouldn't expect to see health care costs ramping up as quickly as they can. The year-on-year investment in our health care system is 29 times greater than it has been for our medicines. That's quite significant.

Ms. Sonia Sidhu: Thank you.

The Vice-Chair (Mr. Len Webber): Thank you, Ms. Sidhu.

We're going to move on to a Conservative member, Rachael Harder. You have seven minutes.

Ms. Rachael Harder: Thank you.

Thank you to each of you for joining us this morning. I know it's quite early there, so thanks for coming in on our behalf.

I was reading some statistics, and The Commonwealth Fund says that 18% of those in New Zealand do not fill their prescriptions. I'm just wondering if you can comment on that and help me understand why 18% of your population would not go about filling them.

Ms. Heather Roy: I think there are a number of reasons. Adherence is a factor, so it's not just not filling prescriptions. Not taking some of the medicines that people have collected is also a significant problem. Many organizations, including us and Pharmac, have turned our minds to this.

I think some of those issues are cultural; people are often reluctant to take medicines, even if their general practitioner has encouraged them to do so. Some people would say that costs are significant, and there were comments previously about the copayment being a barrier, but I don't think it's a significant problem. When you look at the copayments that exist in other countries that have similar health care systems, they are significantly higher.

I think there is a rank of reasons. It's difficult to grapple with. Sometimes it's just the fact that people don't really like taking medicines unless they feel they really have to. It's an educative process that's required, rather than a problem that is caused by the type of system that we have.

● (1225)

Ms. Rachael Harder: Thank you.

My next question has to do with wait times. You've already commented on this. One of the problems that you are identifying with your system is that wait times are 2.4 years on average. That's almost two and a half years. Meanwhile, in Canada our wait times are only 464 days, on average, across the provinces. This is about a half the time, which means that our individuals are accessing medicines that they need in a timely fashion.

One of the things that you're raising as well, if I'm understanding you correctly, is that high-priority medicines are actually being worked somehow to the bottom of the timeline rather than being moved towards the top.

I need some help understanding this, because this appears to be very detrimental to your population.

Dr. Graeme Jarvis: It comes down to transparency, because while their PTAC had the priorities—high, medium, low, or funded but cost-neutral—we're not sure of the criteria that they've come up with for this. We assume it's what they refer to as the factors for consideration, but it's a question that remains unanswered.

They're not the longest waiting times. We have some recommended medicines that have been on the list for up to two years now. Some of the high-priority ones have been as long as six years. It's a question we can ask, but getting an answer would have to come from Pharmac, unfortunately, not us.

Ms. Heather Roy: You raised the point when you were talking to Matthew about the comparison, and you said that New Zealand is at the bottom of the OECD list, and that is absolutely correct. For a first world country, we believe this is unacceptable. We do take a very long time to get access to medicines that people need because they are unwell, and they would have access to those medicines much more quickly if they lived in any of the other 19 countries listed in those OECD statistics.

Ms. Rachael Harder: Thank you very much.

My understanding, along this same line of thinking, is that in New Zealand you are facing some significant delays when it comes to oncology drugs. You mentioned that there were drugs available in Australia that weren't available at all in New Zealand, and again, this is a detriment to those who need access to these medicines.

My understanding is that this time delay is increasingly detrimental, because what it could do is delay or cut back on the number of clinical trials that are performed within your country with regard to these drugs.

Can you comment on that?

Dr. Graeme Jarvis: Yes. The opposite was actually used as the reason for doing clinical trials. The idea was that because you don't get access to the innovative medicines, you should be doing clinical trials in New Zealand, because then patients could actually.... The Health Select Committee investigated this. That was one of the pros for doing trials.

The two are not necessarily linked, to be quite frank. Our companies do a lot of clinical trials in New Zealand; I would like to see them do more. Perversely, I think it is one way of getting access to the innovative medicines. That's why New Zealand is a really good place to recruit for studies. In fact, studies are often moved from Australia to New Zealand because the patients need access. I'm sorry to say it as a New Zealander, but that is actually the case.

● (1230)

Ms. Rachael Harder: Thank you.

It is my understanding that most of the formularies or most of the drugs on the formulary are generic. Generics don't work for everyone, so there will be times when people are going to need to purchase a more expensive name brand medicine.

Could you comment on how that works within your system? How do you make provisions for that?

Dr. Graeme Jarvis: It's the same process that you go through, generic or innovative. About 78% by volume is generic. The majority of the medicines are generics. It's only some that we're aware of that have the rebate system, which I'm sure Matthew touched on.

You go through the same system. Obviously the cost-utility analysis that PTAC does for Pharmac comes a little bit more into focus as a result, because innovative medicines cost a little bit more.

It's the same prices, essentially, but we have a lot less innovative medicines than a lot of other countries.

Ms. Heather Roy: Your comment was quite right. A particular medicine, though approved, might not suit every patient.

One of the difficulties we have in New Zealand is that because there is often a sole-supply issue—one medicine in a family of medicines is chosen for funding, and others aren't—clinicians often don't have the choice that we believe would be beneficial to patients.

It's very difficult for somebody if they can't afford a medicine that isn't funded but is a better one for them. Often they have to do the best they can on one that isn't as effective as another one might be. That lack of choice certainly is problematic for our clinicians.

Dr. Graeme Jarvis: I think about the last round of tenders—

Ms. Rachael Harder: You can finish your thought.

Dr. Graeme Jarvis: It was about 80% in the last round of tenders, which is what Pharmac goes out for. About 80% of the community pharmaceuticals were sole supply, and for hospital medicines it was about 78%.

An interesting little fact is that we have drug shortages in New Zealand. Of the last eight drug shortages that we've had, Australia didn't have those same drug shortages because it had more than one supplier. It does create issues for patients in the health care system, and the pharmacists and doctors. Sometimes when you only have one supplier and they can't get it in the country, you order the medicines as best you can.

Ms. Rachael Harder: Thank you so much.

The Vice-Chair (Mr. Len Webber): We'll have to move on quickly here to seven minutes for the NDP. Go ahead, Mr. Davies.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you for being with us today.

Just to situate where you're coming from, our description of your group is that you're the industry association representing companies engaged in the research, development, manufacturing, and marketing of prescription medicines.

Is that an accurate description of your group?

Ms. Heather Roy: Yes, it is.

Mr. Don Davies: Do you represent only companies that are New Zealand-based or do you represent multinational companies that are also operating in New Zealand?

Ms. Heather Roy: All of our companies are multinational companies operating in New Zealand.

Mr. Don Davies: Can you give me a list of the major companies that you represent?

Ms. Heather Roy: Yes. I can't promise to give them all here off the top of my head—

Mr. Don Davies: Just the main ones.

Ms. Heather Roy: —but they are Novartis, Bristol-Myers Squibb, Pfizer, Sonovion, GSK—

Dr. Graeme Jarvis: Roche.

Ms. Heather Roy: —Roche, Bristol-Myers, I think I said, and Biogen.

Mr. Don Davies: Thank you.

Ms. Heather Roy: Shall I continue?

Mr. Don Davies: No, that's good. That gives me an idea. Thank you.

Where I want to start is...if I have it right, New Zealand created Pharmac in 1993. Is that accurate?

Ms. Heather Roy: Yes.

Mr. Don Davies: I am told that since then New Zealand has achieved the lowest per capita spending on universal drugs in the world. Is that correct?

Ms. Heather Roy: I suspect it is. I can't say categorically it is. I would say that cost containment is only one part of an effective health system, though.

Mr. Don Davies: I heard that. I just wanted to establish that as a fact.

Could you explain to our committee how Pharmac has been so successful in controlling drug prices? What are the major cost drivers resulting in that quite remarkable feat?

Ms. Heather Roy: There are a number of things, I think. You eventually need to ask Pharmac that question to get a comprehensive answer, but I think—and I referred to this in my introductory comments—they deal very aggressively with the companies. They negotiate hard, one company versus another. They've been very effective in driving costs down significantly.

Now, we don't know exactly what those costs are. Only the companies and Pharmac know what they are. We also have a system here of confidential rebates, which are confidential. Nobody knows what those are. Sometimes the cost that is quoted as the list price is not the actual cost. Frequently, for example....

You do need to be a bit careful when you're talking about some of these cost containment measures, because we know that some of the pharmaceuticals appear to be cheaper than they are in Australia, but in fact that isn't the case.

Mr. Don Davies: What about the administration? I know that in Canada, for instance, we have a lot of coverage provided through workplaces, and employers arrange private prescription coverage through a number of carriers. There are hundreds, maybe thousands, of plan administrators in the country.

How is the process of paying for drugs and getting reimbursed for drugs administered in Pharmac? Is it done through a single administration structure or multiple ones? Do you know?

● (1235)

Dr. Graeme Jarvis: It's a publicly funded system. I think it's been mentioned before that most people would access it through going to a doctor to pick up a prescription, then going to a chemist, a local pharmacist, and picking up medicine that way. Essentially the way the system works is that as soon as the scrip is filled, the company gets a cheque from Pharmac for those medicines. That is how the system works.

Mr. Don Davies: Is it publicly administered?

Dr. Graeme Jarvis: Yes, it's a public administration system. It's through public health.

Ms. Heather Roy: There are very few employers in New Zealand who provide medical coverage for their employees. If they do, it is much more likely to be in the surgical space than in the pharmaceutical space.

Mr. Don Davies: I'm curious about your thoughts on the impact of copayment. That's something this committee is having to look at. I know there is a small copayment of $5, I believe it is. There are some exemptions, etc.

Do you have any advice for this committee in terms of whether we should or shouldn't consider copayments?

Ms. Heather Roy: That really is a philosophical question, I think. New Zealand has seemed relatively content on the whole with the $5 copayment. It did increase from $3 several years ago, and that has not altered the pickup rates at all. I think $5 per item is relative low. Sometimes it's not $5 if the cost of the medicine itself is less than that.

As I did mention in my introductory comments, people pay for only 20 items per family, and after that there's no copayment at all. It's a relatively small amount of money.

Mr. Don Davies: I see. Thank you.

Dr. Graeme Jarvis: New Zealand now has a system under which anyone under the age of 13 has free prescriptions at no charge. Young children aren't charged at all.

Mr. Don Davies: Do I have time for one quick question?

The Vice-Chair (Mr. Len Webber): You have one minute remaining.

Mr. Don Davies: Thank you, Mr. Webber.

I'm told I have one minute.

Pardon me if you've covered this point already, but I want to be clear I understand this. Pharmac recently commissioned the "mind the gap" research study in response to commentary that suggested that access to cancer medicine in New Zealand results in poorer health outcomes compared to Australia. I'm told the study showed that more medicines didn't mean better health outcomes. Out of the 35 cancer medicines not funded in New Zealand, only three offered clinically meaningful benefits, with Pharmac already funding one of them, pertuzumab for breast cancer, and considering funding for the other two.

The study concluded that:

> A policy of funding more new cancer medicines in order to achieve numerical parity with Australia or other countries would not result in substantive health improvement and would cost significantly more....

Do you have any comment on that conclusion by Pharmac?

Dr. Graeme Jarvis: It came in for a lot of criticism publicly from oncologists at the time it was first released. It's not based.... As I mentioned, the studies that I saw had been based on the real world, so they were looking at this vast system with their medicines in it.

The Pharmac study was pretty much based on the clinical trial evidence and came in for, not surprisingly, a lot of criticism in Australia. It's like saying the Australian health system is wasting $400 million on cancer medicines that don't achieve anything.

We would refute it; it's not based on real-world evidence. You've got to look at these drugs and where they're utilized, and that study didn't. It was clinical trials. It was based on the clinical trial data.

● (1240)

Mr. Don Davies: Thank you.

The Vice-Chair (Mr. Len Webber): Thank you, Mr. Davies.

We're going to quickly move on to Mr. Ayoub from the Liberal Party.

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Is it me?

The Vice-Chair (Mr. Len Webber): Okay, go ahead, Mr. Darshan Kang.

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

Thanks for getting up early in the morning and sharing your thoughts on Pharmac.

As my first question, you have to bargain with the pharmaceutical companies. It's probably hard bargaining, and this may be time-consuming too. As the power to gain a stronger hand on negotiations is important to savings on costs and also the supply of drugs, how does New Zealand negotiate for drugs for rare disorders, which may have astronomical costs?

Ms. Heather Roy: The area of rare disorders is very problematic, because Pharmac looks at issues from a population perspective, so those rare disorders actually are difficult to deal with. I don't think that those who suffer in New Zealand are particularly generously treated.

A year ago the government instructed Pharmac to reallocate some money for rare disorders, although our understanding is that it hasn't really been spent. It was a small amount for five years, and that budget hasn't been used, but Graeme might have some other comments about that.

Dr. Graeme Jarvis: It's timely, because Pharmac is just reviewing the rare disorders program after five years and invested around $25 million. I think it has 10 medicines that it has put through. Not to be critical, but in one case I'm aware of, the medicine they approved for funding actually has no New Zealand patients, so no one is actually eligible to get this medicine for a rare disorder in New Zealand.

Young patients are eligible, but at the moment we don't have any young patients with this particular rare disease. It was modelled, I think, on the Scottish rare disease fund, so it's a separate amount of money, but when someone inquired under an official information act request to Pharmac, they found out that the money wasn't referenced for that fund at all.

They're just reviewing that fund at the moment. As Heather said, it's quite full, because the medicines are quite expensive. It's not for a lot of people, and Pharmac buys on behalf of the entire population of the community of New Zealand.

Mr. Darshan Singh Kang: Are they reviewing that secret fund they have there? How long does it take for somebody to tap into that fund? Is it efficient, or is it a tedious kind of process if somebody requests some special medication?

Dr. Graeme Jarvis: You go through the same process for the rare disease medicines that you go through for every other medicine. The process is identical. There is no difference. It's just actually about how you calculate. The cost-utility analysis becomes quite difficult when you have so few patients, and I think that's why a separate fund was set up within the broader community pharmaceutical budget, although, as I said, it—

Mr. Darshan Singh Kang: Does that mean that a medicine may not be on the formulary, if we're talking about some special medication?

Dr. Graeme Jarvis: Because it's for a small population group, it's not necessarily on the formulary, but it will have to be listed through Pharmac.

Mr. Darshan Singh Kang: Thank you.

How transparent are decisions for funding pharmaceuticals in your nation's system? Are the negotiations open to the public in any way, and if not, why not?

Ms. Heather Roy: We think that transparency, or lack of transparency, is a significant issue. That happens at a number of different levels. The area that we are most concerned about is that in the best practices of a health technology assistance system, you wouldn't have your advisory committee as part of the pharmacare system. It should be independent and stand outside of that, but in New Zealand it doesn't. It's all part of the same organization.

The committee is operated by Pharmac. It makes recommendations to the board, so they're making recommendations to themselves, basically. We think that is problematic. There is a lack of transparency. As Graeme described before, we don't know how their assessments are made. We speak often to Pharmac and ask for explanations, but they're very reluctant to shed any light on how they go about making those decisions.

Given that low-priority medicines are often funded ahead of high-priority medicines that might be more expensive, the conclusion we often come to is that these decisions are made on financial grounds rather than on quality scientific grounds.

● (1245)

The Vice-Chair (Mr. Len Webber): You have one minute and 25 seconds.

Mr. Darshan Singh Kang: We are always talking about cost-effectiveness, but quality of life is also important. Chronic health problems are persistent and costly for many, so how does having universal pharmacare affect the quality of life for those people?

Dr. Graeme Jarvis: I will use diabetes as an example. One in 16 New Zealanders has type 2 diabetes, so there are about 250,000 type 2 diabetics in New Zealand in a population of 4.7 million.

Again, it's not just us saying this. I understand, from looking at your formulary, that diabetics in Canada can get access to three different classes of diabetes medicine, such as GLP-1s, DPP-4s, etc.

In New Zealand we have metformin and sulfonylureas and insulin, which is more for type 1 diabetics. Clinicians and specialists have basically argued in the public domain that type 2 diabetics need to have access to some, not all, of these medicines, because they help reduce the comorbidities of diabetes, which at the moment cost New Zealand about $1.1 billion a year.

These are medicines that you get in Canada. These are medicines that are recommended in international guidelines for the treatment of diabetes, and at the moment type 2 diabetics in New Zealand aren't getting access to them. Mainly it's 10% to 20% of type 2 diabetics who actually really need these. It's great to have metformin, but we need these other medicines.

It comes down to getting a good balance. It does have an impact on the chronic disease burden if you're not getting the right treatments that clinicians know would make a difference.

Ms. Heather Roy: The flow-on effect, obviously, is that the costs to the health system overall are much greater further down the track when we don't treat chronic conditions that could have been dealt with more cheaply earlier on.

The Vice-Chair (Mr. Len Webber): Thank you, Mr. Kang.

We'll quickly move on to our Conservative colleague, Dr. Carrie, for five minutes.

Mr. Colin Carrie: Thank you very much, Mr. Chair.

I want to thank the witnesses for getting up early and being with us, as everyone says.

I want to move along this line of questioning about costs versus quality. I believe, Heather, you said that you had been an MP, so you were sort of in that situation that we see ourselves in. We talked about the concern about balance, getting the best outcome for a limited budget and the best return on investment. I guess that's okay, as long as you're not the person who needs the innovative medicine.

You mentioned melanoma. I think to myself, what if I was a New Zealand citizen who had paid for my whole life into this system for pharmaceuticals, but when the day came that I needed an innovative drug, I couldn't get it? In Canada, we have a very vibrant private sector insurance industry. We have vibrant generics and name brand industries.

Do you have any data on people who can't get these innovative drugs? Have you ever had a lawsuit? As I was saying, if I'm part of society down there and I've paid for this entire system my entire life, and then some bureaucrat makes a ruling that I can't have that drug, what do I do if I'm a New Zealand citizen and I need treatment?

● (1250)

Ms. Heather Roy: We don't have lawsuits, for two reasons. First, Pharmac has an exemption from the Commerce Act, so there aren't lawsuits—company versus Pharmac—for that reason. We also have a public insurance-based system called Accident Compensation that deals with accidents only, not illnesses. That system was put in place also to prevent lawsuits from being prevalent in New Zealand. They're not impossible, but they tend not to happen.

With regard to your comment, it's very hard to get data on who's missing out. It's much easier to get data on who is taking medicines, but that leaves a big gap in terms of how many people are missing out.

In the absence of data, we measure how much noise there is out there in the community about people who are not getting access. People think we have a pretty good system, by and large, until they or somebody very close to them develops a disease and is presented with a lack of access to something that their doctor knows would help them with the illness that they have by treating them or curing them. We have had some pretty high-profile public cases in which patients have taken petitions to Parliament, stood on the steps of Parliament. Recently we had a case of melanoma treatment where that exact thing happened. That person's just been awarded the New Zealander of the Year title for 2016.

There is disquiet out there. Many of the patient groups are very vocal and lobby hard because of the lack of access to drugs that they know they would have automatic access to if they lived in Australia, Canada, or the United Kingdom.

The balance is really important. I would like to see much greater transparency around the Pharmac decision-making process, and we would like to see government committing more to the amount of funding that they allocate to Pharmac for pharmaceutical funding.

Mr. Colin Carrie: I find your comments interesting, because in Canada I do have the right as a citizen to purchase private health insurance for pharmaceuticals if I so wish.

Just out of curiosity, from an industry standpoint, I guess, does the private insurance industry for pharmaceuticals down there employ a lot of people? Do you have an industry? I know you have name brand companies down there, but do they actually do a lot of the innovative research in New Zealand, or are you more just purchasers?

It's the same with the generics in Canada. In my community, we have a company that not only does generic manufacturing, but also does research and development, and there are jobs that are included with that. Does New Zealand have that industry that helps the economy overall, or is it pretty much just buying, and that's about it?

Dr. Graeme Jarvis: We are a net importer of pharmaceuticals. Back in 1990 we had two or three domestic New Zealand companies that were mainly generics companies, but one of those companies no longer exists. The other one is a net exporter of generics out of New Zealand. It changed its model in the 1990s. It had to, to be quite frank—I talked to the then owner, who unfortunately has passed away—because of the Pharmac model. Perversely, then, a New Zealand-based generics manufacturer is a net exporter as well.

Our industry nevertheless does have a better economic impact in New Zealand—we just completed a study on this—because they invest in research and development and clinical trials and because they buy raw materials. We've shown that over the past few years, $380 million of goods and services were purchased by our member companies, and the GDP impact from our member companies per annum was $384 million.

Even though we're a net importer in New Zealand, the industry thus still has quite an economic contribution to make. For every person who is working in the industry in New Zealand, another nine New Zealanders are in active employment or partially in employment because of this. The economic multiplier is quite significant from an industry. I'd love to see a bigger domestic industry, but as I've indicated, there are some strong headwinds facing that goal at the moment.

● (1255)

Ms. Heather Roy: None of our member companies manufacture in New Zealand—that all happens offshore—but there are a number of clinical trials done. One tricky thing for them is that they have ethical dilemmas around.... There's never any hope of having our products funded, should we even bother with registering them in New Zealand, and that's problematic, because it means that clinicians have no access to those medicines, even for the private market, should they want to prescribe them.

The Vice-Chair (Mr. Len Webber): Thank you, and thank you, Mr. Carrie.

We'll move quickly on to our friend John Oliver, of the Liberal Party.

Mr. John Oliver: Thank you very much.

Thank you for your testimony. I want to continue on that line of questioning, to make sure I understand this.

You cited a number of delays whereby people in New Zealand aren't able to access certain drugs that would be available in Canada today. Is there a means for people of means to acquire those drugs? Can people leave New Zealand, buy them, bring them in, and continue with their treatments? Is there a private insurance sector in New Zealand that insures people for drugs that aren't available through Pharmac?

Ms. Heather Roy: Our private health care is pretty tiny. About 30% of New Zealanders take out private insurance of some type, but that's predominantly—

Mr. John Oliver: Is that for pharma?

Ms. Heather Roy: No, it's not for pharma; it's predominantly surgical coverage. I think the biggest private insurer allocates a small amount of funding for pharmaceuticals.

Mr. John Oliver: Isn't there a big public demand, then, for private insurance, and for pharma specifically?

Ms. Heather Roy: It's not an offering. I think there is a demand, but it's not an offering.

Mr. John Oliver: Are there any laws prohibiting private insurance from—

Ms. Heather Roy: No.

Dr. Graeme Jarvis: They tend to cover copayments sometimes for Pharmac-funded medicines. Some of the private insurers, to be honest, have started to invest or have special packages for cancer treatments for melanoma and other things, but these are additional, on top of the system proper—

Mr. John Oliver: I only have a few minutes left, so I'm going to keep moving you along. I apologize for seeming rushed at the end of your testimony.

For my second question, I'm curious about the political discourse in New Zealand around pharmacare and what you're doing. The National Party is probably right of centre, and the New Zealand First party is probably further right.

In Canada we have probably 200-plus private insurance companies. If you're not insured through a public system, then you're on your own, pretty much, through employers or through private plans. Is any political party in New Zealand pushing to go back to that kind of fractured private insurance model, or are all the parties focusing on how to do a better job of delivering the national pharma model?

Ms. Heather Roy: The latter was the case in New Zealand.

Mr. John Oliver: Nobody is pushing to replicate what we're doing in Canada and to have huge parts of our population uninsured and uncovered in a very much discombobulated sort of marketplace.

Ms. Heather Roy: No.

Mr. John Oliver: I noticed in your values that you said you recognize the fiscal pressures of providing health services and that you offer solutions before criticism, so I am curious: what have you done through the large pharma companies that are behind you? What are the top things you've recommended as solutions to some of the problems you've identified today?

Dr. Graeme Jarvis: A lot of it has been just to open up the discourse. Quite clearly the companies have asked for transparency in the Pharmac decision-making process. They would be comfortable, I think, Heather, if they were able to sit there when the decisions were being made, to hear that their medicine hasn't been funded for the following reasons. There are delays even in getting those decisions out to them, and time is a pressure for everyone in business.

Those are the sorts of solutions that we've asked for, improvement in the actual processes. I think even politicians in New Zealand from all different parties have also seen that a simple solution is actually to fund it at the correct level. Have we gone too conservative in the way that we actually fund the medicines? I think today we've talked about the evidence that indicates we may have.

Just getting the funding equation correct is a problem for every government, and we want to be part of that solution.

● (1300)

Ms. Heather Roy: The ultimate solution is having a population that is well, so that everyone is able to care well for their families and everybody in work. When you're sick and you can't get the cures that you need to allow those things to happen, you have a problem. The current government actually has a very active program about getting people back to work and making sure that wellness rather than treating illness is a focus.

Mr. John Oliver: In regard to the slowness in bringing in some of the new diabetic treatments and some of the new cancer treatments that you've described today, do you view that as budgetary constraint or do you view it as a slow bureaucratic process in Pharmac? What do you view as the reasons it is not more timely? Have you provided any recommendations to Pharmac on how to improve the timeliness?

Ms. Heather Roy: The short answer to the question is yes. I think there are a number of factors, both budgetary and operational.

Around timeliness for our companies, Pharmac doesn't have to make a decision. It doesn't have to say to a submission that's made, “Yes, we will accept this and fund your new medication” or “No, we won't”. One of the things we have pushed long and hard for is to have timelines in place so that if the answer is no, a company can stop negotiating with Pharmac, which is a very time-consuming thing, and just move on to whatever is next in the pipeline.

Pharmac has been very resistant to putting any sorts of timelines in place at all. We believe that if you can't get to the point where your negotiation is complete in 18 months, you probably don't have something that's worth negotiating over.

Pharmac likes stringing these negotiations out for longer because the patent period during that time becomes smaller, and if they do eventually decide to fund something, the cost isn't going to be so great.

Mr. John Oliver: Thank you very much.

The Vice-Chair (Mr. Len Webber): Thank you. Mr. Oliver, your time is up.

We are past the time available for our session here today. We need to move on and get back to other meetings. However, we do want to thank you sincerely, Mr. Jarvis, Ms. Roy, and Mr. Brougham, for being here today and presenting to us. Your insight was very valuable, so thank you very much.

I just have one very quick question for Ms. Roy, and I'm sure everybody around the table is curious about this. You served in Parliament in New Zealand. Where are you on that political spectrum? What party did you represent?

Some hon. members: Oh, oh!

Ms. Heather Roy: I hate describing things in terms of left and right. I belonged to a very small party called the ACT Party, which still has a presence in Parliament. It's an economically and socially liberal party.

The Vice-Chair (Mr. Len Webber): Okay. That's interesting.

Ms. Heather Roy: Some would say it's far right.

The Vice-Chair (Mr. Len Webber): Very good.

Mr. Ayoub wants to bring something up.

Mr. Ramez Ayoub: It's maybe committee business.

The Vice-Chair (Mr. Len Webber): Okay. Yes, sure, we'll take it up in committee business.

We thank you all very much for being here. We'll move now into committee business.

Dr. Graeme Jarvis: Thank you.

Ms. Heather Roy: Thank you.

The Vice-Chair (Mr. Len Webber): We'll move quickly to committee business.

Go ahead, Mr. Ayoub.

[*Translation*]

Mr. Ramez Ayoub: I'd simply like to raise a technical question, Mr. Chair.

[*English*]

You might want to use your earpieces, because the issue is about translation.

[*Translation*]

While I was listening to the interpretation channel, there were several moments where there was no interpretation at all. Our interpreters are not the problem. There are some technical issues. We have witnesses from New Zealand, and we've had all sorts of technical difficulties today during the entire question period. Personally, I don't always need the interpretation, but today because of the witnesses' accent, among other things, I wanted to listen to the interpretation. And in doing so, I lost a good part of the content of the discussion.

This is in fact an argument in favour of travelling. Things are different when people are on site. This is the type of technical difficulty that arises when we put questions to people who are at the other ends of the earth, and I find this unfortunate. These people are far away, and when we call them, we should take Canada's two official languages into account as we usually do. That is fundamental.

What would have happened if I'd asked a question in French? I don't even know if they have an interpreter on their side. I saw no earphones nor any other such preparation to answer questions. I don't have the impression that they were equipped to do interpretation on their side.

I would like us to take that into consideration for the next time.

● (1305)

[*English*]

The Vice-Chair (Mr. Len Webber): Absolutely, Mr. Ayoub. Thank you for that.

We will have our clerk follow up with translation services to see what we can do for this in the future.

Thank you.

The meeting is adjourned.