HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 073 • 1st SESSION • 42nd PARLIAMENT

EVIDENCE

Tuesday, October 17, 2017

Chair

Mr. Bill Casey

Standing Committee on Health

Tuesday, October 17, 2017

● (1530)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): I call to order meeting number 73 of the Standing Committee on Health. Today we are fortunate to have with us the parliamentary budget officer and several officials from that office.

We welcome Mr. Jean-Denis Fréchette, parliamentary budget officer.

We thank all of you for your assistance on this.

We have with us Mostafa Askari; Carleigh Malanik, financial analyst; Jason Jacques, senior director; and Mark Mahabir, director of policy. Welcome.

My understanding, Mr. Fréchette, is that you are going to start with a short introduction and split your time. The floor is yours.

[*Translation*]

Mr. Jean-Denis Fréchette (Parliamentary Budget Officer, Library of Parliament): Thank you, Chair.

Vice-Chairs, members of the committee, thank you for inviting us to discuss the results of our study.

[*English*]

I would also like to thank you for your motion requesting the PBO to conduct a study on the costing of national pharmacare. It was certainly a challenge, but everyone on the team greatly appreciated the opportunity of working on such a study. It has certainly been a highlight among all our projects.

With your authorization, Mr. Chair, I would like to ask my colleague Carleigh Busby Malanik to make a short presentation on the main points of the report.

[*Translation*]

Thank you, Chair.

[*English*]

Ms. Carleigh Malanik (Financial Analyst, Office of the Parliamentary Budget Officer, Library of Parliament): Thank you.

Seeing as how I have under 10 minutes, I'll jump right in.

The first slide we have is on recollection. It was roughly a year ago today that the committee requested that the PBO cost a pharmacare program. It was also the committee that provided to PBO the parameters of that pharmacare program.

Very quickly, I'll note that it was to be universally accessible to all Canadians and have a standardized list of drugs that would be reimbursed, and that list would be equivalent to the drugs listed on Quebec's public drug plan. There would be a $5 copayment for all brand-name drug prescriptions, and there would be a copayment exemption for these that would match what the U.K. currently offers as exemptions.

Consistent with our general practice, we reviewed the literature, reached out to stakeholders in the public and private sector, and received feedback along the way. Once the draft was completed, we had it peer reviewed and incorporated the feedback we received.

I'm very happy to be here today to present the results of this year-long collaboration.

This first slide presents a few things. I'll point your attention to the bolded or dark line at the bottom, where you can see that in 2015-16 Canadians spent roughly $28.5 billion on prescription drugs. This amount excludes any over-the-counter medications, and it excludes any prescriptions that were administered in hospitals. I'll turn your attention to the far bottom right of the slide, which shows that in 2015-16 public plans represented roughly 46% of this total expenditure. The remaining amounts were paid for by private insurers or out of pocket.

I would also like to add at this time that the out-of-pocket expenditures do not include any insurance premiums paid to the insurance providers. They are strictly what was paid for the drug itself.

The drug expenditures include the cost of the medication, any markups from wholesale, and any professional fees that were charged.

Lastly, what this table shows is that, consistent with what previous literature has shown, there is a variation in the level of coverage for pharmaceutical drug insurance across the provinces.

The next two slides speak to the government's role currently in pharmaceutical spending and drug insurance coverage.

Beginning with the federal government, we can see that they have some direct spending for some populations, which is estimated at $645 million in 2015-16. They play a larger role in the regulatory area. They also offer some relief to taxpayers through the tax and transfer system. Also, a larger role is that of funding the provinces through the Canada health transfer and the Canada Health Act.

The next slide speaks to the provincial counterparts. You can see on the chart on the right that their spending on prescribed drugs is an estimated $13.1 billion. That is because they're responsible for the delivery of these services and the funding and financing of them. They also have some control, in that they are responsible for creating the formularies, or the specific drugs that will be reimbursed on their plans, and also for stipulating the eligibility criteria for the populations that would receive coverage.

Before jumping into the pharmacare and the results, I would like to take this time to discuss the scope of this report, particularly the scope of the cost estimate that was included in this report.

To be as specific as I can, it reflects the cost to the federal government for the drug expenditures under a pharmacare plan; that is, it includes the cost of the medication, any markups, and any fees. It does not include things such as any savings or costs resulting from a consolidated administration; any new costs from legislation, regulations, or negotiations; and any other impacts to other sectors. Until PBO is provided with a policy including how this program will be implemented, it is really difficult to get at these additional costs.

The next slide shows an overview of the parameters provided by this committee and marries them with PBO's own assumptions that we've made. As shown on the left of the slide, we have our patients currently consuming drugs at current prices and at current volume. Summed up, this is our $28.5 billion. When we're talking about pharmacare, we're talking about a subset of drugs: just those listed on Quebec's public plan.

● (1535)

This is where PBO begins to make some assumptions: first, since it is a single-payer system, PBO assumed that the federal government would be able to negotiate lower prices for these specific drugs, and second, this plan would operate as current public plans do, in that they impose generic substitution. What it means is that if a patient is consuming a brand-name drug, they would be switched over to the generic, which typically costs less, assuming that it is safe to do so and there is one available.

We have the other parameter provided by this committee: the copayments on brand-name drugs. This would be a source of revenue for the government and would bring down the cost of pharmacare.

Also, as shown at the top of the slide, we also have a PBO assumption, which is that because this pharmacare plan is universally accessible, and because the out-of-pocket costs to patients would be reduced to zero if they're purchasing a generic —or $5 if they're purchasing a brand-name drug—we would see an increase in the volume of drugs consumed.

The next two slides walk you through these results, adding on the assumptions one by one. At the beginning, we have our $28.5 billion currently consumed in 2015-16. When we add on the formulary, we're talking about $24.6 billion. When we add on our next assumption of it being universally accessible, we would see an increase in volume of roughly 12.5%. This assumption was applied to all but a select group of drugs on the formulary. This resulted in an increase in costs of roughly $26.3 billion.

Offsetting this increase, however, is PBO's assumption around the price negotiations the federal government would be able to achieve. This was done in a two-step process. The first was that we assumed the federal government would be able to achieve the lowest price currently observed in Canada. Typically this was the price in Quebec, since that is what Quebec demands of the drug manufacturers. On top of that, PBO assumed that there would be a price discount of 25%. This represents an average savings across the board for all of these drugs on the formulary. In reality, when this is negotiated, this could vary significantly drug by drug or drug class by drug class.

We arrived at this 25% by consultation with the stakeholders and with our peer reviewers, who looked at an estimate of what the pan-Canadian pharmaceutical alliance might currently be achieving through their negotiations, and also in recognizing that Canadians typically spend a lot more on drugs compared to other nations. That 25% represents our average best guess, although we do provide sensitivity analysis in the appendix.

The final assumption to get our gross cost estimate is the generic substitution. That's where we arrive at $20.4 billion. To arrive at the net cost estimate for the federal government, we subtract the copayment revenues, net of any exemptions. As well, we subtract the amount the federal government is currently spending on some subpopulations. It's with this that we arrive at our net cost estimate of $19.3 billion.

I've listed the amounts of the net copayments and the direct expenditures underneath the table, as well as one other number: the markups and fees. There are two reasons why I highlighted this. The first reason is that the $7.4 billion associated with markups and fees is a sizable portion of this gross cost and net cost estimate, but it's also to remind myself to tell you that it's because we didn't make any assumptions about what would happen to these markups and fees. We assumed that the rates would remain as currently observed, but we adjusted them to account for this increase in volume. In reality, this is something that could be adjusted or negotiated.

Turning quickly now to the conclusions of the report, first and foremost, our net cost estimate to the federal government for this pharmacare plan is $19.3 billion. This cost estimate of course is sensitive to the parameters provided, as well as the assumptions the PBO made. We do provide some sensitivity analysis.

Next is that patients' out-of-pocket expenditures are expected to decrease, and we estimate by 90% on average. This of course would vary, depending on what the patient currently pays. Under pharmacare their costs could go to zero—or a 100% decrease—if they're purchasing a generic or to $5 if they're purchasing a brand-name drug.

In general, the results suggest that there could be savings under a single-payer system, as long as the savings can be achieved through the assumptions the PBO has made.

● (1540)

The last slide presents our five-year projection for pharmacare, both the gross cost and the net cost estimates. In 2020-21, PBO estimates that the gross pharmacare cost would increase to $23.7 billion and the net cost to $22.6 billion. Again, these projections are also sensitive to what would be coming down the pipeline, market composition, and future drug prices.

That concludes my presentation.

The Chair: Thank you very much.

We'll go now to our seven-minute rounds of questions, starting with Mr. Oliver.

Mr. John Oliver (Oakville, Lib.): Thank you, Chair.

Thank you very much for preparing an excellent report. It certainly sheds a lot of light on the model, the costing, and the approaches to the model that we've been discussing for some time now here at committee, so thank you very much for that.

I want to summarize to make sure I have this right. In 2015-16, $28.5 billion was spent on prescription medicines outside of hospitals across Canada. Approximately $3.9 billion wouldn't have qualified for coverage under the Quebec model, which, we understand, is a sort of gold-plated model.

Some $4.2 billion would result in efficiencies, savings, and changes in pricing consumption, leaving a net cost to the federal government of $20.4 billion to cover all Canadians. All Canadians would be covered with $20.4 billion, because you've built in those that were not covered.

Then, in the same period of time, 2015-16, the public sector spent $13.1 billion and the private sector spent $10.7 billion—these are employers—so the public and private employers spent $23.8 billion.

Can I safely put those numbers together and say that we need $20.4 billion to cover every Canadian with a national pharmacare model and that $23.8 billion is already in play to cover drug plans? We could actually fully implement a pharmacare model and save employers $3.4 billion at the same time. Have I put all that together correctly?

● (1545)

Ms. Carleigh Malanik: To answer the first part of your question, yes, you broke down the expenditures and the net cost to the federal government.

We didn't directly provide a comparison of what it would save private payers or public payers, because there are still a lot of moving parts that we weren't able to account for. All I can really say at this point is that if you wanted to cover this list of drugs, it would cost the government $20.4 billion, that public plans are paying $13.1 billion right now, and that the private sector is paying $10.7 billion. It's just a little hard to put together because of all the additional moving parts.

Mr. John Oliver: Do you have reasonable confidence in that private employer number, though?

Mr. Mostafa Askari (Assistant Parliamentary Budget Officer, Office of the Parliamentary Budget Officer, Library of Parliament): I think the point is that on the private expenditures, they cover some of the drugs that are not in the Quebec formulary, so it's hard to know exactly how you can divide those. There will certainly be savings on the part of the private sector, but we haven't really figured out exactly how that will be divided because of the differences in the coverage.

Mr. John Oliver: On the $3.9 billion that was excluded because it was not in the Quebec formulary, would that have been spread pretty equally across both public and private employer populations?

Mr. Mostafa Askari: I don't think we can say that, really.

Ms. Carleigh Malanik: No, we didn't actually look at the $3.9 billion. It was only the remaining $20.4 billion.

Mr. John Oliver: Okay.

On those employer costs and the admin fee, there are private insurance companies that administrate these plans for them. I think they typically charge an admin fee of 4% to 5%. In the public and private employer costings, do the costs of the drugs you've covered include the admin fee or just the cost of the pharmaceuticals themselves?

Ms. Carleigh Malanik: It includes the cost of medication, any markups from wholesale to the distributers, and any pharmacist fees that would be applied. It's not including anything charged to the patients to pay for their insurance.

Mr. John Oliver: But the company itself.... I used to run a hospital. I know that our hospital system had a drug plan. It was administered by a private insurer; I won't mention the name. They would charge a percentage to the employer to administrate the fund for them. They would get a 5% add-on to the cost of the drugs to cover the cost of the plan. In these costings, have you built that in or not?

Ms. Carleigh Malanik: No, that would not be included in the costing.

Mr. John Oliver: Okay. So there would be a further 3%, 4% or 5% gain for all the public and private employers based on plan administration. That is sitting there not yet quantified.

Ms. Carleigh Malanik: Yes. An additional insurance premium is paid by patients.

Mr. John Oliver: Okay. Thank you.

In terms of the value, I think you said that pricing would be reduced by about 25% across the board in terms of one of the efficiencies of moving to a national plan, but I noted that the U.S. Veterans Health Administration pays about 50% less than the Canadian public plans pay for generic drugs, and about 40% less than the current Canadian list brands for brand-name drugs.

In terms of that 25%, it looks like another big bulk buying group, smaller even than what Canada would have, with regard to the VA, can get better than 25%. You were just being conservative with that? Or did you have another reason for that 25%?

● (1550)

Mr. Jean-Denis Fréchette: We're prudent.

Ms. Carleigh Malanik: As Jean-Denis said, we're prudent. It reflects our best guess. No one seems to really know where we could land, and 25% seemed to be an agreeable number when we reached out to stakeholders. Again, we do go up to 30% in our sensitivity analysis. I think it's very easy to assume as well that if the savings were to be even greater, you can do that calculation quite simply and see where you would arrive.

Mr. John Oliver: To go back to the employers, I know that we didn't ask you in your pricing, but in looking at the private sector employers, did you have any sense of the size of these firms? Were they mostly businesses with 50 or more employees? In my riding, most small businesses with one or two employees don't often provide drug coverage. Do you have any sense of the scale of the private sector firms that are providing drug coverage?

Ms. Carleigh Malanik: No, unfortunately not. The only statistics that we looked at and were able to provide are listed in the report. Generally, if you were going to pay a copayment or have co-insurance and things like that, we didn't really get into the scale of these programs.

The Chair: Okay. We're moving to Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair.

I appreciate the hard work and time that has gone into this costing study. I am curious to know how accurate the PBO cost forecasts have turned out to be in the past.

Can you give examples of costing projections that you have done and give me your best and worst results, preferably as a percentage of error? What is the PBO track record on costing projections? How accurate and how inaccurate has the PBO been in the past?

Mr. Jean-Denis Fréchette: That's a good question.

I'm looking at my senior director of costing right now. I don't think we did that kind of accuracy measure.

Mr. Jason Jacques (Senior Director, Costing and Budget Analysis, Office of the Parliamentary Budget Officer, Library of Parliament): No, we haven't. We have done work with respect to our economic and fiscal outlook and do regular work on an ongoing basis, particularly in looking at the accuracy of those forecasts five years out.

With respect to more comprehensive costing reports, we haven't done anything on a comprehensive basis, although I would hasten to add that for us we always like to place the emphasis not on the numbers themselves, but on the planning framework that we're actually providing to parliamentarians. For us, we know that at the end of the day the numbers will always be wrong, as a matter of fact.

More important, of course, is the question of the assumptions that go into those numbers and, more importantly, the planning framework, those levers that we're identifying in terms of the cost drivers and that we highlight to parliamentarians, so that when parliamentarians are developing policy they have a good sense of how those are actually connected to the policy outcomes. I think that in that regard we've done an excellent job.

Mr. Jean-Denis Fréchette: If I may, we can give you a couple of examples. On costing the ships for National Defence, for example, we were pretty accurate. The same thing can be said about the F-35 with regard to my predecessor. We do have these kinds of examples where we do the costing.

In costing, fiscal measures are easier to measure, because after the fact you know exactly that Finance will come with its own numbers and we can compare. Costing a model like that is totally different because we have some factors that.... It's always a balanced approach that we have for these kinds of projects. Measuring how precise it could be can be very difficult.

Mr. Len Webber: Yes. I was told when I first came here to Ottawa that for any number the government budgeted for, you could basically double that to be accurate, and that for anything that involves IT, it can be tripled.

You did answer what my next question was going to be by giving me some examples of where the federal government accurately budgeted and delivered a large program. I'll move on, then, to my province of Alberta. As you know, in Alberta there's a growing number of people who are upset with the equalization program. I have talked to a lot of people who tell me that Alberta would be able to offer more services, such as pharmacare, if they didn't have to pay so much in equalization.

Quebec has been the largest beneficiary of equalization payments over the years. This was the model chosen for this study, if I'm correct. Why did we pick Quebec as the foundation for this study? Was that something that we did as a committee to instruct the PBO? Can you talk a bit about why we chose Quebec?

● (1555)

Mr. Jean-Denis Fréchette: Yes. Thank you for the question.

After the first motion from this committee, we came back and asked for some specific measures or models that we could use. After the second meeting, the model of Quebec was used, because it's very comprehensive. As we mentioned, it covers about 80% to 90% of the expenditures of all provinces. It is comprehensive. It is an expensive program, believe me. I live in Quebec, so I know how much it costs. That was the committee's decision to use Quebec's RAMQ model.

Mr. Len Webber: Okay.

How much time do I have, Mr. Chair?

The Chair: You have two more minutes and a bit.

Mr. Len Webber: Okay. Here's another question. If the federal government starts covering drug costs, why would the insurance industry not just stop paying for those same drugs they currently cover? Really, they are a business and would love to off-load their costs, of course.

How did your costing model take this scenario or effect into account? Does your model assume that the private sector would voluntarily continue to cover all the costs that they currently do?

Ms. Carleigh Malanik: Consistent with what was asked of us and how the pharmacare plan would look according to the committee, it was our understanding that this public plan would supplant all other insurers for those particular drugs. Inherently, we assumed that this $3.9 billion that's not included in the formulary would continue to operate, but we made no further assumptions as to whether the private sector would continue to provide insurance for that or not.

Mr. Len Webber: Shouldn't we assume that any drug the government is willing to pick up for those without coverage currently would be delisted by private insurers? If this were to happen, what additional costs should we expect to be added to your model?

Mr. Mostafa Askari: It shouldn't really have any impact on the costs from the model, because we are assuming that those drugs will be replaced and will be paid for by public insurance. There isn't really any additional cost.

Mr. Len Webber: All right.

Do you have any questions you can add here, Marilyn?

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): When we look at the total cost of the plan to cover all Canadians, we come to $19.3 billion, if everything goes as planned. In looking at your report, it looks to me as though today about 12% of Canadians don't have full coverage, with 2% who don't have any coverage, and 10% who have partial payout, which I think you reference in your report.

If we look at these numbers and that 12% of $19.3 billion, which is about $2.3 billion, does that mean how much it would cost if we just wanted to cover people who aren't covered today? Is that a fair assumption?

Ms. Carleigh Malanik: I would say that it would be a real ballpark estimate. You would have to know what drugs in particular those patients are not buying or not buying as much of. There could be much higher costs or much lower. It's hard to say.

The Chair: Thank you. The time is up.

Mr. Davies, please.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Chair.

Thanks to all of you for your fine work. You've done groundbreaking work that I think will form the basis for what I think should be the next expansion of a national social program in this country.

I want to start with a basic description. I read the totality of your report, and here's the proposition I would like to put to you. It seems to me that you took prudent assumptions—let's call them conservative assumptions—you ignored certain cost-saving measures, you used perhaps one of the widest formularies in the country, if not the widest, which is Quebec's, and your net conclusion was that, using that approach, we would have, as a nation, saved about $4 billion in 2015-16. Do I have that correct?

Ms. Carleigh Malanik: Yes, you do.

Mr. Jean-Denis Fréchette: I would just say that it's a balanced approach, not only prudent, but balanced in terms of what we saw in the literature and so on.

Mr. Don Davies: Right, and I congratulate you on that approach, too, because there are a lot of assumptions that we make in these costing premises.

I want to go through some of these cost savings that have been identified throughout our study and by other stakeholders that I think you did not include as savings measures in your report. One of them I think you've already identified. Am I correct in assuming that potential savings from a streamlined administration system are possible but were not costed in your report? Is that correct?

● (1600)

Ms. Carleigh Malanik: Yes, and it is something that we did indicate in our report.

Mr. Don Davies: Okay.

Second, many have identified the current cost in our system of what's called “cost-related non-adherence”, which is the technical term for what happens when patients get more seriously ill from not taking their medication. Is that an area of potential savings that you did not put a savings figure on in this report?

Ms. Carleigh Malanik: Yes, that is correct.

Mr. Don Davies: Thanks.

With regard to a fixed dispensing regime or a disciplined formulary, I think you've identified that in your report as another source of potential savings for pharmacare, but you also didn't put a number on that in terms of reducing the cost of pharmacare to Canadians. Do I have that right?

Ms. Carleigh Malanik: I'm sorry, but I'm not familiar with the term “fixed dispensing” fees.

Mr. Don Davies: I think you commented on dispensing fees. There was another term you used—

Mr. Mostafa Askari: Markups.

Ms. Carleigh Malanik: Was it markups?

Mr. Don Davies: Markups in dispensing fees, yes.

Ms. Carleigh Malanik: Oh, I see. We assumed they would remain as currently observed.

Mr. Don Davies: Right, so here's my question about it. I think you've identified that as a potential area of further cost savings that could exist, but you didn't put a figure on it.

Ms. Carleigh Malanik: For this one, I'll put a point of caution on it. It could be that you could negotiate these lower, or it could be that pharmacists may need to negotiate a higher fee in order to offset any other rebates they might have been receiving from the drug companies. On that one, we're not exactly sure about which way it would move.

Mr. Don Davies: Okay.

On existing tax subsidies, your report indicated the fact that because "the federal government does not include benefits received" by employees from employer-sponsored health care plans in an employee's taxable income, it is an indirect tax subsidy. I think you estimated that at about "$2,605 million in 2016".

Would I be correct in assuming that if we went to a system that cancelled those existing tax subsidies under national pharmacare, it could be a source of additional savings to the government? Do I have that right?

Ms. Carleigh Malanik: Again, it should, but it would depend on whether wages and salaries would be moved to compensate for that loss of benefit.

Mr. Don Davies: Right. That's assuming that it would no longer be necessary, but that could be a source of potential savings.

Ms. Carleigh Malanik: Potentially, yes.

Mr. Don Davies: Yes.

With regard to something that was touched on by Mr. Oliver, you also used what I will call a conservative discount rate of 25% on a truly national bulk-buying program. We've heard references to the pan-Canadian pharmaceutical alliance, but my understanding is that it's a public purchasing plan. It's not buying all the drugs for all private and public plans in the country.

My information is that the U.S. veterans association pays about 50% less than the Canadian public plans pay for generic drugs, and 40% less than current Canadian list prices. A study in health care policy found that New Zealand paid 51% less than British Columbia for four large established classes of drugs. A recent study by the Patented Medicine Prices Review Board, in comparing the prices of prescription generics in Canada to other industrialized countries, found that for most programs potential cost savings of 40% to 50% seemed feasible.

Would I be correct in assuming that your 25% assumption is probably prudent and it is possible that we achieve savings beyond 25% over current prices from bulk buying?

Ms. Carleigh Malanik: It's certainly a possibility. Again, it would all depend on how well the federal government is able to negotiate for reduced prices for this particular list of drugs.

Mr. Don Davies: Of course, but it seems that international experience as well puts you directly.... In real life, what other countries and jurisdictions are experiencing are savings of 40% to 50% when they go to national bulk buying, but you used a figure of 25%. I'll put it to you again. Would you agree with me that 25% is likely a prudent estimate of the savings that may come from national bulk buying?

Ms. Carleigh Malanik: I'll go this far: 25% is our best guess. We really don't know more of what was in the literature in Canada.

Mr. Don Davies: Okay.

I have one last question if I have time, Mr. Chair.

The Chair: You do.

Mr. Don Davies: We passed a motion at this committee, which said:

> That, in relation to the study of the Development of a National Pharmacare Program, the Chair contact the Parliamentary Budget Officer to:
>
> a. request that his analysis be finished by May 1st, 2017; and that, if not feasible, the Parliamentary Budget Officer be invited to appear before the Subcommittee on Agenda and Procedure to negotiate a schedule; and
>
> b. request that his analysis include the World Health Organization formulary.

Obviously, the first part of it, May 1, came and went, but I'm just curious. Were you ever contacted by the chair to include in your analysis a comparison of the World Health Organization formulary, in addition to the Quebec formulary? I notice that it's not in your report to cost out.

● (1605)

Mr. Jean-Denis Fréchette: No. We had a meeting following the motion, when we discussed the motion with the chair, and it was decided that we would do exactly what the motion said about the RAMQ, and it was the beginning of our study. We told the chair that we may have a follow-up to do eventually on this report.

Mr. Don Davies: My question is, were you ever contacted to then include also the World Health Organization formulary?

Mr. Jean-Denis Fréchette: At the beginning...?

Mr. Don Davies: No, later on.

Mr. Jean-Denis Fréchette: Not that I remember during the meeting.... When we had the meeting just to discuss what we would do and so on, we gave the chair the procedure that we have for all our reports: when we deal with a committee or an individual, we will present the methodology, what will be the approach, and then there's an agreement that we will follow it. At the end of that, if there is some follow-up to do, or additional information, we will be happy to do it. The World Health Organization was discussed in the context of follow-up eventually.

If I may, Mr. Chair, I want to come back to one thing.

You mentioned the 25%. Yes, it is prudent. It is a balance. I can tell you, for example, that the Quebec government already negotiated something else with its own suppliers, which is much higher than that. It is not yet in force in Quebec, but they reached an agreement of almost a 38% reduction on generics. You can see that with the purchasing power, if it's there at the national level, certainly you can go way beyond the 25%.

Thank you.

The Chair: Thanks so much.

Mr. Davies, as I recall—and I stand to be corrected—when we first gave the criteria for the study and the parliamentary budget officer came back and said he couldn't meet the May 1 deadline, we agreed, I think as a committee, to accept the Quebec formulary, instead of the WHO formulary. I might be wrong, but that is my recollection. We went with the Quebec formulary.

Mr. Don Davies: It's my understanding, Mr. Chair, that initially we did give the parliamentary budget officer the Quebec formulary and later on passed another motion that said we would also like to see a costing of the WHO formulary so that we'd have two. It's not a big deal. I'm just trying to find out why it's not there.

The Chair: Dr. Eyolfson, go ahead.

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

My friend Mr. Davies is very adept at stealing my questions today—not deliberately—and I would like to go further on that. We do know that the World Health Organization formulary is a fair bit less inclusive than the Quebec formulary. At any time, did you have access to the expense of the WHO formulary relative to the Quebec formulary? I know that it wasn't included in this.

Ms. Carleigh Malanik: No, we did not.

Mr. Doug Eyolfson: Okay. If that were looked at and were less expensive, would it be a reasonable assumption that this would increase the savings in this model?

Ms. Carleigh Malanik: Yes, the total dollar value would be lower.

In our sensitivity analysis, we used P.E.I. as an example of a different formulary since we could already map it in our data. You can see there that the nominal value does decrease, but the savings are still roughly around $4 billion.

Mr. Doug Eyolfson: Okay. Thank you.

I was going to ask another question, and I will have to expand on it, because again my friend Mr. Davies asked it before I could. This is in regard to the secondary costs of non-compliance. We've discussed that at length. People who can't afford their medications become ill and present to the hospital system. Depending on the nature of their illness, that cost can be quite substantial. For diabetics who go into renal failure, dialysis is going to cost about $70,000 a year per patient.

The Morgan paper “Pharmacare 2020”, by Steve Morgan, says that with the system we have now, without the checks and balances of a national plan, we have “underuse, overuse, and misuse”. The best estimate is that it costs about $5 billion a year. Could we safely assume that if we had this in place and it prevented that, we might encounter savings that would be additional to the savings that you're suggesting?

● (1610)

Mr. Mostafa Askari: Typically in our costing of any program we do not take into account the secondary impacts like the one you mention. The reason for that is that it's very difficult to actually measure those things and come up with an estimate that is reasonable and acceptable to everybody. That's why. Those kinds of health effects are extremely difficult to identify and measure. Because of that, we don't really go there, typically, so we can't really say that the estimate of $5 billion is accurate or reasonable or not. We don't really look at that at all.

Mr. Doug Eyolfson: Okay. If at any time we were to ask that question at a future date, is that the kind of question we could ask?

Mr. Mostafa Askari: Well, as I said, typically we don't do that because it's extremely difficult and you're getting into the area of cost-benefit analysis of a policy. We don't really do that. We only look at the direct financial cost or benefits of any program in that form.

We're trying to be more objective in this, simply because once you get into those areas you're going to have to make huge assumptions, and it becomes somewhat subjective as to what the benefits are of something like that, for example.

Mr. Doug Eyolfson: Just to clarify, you said that you had savings of $4 billion if you used the Quebec model. What were the savings if you used the P.E.I. model?

Ms. Carleigh Malanik: It was just under $4 billion, I believe.

Mr. Doug Eyolfson: Just under?

Ms. Carleigh Malanik: Yes.

Mr. Doug Eyolfson: Okay. Thank you.

That's all I can think of for now, except to say this, just as a follow-up to something my friend Mr. Webber said. He said that the assumption is that if anything in the government comes up with a figure, you can double it. I hope that's true in regard to the projected savings and that we could double it.

Voices: Oh, oh!

The Chair: Thanks very much.

Now we go to our five-minute round, starting with Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair.

Thank you to all our witnesses here today for the work you've done on this great report.

The first question I have has to do with the $5 copay for the brand name. What portion of the $400 million savings in going to the generic is that $5?

Ms. Carleigh Malanik: I'm not sure I understand the question.

Ms. Marilyn Gladu: I think the $5 copay is part of the total in going to the generic plan. In the cost estimate, it looked like the generic substitution was $20.4 billion. It brought the cost down to $20.4 billion from $20.8 billion, so that would be a difference of $400 million. Out of that $400 million, how much is that $5...? It just sounds like a really small amount if I think about the differential between what we pay for brands versus generics.

Ms. Carleigh Malanik: Those two items you point out are actually separate. The $5 copayment is revenue generated to the federal government. That's what we subtract at the end there, I believe, to get down to $20 billion in our presentation. The generic substitution we speak of is the cost of moving from a higher-priced brand to a lower-priced generic.

Ms. Marilyn Gladu: Okay. Very good.

When we go to the total replacement of what's in place privately and publicly, is the intent to pick one provider company? The federal government today has one provider company. My concern is that if you get into a monopoly situation and everybody across the country is provided the same service by one company, the price usually goes up. I don't see that included in your analysis.

Ms. Carleigh Malanik: That is mostly outside our scope because we don't know how this program would actually be implemented. The cost estimate just reflects what the government would be paying, assuming that these drugs would be purchased at a pharmacy and then patients would seek reimbursement. The federal government would pay for that.

Ms. Marilyn Gladu: You may not know this because it might not be part of the study, but was there any information about what the impact will be for pharmaceutical companies in Canada? How many jobs are involved in pharmaceutical companies in Canada that produce brands versus generics? Did you get any information on that?

● (1615)

Ms. Carleigh Malanik: Unfortunately, you are correct. We did not look at that in our report.

Ms. Marilyn Gladu: All right. Too bad.

What has the reaction been to your report from the media and the stakeholders?

Mr. Mostafa Askari: I don't think we have had many reactions. We have seen positive reports, and we are seeing a lot of questions from the public in terms of how this program is going to be implemented. A lot of people are interested in the implementation of the program rather than just the cost, and the implementation is something that we did not really look at.

Ms. Marilyn Gladu: I'm late getting to the dance on this whole study, but can you give me some information about the difference in drug formularies across the provinces? How different are provinces from Quebec? Is it a 10% different list or are they hugely different?

Ms. Carleigh Malanik: We did try to calculate this in one of our tables in the report. Also, the PMPRB released a report looking at just that. In general, there isn't that much variation. Plans typically cover what other public plans are covering in terms of expenditure and the number of drugs. There's some proportion, of course, that would have some variation.

When we looked at how much of the Quebec formulary was covered by other plans, we found results consistent with the PMPRB's. It is very representative across the public plans.

Ms. Marilyn Gladu: Excellent.

There are very expensive drugs that are included in the formularies today. In some cases, there are programs in place to fund those. Did you change any assumptions about those or just assume that it would stay the same?

Ms. Carleigh Malanik: Thank you for that question. If it was covered in the Quebec plan, it would be included in here. There are some drugs identified as the more expensive ones. They're called “exceptional” medications. Typically, the patient has to meet a very strict set of eligibility criteria in order to be reimbursed. We included them in the cost. We assumed that the price discount would be applied to these drugs as well.

The only I guess exception that we made for these drugs was our assumption around increase in utilization. We assumed that drug volume will increase by 12.5% across the board, except for these drugs. With these drugs, we didn't make any increase-in-volume assumptions. The reason for this is that we assumed, because of the strict eligibility criteria in place, that just because the cost is down for the patients, they're not going to start consuming this drug more. We would assume that those strict criteria would remain intact.

The Chair: Thank you very much.

Mr. McKinnon, you have five minutes.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair.

Mr. Davies touched on this and Dr. Eyolfson went at it in more depth, but I want to carry on with it. Last night, I was speaking with a constituent who was telling me of friends who end up in the hospital or the emergency ward on a fairly regularly basis because they couldn't afford their meds. Of course, this represents a considerable cost to the particular hospital and to the provincial plans. It's a cost of not having an effective pharmacare program in place for those people.

Mr. Askari, I believe you spoke of not being comfortable with speculating on what such costs might be. Is that correct?

Mr. Mostafa Askari: That's correct, because, as I said, measuring the health benefits of having the coverage versus not having the coverage is extremely difficult to estimate. It depends on the specific situation, the patients, and the kinds of problems the patients have.

Instead of getting into that area, which becomes somewhat speculative, we decided not to take that into account. Typically in all our costing that's how we do it: we do not take into account the secondary impacts and the knock-on impacts of any program.

Mr. Ron McKinnon: I was speaking with Mr. Jacques before the meeting. He suggested that because of doing this study you have quite a number of people who are experts in these areas. Is that a topic that you would be able to entertain and to give us a number, with suitable caveats and plus or minus error bars and those kinds of things?

Mr. Mostafa Askari: It would take us into an area where we have not been before. That's going to be a completely different area. We do have expertise in terms of the data on pharmacare. Carleigh is obviously an expert in our office now, but in terms of getting the health benefits of this, it is moving a couple of steps beyond what we normally do.

● (1620)

Mr. Ron McKinnon: You wouldn't feel comfortable about being able to give us a number that's plus or minus a billion dollars or something like that.

Mr. Mostafa Askari: It would be extremely difficult for us to do that, yes.

Mr. Ron McKinnon: Are there any other areas you can see like that, areas that we should look at ourselves, in terms of evaluating the benefits of a pharmacare program or the costs of not having one?

That's for anybody.

Mr. Jason Jacques: No. Again, for the purposes of the mandate of the committee, I think our report is an excellent starting point in terms of trying to identify some of the major cost drivers and factors that parliamentarians need to consider if they decide they want to move forward on solving some of the policy problems they've identified with respect to drug coverage across the country, as well as the escalation costs around drugs.

As well, in looking at some of the questions that have been raised around the committee table this afternoon, I think there are evident areas we did not cover in the report, areas that were out of scope, such as looking at the potential impact on the private sector and looking at areas around potential cost savings, including the costs associated with non-adherence to prescription medications when people actually can't afford those medications.

Whether we are best placed to look at those areas that are out of scope or not I think is open to debate. For instance, with respect to the potential cost savings, for the cost savings associated with people not taking their prescription medications, one of the major impediments on that front, of course, is just the lack of data. We're very good at analyzing data. We're very good at manipulating data. Carleigh is well placed to build you a 700-equation model with respect to a new national pharmacare program, but if you don't have data and you don't have good data, then the model isn't really worth a lot.

Just to offer a recommendation, there are other partners we've been working with, such as Statistics Canada, Health Canada, the Patented Medicine Prices Review Board, and the Canadian Institutes of Health Information. They were instrumental in helping us prepare this report in the first place. Many of you have seen them appear as witnesses in the past. I think they would be the first places to turn to in order to collect some of this data. Again, intuitively, in terms of the cost savings associated with people taking the medications their doctors prescribe for them and ensuring that they can afford to do that, there's potential for savings there, and we're happy to analyze that once there's actually good data in place.

Mr. Ron McKinnon: Thank you.

The Chair: Your time is up.

Mr. Van Kesteren.

Mr. Dave Van Kesteren (Chatham-Kent—Leamington, CPC): Thank you, Chair.

It's good to see you again, sir, and likewise Mr. Askari.

I notice that you've picked up a great new employee. Mark was with us on the finance committee.

It's good to see you as well, Mark.

Help me out. You have to dumb this down for me. If I go to page 3, what you're saying is that the total out-of-pocket is $4.7 billion. I guess I should be directing this to Ms. Malanik.

Ms. Carleigh Malanik: Yes.

Mr. Dave Van Kesteren: Did I get that $4.7 billion right? The private sector—the private insurance companies—spends $10.6 million.

Ms. Carleigh Malanik: Yes.

Mr. Dave Van Kesteren: The public sector spends $13.142 million, and the total we're spending in Canada is $28.5 million.

The public sector would represent about what...? Is it 28% of the population, or 35%? What is it? Does anybody know? Do you have that figure?

Ms. Carleigh Malanik: I'm sorry. Did you say the public or the federal...?

Mr. Dave Van Kesteren: I said “public”. It's that column there. What percentage of the population would that be?

Mr. Mostafa Askari: The public we mention is not what the government uses for its own employees. That is the coverage they provide for their population. The various provinces have public insurance for certain groups in their population, such as seniors or people with low incomes. That's the cost for those groups. For example, seniors in Ontario get their prescription drugs free and that costs the Ontario government a certain amount of money. That $13.1 million covers them.

Mr. Dave Van Kesteren: Who would they cover? Can you give us a list?

Mr. Mostafa Askari: Each province is different. Each province has a different kind of program.

As I said, Ontario, for example, covers all the seniors and also some people on welfare. British Columbia has a different kind of public program. They have some income testing, some means testing measures, and they cover certain people below a certain level of income. Each province has a different kind of program, but they all do have some kind of public program for prescription drugs.

● (1625)

Mr. Dave Van Kesteren: Where would MPs fall?

Mr. Mostafa Askari: Pardon me?

Mr. Dave Van Kesteren: Where would MPs fall? Where would we all fall?

Mr. Mostafa Askari: You are part of the cost to the federal government for the insurance it provides to its employees, including Parliament, the RCMP, and the military.

Mr. Dave Van Kesteren: So where would they fall in these...?

Mr. Mostafa Askari: They're not in those numbers.

Mr. Dave Van Kesteren: None of them?

Ms. Carleigh Malanik: Perhaps some of you would be covered by your public plan if you were eligible, but otherwise, if you're talking just about what federal employees receive, this is that $645 million that we're talking about on page 2.

Mr. Dave Van Kesteren: Okay. I'm just a little confused, because on this context, I understand that in total we spend in Canada.... Is $28.5 billion not the total cost spent on drugs in Canada?

Ms. Carleigh Malanik: That's correct.

Mr. Dave Van Kesteren: Again, my question is, where in those three columns—out-of-pocket, private, and public—would a federal employee fall?

Ms. Carleigh Malanik: If they have private insurance, it would fall under the private insurance column.

Mr. Dave Van Kesteren: Do we classify the government's as private insurance?

Ms. Carleigh Malanik: Yes.

Mr. Dave Van Kesteren: All right. The public is, as you mentioned, the groups that would qualify for assistance. Do I have that right?

Ms. Carleigh Malanik: They are eligible for their province's public drug plan. There could be various criteria to meet that.

Mr. Dave Van Kesteren: Okay. Then the out-of-pocket are those who have no plan?

Ms. Carleigh Malanik: In this dataset, it can include those folks. It can also include those who pay the majority of the costs out-of-pocket, so it's possible that this out-of-pocket expenditure is capturing some people who paid the full deductible and then, for the remaining prescriptions, were covered under private insurance.

Mr. Dave Van Kesteren: Okay. Take me to your final analysis, which is that if we, as the federal government, take over all of those groups of people, which encapsulates everyone, it would then cost us $20 billion as opposed to $28 billion. Do I have that right?

Ms. Carleigh Malanik: Yes. Then you can net off any of the copayment revenues that were generated under this pharmacare scenario, then as well subtract that $645 million that they're spending directly on some populations, and then we arrive at the $19.3 billion net cost estimate.

Mr. Dave Van Kesteren: Forgive me for being skeptical, but—

The Chair: We're very short on time.

Mr. Dave Van Kesteren: I'm sorry. What's the difference between the cost per capita in the private sector insurance companies as opposed to what the federal government...? Or do the federal government and all the others use private insurance companies? I guess they would, wouldn't they? It's all private.

Do I have enough time for any more questions?

The Chair: No, your time is up, but thanks very much. It was riveting.

Mr. Ayoub, you have five minutes.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Chair.

We had been waiting for a costing study for a good while. Obviously, it's great to have data at hand when making decisions.

Given the results that you have presented, which include possible cost reductions, my first reaction is to say that clearly, we can make improvements here.

In your study, you used the list of drugs covered by the Régie de l'assurance-maladie du Québec, the RAMQ. Are you able to say if the results could apply elsewhere, using Quebec as an example? Would it be possible to reduce current costs in each and every province using the comparison model that you have in your study, without creating a pan-Canadian pharmacare plan per se?

Have I expressed myself clearly?

Mr. Jean-Denis Fréchette: Thank you for the question.

That would mean not aggregating all the provinces as we have done. You are asking if the RAMQ model could be used everywhere.

I would say that it all comes down essentially to one's capacity to negotiate. Someone gave the example of U.S. veterans. If all the provinces came together, then that group's strength and the volume of drugs are what gives it negotiating clout.

The RAMQ in Quebec is able to negotiate because it manages a universal program which is much more extensive than that of many of the other provinces. That is the first factor to take into account.

Here is the second. You know very well what is also going on in Quebec, i.e., in terms of pharmacists' dispensing fees. You will have followed the debate. Dispensing fees in Quebec range from 8% to 90% of a drug's price. The RAMQ, because it buys huge quantities and has total control over its formulary, is able to negotiate and impose certain rules.

If we did indeed have a national program, and this is what we're trying to prove in our study, as long as all the provinces have negotiating power, this national program would wield enough clout that we would be able to save $4 billion post-negotiation and enjoy price reductions, as well as provide much more extensive coverage. What's more, we could cover everyone, which is currently not the case.

● (1630)

Mr. Ramez Ayoub: Would I be wrong in assuming that the provinces could save quite a bit if they came together to increase their purchasing power, but without offering the exact same coverage? Would that sort of set-up be possible?

Mr. Jean-Denis Fréchette: It's already the case now. There is an alliance that brings together all the provinces in negotiations in order to establish a national price. We could go even further.

Mr. Ramez Ayoub: According to the study that you've presented to us, to go further would mean that we would save more. Is that right?

Mr. Jean-Denis Fréchette: Absolutely.

Mr. Ramez Ayoub: There was another study published in 2015, the Morgan study.

Could you explain to us the differences as to methodology or cost analysis? There is a difference in savings between $7.3 billion in the Morgan study and $4.2 billion in the study you presented here today. Could you expound on that?

Many studies contain different figures. Obviously, the methodologies and analyses used aren't necessarily the same. How can we trust one study more than an other?

We would like to be able to quickly move ahead, because we desperately want to save money and offer the best service possible to Canadians when it comes to drug accessibility.

Mr. Jean-Denis Fréchette: Thank you for the question.

I will give Ms. Malanik a minute to prepare her answer to your question.

While we are waiting, I can state that the authors of the Morgan study, which was done in 2015, used a different formulary. The analysis is therefore not the same. They also used data that was older than ours. We spent money in order to obtain the most recent data possible and this is exactly what allowed us to develop the model which we've presented today.

[*English*]

I don't know, Carleigh, if you want to add something.

Ms. Carleigh Malanik: In particular, if you're speaking about his 2015 article that came out, you're exactly right: the differences stem mostly from methodology and a little bit from scope. It's our understanding that we're using a formulary, whereas his 2015 article didn't use a particular formulary. It was even more encompassing.

Beyond that, it was the assumptions around, for example, an increase in volume due to lower costs to the patient. Generic substitution effects in our database were targeted based on what we observed nationally, whereas in Professor Morgan's report he used rates observed in public plans and targeted a specific rate. The prices themselves as well were targeting other nations, as opposed to using a 25% price discount, and they varied by the drug class.

Finally, I believe that we were able to calculate—more or less—the pharmacists' fees and the markups together, whereas Professor Morgan was only able to estimate them and try to guess at what they were.

Mr. Ramez Ayoub: Thank you.

I think my time is up.

The Chair: Yes, your time is up.

Mr. Davies, you have three minutes.

Mr. Don Davies: Thank you.

I just have some quick snappers.

You said your report was peer reviewed. Who reviewed it?

● (1635)

Ms. Carleigh Malanik: We do have a list that is provided on the cover. We had two academics. I'm sorry, but I don't have the latest draft.

Mr. Don Davies: It's on the inside cover...? Is that where it is?

Ms. Carleigh Malanik: Yes.

Mr. Don Davies: Okay.

Ms. Carleigh Malanik: We had the academics and then the representatives from the Patented Medicine Prices Review Board and the Canadian Institute for Health Information.

Mr. Don Davies: Thanks.

On cost-related non-adherence, it seems to me that you wisely didn't try to estimate, because of the reasoning you gave, Mr. Askari, but was there any research already done by independent sources that have attempted to estimate what the savings might or might not be from cost-related non-adherence? I know you couldn't do it, but could anybody else do it?

Mr. Mostafa Askari: I'm sure there are others who can do it and have tried to do it. I am not aware of any in a specific study.

Jason, have you?

Mr. Jason Jacques: Yes, there was one paper in particular in a Canadian context, but it was going back to the mid-1990s. It was a very small sample size. It was very targeted to one single organization. It was over 20 years old. Even by PBO standards, we thought that it was probably precarious to base an assumption on that.

Mr. Don Davies: So you did look for...?

Mr. Jason Jacques: We did. It was an exhaustive literature review.

Mr. Don Davies: I'm just going to put a very blunt question to you. This is my conclusion from your report. Using your conservative assumptions, leaving out certain cost drivers and using a wide formulary, you came to the conclusion, even in that context, that Canada would have saved $4.2 billion in 2015-16. Am I correct that it's likely the savings would be more than that? Isn't that the logical conclusion from leaving out five or six different cost savings that you've identified as cost savers but are things that you didn't put a number on?

Mr. Mostafa Askari: It is likely to be less than that. It's also likely to be more than that, because we are also making assumptions about increasing consumption, which again is an estimate, based on the numbers that we have in the literature. The consumption may actually be higher than that. That's a possibility.

Mr. Don Davies: Yes, but Mr. Askari, you put a number on increased consumption and you get an estimate. I'm talking about five different areas—and there are actually a few more—that you identified in your report as cost savings, but you didn't attribute a dollar to them. Your own report says, “Here are other places where we could save money, but we don't want to put any cost savings on that.”

I'm making the assumption, which is what I'm putting to you, is that it's likely that if there are cost savings, that $4.2 billion, there would likely be even more savings. What am I missing there?

Mr. Jason Jacques: The reason that the parliamentary budget officer identified our number is that we call it a “balance number”. On the other side, of course, we end up having, for the 2015-16 savings estimate, a complete immediate phase-in of the actual negotiated savings with respect to negotiation around drug pricing. I think for most people in this room imagining that tomorrow the Government of Canada will go out and negotiate an immediate 25% savings.... It's simply not something that's going to happen overnight. As well—

Mr. Don Davies: Can I—

The Chair: Your time is up.

Mr. Jason Jacques: As well, looking at that, drug prices are of course moving targets. We have probably the best dataset available within the public sector right now with respect to the composition of drugs and drug consumption. That is changing dynamically over time.

Going back to a point I made earlier, which my colleagues will likely strangle me for saying, we produce these forecasts not because we're going to be right. We produce these forecasts to set up a planning environment for parliamentarians. Conceptually, based upon this paper, are we comfortable that this is a balanced estimate of the potential savings? Absolutely. In order to achieve those savings, are there many open questions with respect to the implementation? Absolutely. Will that implementation directly affect the actual savings that could potentially be realized by the federal government? Most certainly.

The Chair: Okay. Thanks very much.

It's twenty minutes to five. We have time for another round of five-minute questions. Is that the consensus?

Before I do that, I want to clarify that the next meeting on Thursday is the round table meeting. On the 24th and 26th, we have no meetings scheduled. On the 31st, we have drafting instructions. I wanted to make sure everybody was clear on that, because there was a little confusion.

For the next round, I have Mr. Oliver up first.

Mr. John Oliver: Thank you.

I first wanted to ask again about this and make sure I understand what is in the public insurance plans and what is in the private insurance plans. I'm trying to figure out what taxpayers are already on the hook for.

If I think about the CHUMS group—colleges, hospitals, universities, municipalities, schools, and government—those employees are covered by employer plans. Would they be in the private insurance plans or the public insurance plan...?

● (1640)

Ms. Carleigh Malanik: They'd be in the private insurance plans.

Mr. John Oliver: Taxpayers, then, are already paying for the $13 billion that is in the public insurance plans. Of that $10.7 billion, do you have any idea on what are private employers and what are the CHUMS publicly funded private employers?

Ms. Carleigh Malanik: No, we don't.

Mr. John Oliver: Taxpayers are already, then, covering a much greater proportion of these drug costs. I thought they were just in that $13 billion. That makes this even more affordable if I think about implementation going forward.

In the exclusion of the roughly $3.8 billion that was excluded based on the Quebec formulary, I saw a sub-note saying that it was mostly medicinal dressings or dressings with medicinal additives. What else is excluded? What would somebody in a private plan today not have access to because of the Quebec formulary? Is it mostly lifestyle drugs, besides dressings?

Ms. Carleigh Malanik: The medicinal dressings you're talking about were the drugs that I wasn't able to.... They're on the RAMQ formulary. I just wasn't able to link them into our dataset. It's not that they're missing from the private plan.

The amounts you're talking about that are missing are only exclusively in the private plan and would fall into that $3.9 billion that we didn't look at. We didn't take another look at what was in there at all, but we do have that information.

Mr. John Oliver: Maybe you were asked, but is that something you would easily be able to produce for us just so we can see what would be excluded? We could get some sense if we went forward with this plan of currently what people who are employed would have access to and what they wouldn't. Is that an accessible file for you?

Ms. Carleigh Malanik: Yes. We could break down that $3.9 billion.

Mr. John Oliver: That's great. It would be good to know just what would be excluded.

For me, then, if I look at this, let's say we have a single mom, unemployed, who takes her kid to the doctor's office and doesn't have benefits. Under this model, she would get a prescription from her family doctor or nurse practitioner. That prescription would be tested against a formulary of some kind—hopefully one that's national and put together by the feds, the provinces, and the territories—and she would then go to a local pharmacy and have the prescription filled.

Depending on the means test, there may or may not be a $5 copayment; I guess that's whether or not she chooses generics. The cost of those meds, if we went to a single-payer system, would likely be covered by the province or territory through the existing payment systems in place in pharmacies for the ODB and other provincial plans. She would be able to go home.

The cost to us of the government doing that would be about $20.4 billion, and we already have more than $23 billion being spent just on employed people in Canada, so we could set that mom up with an insured plan and still save public funds on top of the $4 billion that you've identified as savings.

Ms. Carleigh Malanik: Ultimately, Canadians are the ones paying for everything here. If you're talking about who's paying that way, then yes, we're still talking about the taxpayer.

Mr. John Oliver: Yes, but they're already putting in $13.1 billion, and then some big chunk of that $10.7 billion is the CHUMS and government employees, so the taxpayer is already there.

Then for the private employers—the true private employers, not the businesses that have a number of employees and have their own benefit plans—we could say to them that we could insure their employees and offer them a significant.... We could say that we could cover their employees for them and they'll get a significant portion of their current benefit plan payments back. Is that correct, depending on how the assumptions are made around how we make the payment happen, the $20.4 billion?

Ms. Carleigh Malanik: If I understand correctly, I think what you're asking me is not how much Canadians are paying, but how much governments are paying. Is that correct?

Mr. John Oliver: It's governments and the private sector employers who have plans for their employees. We could say to them as well that we will cover their employees, make sure they have access to the drugs they need so that they're healthy for their workplace, and they'll get some savings back on top of that.

Ms. Carleigh Malanik: I don't know the breakdown of that $10.7 billion, but the idea is that, yes, the federal government would be responsible for paying this and all other insurers would go away under the pharmacare plan for those drugs. I'm sorry that I can't be more specific about the breakdown of that $10.7 billion.

● (1645)

Mr. John Oliver: Okay.

The Chair: Your time is up.

Mr. Jean-Denis Fréchette: I'm sorry, Mr. Chair, but could I add something?

The Chair: Yes, briefly.

Mr. Jean-Denis Fréchette: There is something interesting in the report that is exactly about what you are mentioning. I think the question was raised about how the members here and all in the public service are covered by the private insurance of the public service, which is at $654 million. It's exactly—this is the magic of numbers—what the national pharmacare plan would cover for the same public, which means the public service and the members of this committee. It tells you that a national program will cover exactly what private insurance companies are covering right now for the public service.

Mr. John Oliver: And save the admin fee on top?

Mr. Jean-Denis Fréchette: You said that.

Voices: Oh, oh!

The Chair: Thank you very much.

Now we go to Ms. Gladu for five minutes.

Ms. Marilyn Gladu: Thank you, Chair.

If we decide to go ahead and do a national pharmacare program, I'm assuming that we'll need more government employees to administer the program. Are the costs of that included in this report? If so, how many employees do you think it will take?

Mr. Mostafa Askari: The structure that is going to run this administratively is not something that we have taken into account in terms of how this plan is going to be implemented. If the program is approved and the government wants to go ahead with it, there obviously have to be negotiations between the federal government and the provinces to see how they want to implement it.

The provinces already pay about $13 billion for such a program, but if there are going to be negotiations, they are obviously not going to be easy ones. As for how they decide to do that and whether it's going to be a federal program completely run by the federal government, or a program run by each province separately that the federal government would contribute to, those are the things that we have not taken into account at all.

Ms. Marilyn Gladu: I'm also trying to figure out exactly how much extra money, besides what we're paying already, we would have to pay to implement this. Regarding the public column, is that money today all from the federal transfer payments, or is some of that provincial money that's being spent as well?

Ms. Carleigh Malanik: That $13.1 billion is what the provinces are spending on their public drug plans. They do receive the Canada health transfer. Those transfers are meant for many more health services than just pharmaceuticals. They enter the provinces like general revenues, and they can spend them as they want. Conceivably, a portion of that transfer is paying for some of this drug expenditure, but we can't say how much.

Ms. Marilyn Gladu: You can't really say, then, that of the $19.3 billion it's going to cost we're already transferring to the provinces $13.1 billion for this, so it's the differential that's really the net line item that we would have to put in the budget.

Ms. Carleigh Malanik: That's correct. Again, the Canada health transfer is for much more than pharmaceuticals.

Ms. Marilyn Gladu: All right.

Did you do any benchmarking with other jurisdictions? There are a lot of places in the world that have a national pharmacare program. Did you look at what the costs of their programs are? Is there any information we could benchmark to see whether this is reasonable?

Ms. Carleigh Malanik: When we looked at the literature, there was nothing so clean cut to compare it to in that way, but we did look to international literature for help in our assumptions. For example, this assumption that volume would increase by 12.5% was calculated based on the price elasticity. We used a Canadian price elasticity, but we looked at the international literature to see how this compares to other nations, and they were fairly consistent. Those were the kinds of ways we looked at international literature.

Ms. Marilyn Gladu: I have one specific question: are most cancer drugs covered on the Quebec formulary?

Ms. Carleigh Malanik: I don't have an explicit answer on this, and I'll tell you why. We could find out. Whatever is dispensed and paid for in a pharmacy outside of hospitals that's listed on the Quebec plan is included.

My knowledge of how cancer drugs in particular are administered and whether there is a wealth of them administered in hospitals or not is that if they are, then they're not captured. If we had a way of identifying all of the cancer drugs, we could take a look and see what is in there.

● (1650)

Ms. Marilyn Gladu: I have the same question for palliative care. I'm not sure how palliative care is covered in Quebec. Are the palliative care drugs covered under the Quebec formulary?

Ms. Carleigh Malanik: It's possible that some of the drugs listed on the plan are covered. Again, I don't have a definitive answer, but as long as those drugs were purchased at a pharmacy, then we're capturing them.

Ms. Marilyn Gladu: Probably not if they were in a hospice or in a hospital?

Ms. Carleigh Malanik: That's correct.

Ms. Marilyn Gladu: Okay.

Those are my questions, Mr. Chair. Thank you.

The Chair: Next is Mr. Davies for five minutes.

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

Let's take a look into the future. As Mr. Jacques pointed out, we're making a lot of assumptions and there are a lot of moving parts as we roll this out into the future. A plan like this might take three, four, five, or ten years to be fully rolled out and to realize all of the potential cost savings and maybe even the cost drivers of the program.

I want to focus on some of your numbers. You took 2015-16 as a bit of a base year. If I understand correctly, had we had pharmacare in that year, based on the Quebec formulary, we would have spent as a nation $4.2 billion less that we in fact did.

Ms. Carleigh Malanik: Yes. Also, the comparator number you want to use is the $24.6 billion spent on the RAMQ drugs.

Mr. Don Davies: Right. I understand that there's the $20 billion, but you subtracted from that $4 billion of drugs that would not be covered under a formulary.

Ms. Carleigh Malanik: That's correct.

Mr. Don Davies: The real thing is that we spent $24 billion as a country in 2015-16 and we would have spent about $20 billion. Do I have that right?

Ms. Carleigh Malanik: Yes.

Mr. Don Davies: Okay.

You have extrapolated your numbers to 2021. You say that the net pharmacare cost would be $22.6 billion.

Ms. Carleigh Malanik: Yes.

Mr. Don Davies: I have a number of questions around that, but I'll start with the most important one, I think, which is, what we would have spent in that year without a net pharmacare system? In other words, what would be the savings in 2021?

Ms. Carleigh Malanik: I believe it's in the report.

Mark, do you recall?

Mr. Mark Mahabir (Director of Policy (Costing) and General Counsel, Office of the Parliamentary Budget Officer, Library of Parliament): It's in the executive summary of the report. We use a baseline using the same factors, so the savings are exactly the same: $4.2 billion throughout the five-year period.

Mr. Don Davies: Okay. We would save $4.2 billion each and every year—

Mr. Mark Mahabir: Yes.

Mr. Don Davies: —of your five-year extrapolation into the future, based on these assumptions. Do I have that correct?

Ms. Carleigh Malanik: Yes.

Mr. Don Davies: Thank you.

One question about the assumption of spending is that you assume we spent $19.3 billion in 2015-16, and then $22.6 billion.... That's $3.3 billion more. By my bad math, that's 17% more, which is about a 6% increase per year: 17% divided by three is 5.8% and something. I'm just curious. That seems like a fairly high annual percentage increase. What went into that assumption?

Mr. Mark Mahabir: Thank you for the question.

We used cost drivers that were published by the PMPRB over the previous four-year period. Multiple factors were considered in the growth. The major one was the cost of biologics, which was a large driver. For patented drugs, there was actually a decrease over the last four years of 1.8%. Most of the increase was due to extraordinary drugs to treat hep C: the direct-acting antivirals. That was a large proportion of the costs. The biologics were another large proportion.

We did factor in a decrease in the overall yearly cost for the direct-acting antivirals, but for biologics we factored in an increase over the five-year period. That's due to the higher costs of biologics when compared to other drugs.

Mr. Don Davies: I want to get in one last quick question, because I think this is the fundamentally critical part of this whole study and I want to make sure I have this correct. This is all assuming that 12% of Canadians who effectively have no coverage now would be covered under this system, as well as achieving the annual cost savings of $4.2 billion a year. Do I have that right? We'd save $4.2 billion a year and it would cover an additional 12% of Canadians who aren't covered.

I see you're all nodding, so that's a yes?

● (1655)

[*Translation*]

Mr. Jean-Denis Fréchette: Yes.

[*English*]

Ms. Carleigh Malanik: Yes.

Mr. Jean-Denis Fréchette: You're correct.

Mr. Don Davies: Okay.

Thank you. I don't have any other questions.

The Chair: Thank you very much.

Dr. Eyolfson.

Mr. Doug Eyolfson: Thank you, Mr. Chair.

Ms. Malanik, I'd like to get back to something you said at the very beginning of your presentation. You talked about out-of-pocket expenses. You said that in your analysis the figures for out-of-pocket expenses did not include paying out for insurance premiums.

Ms. Carleigh Malanik: Yes, that is correct.

Mr. Doug Eyolfson: Okay. I'm not going to ask for any numbers regarding that, but I have a question regarding trends, overall societal trends. In managing our economy, we have employers who have to deal with payroll taxes, and there's always the criticism that a payroll tax can hurt the economy because you have employers having to pay this.

Here's what has not been included in this: would you not say this would be relieving a lot of private employers of a proportion of their payroll tax?

Ms. Carleigh Malanik: Yes, it should, potentially. Again, we don't know what would happen to wages and salaries that would be paid out in lieu of this benefit no longer being offered by employers.

Mr. Doug Eyolfson: I understand that, yes. I know that would be too much to.... As I say, it's beyond...so we're into guesswork by then, but just the binary.... Would it relieve employers of paying this portion of a payroll tax?

Ms. Carleigh Malanik: Yes.

Mr. Doug Eyolfson: All right. Thank you.

I still have some time. Does anyone have more to ask? Okay. There are no more questions.

Thank you.

The Chair: Thanks very much. That completes our extra round.

We are going to have bells for a vote, so I'm going to suggest that we wind up. Is that...?

Mr. Van Kesteren.

Mr. Dave Van Kesteren: I just want to clarify something about that, Ms. Malanik. The question by Mr. Eyolfson was about how this would decrease the cost for the employer, but wouldn't it also be safe to say that in a deficit position—our government is in a deficit position—the overall cost to Canadians would be $4 billion? I'm looking for some balance there. On the one hand, it sounds really great, but am I wrong in making the assumption that there will be an increased deficit?

This is the thing that would drive me crazy when I was on the finance committee as well: we never look at who we owe that money to when we owe $700 billion. Canadians owe that money, so wouldn't that—

The Chair: In fairness, what is your question?

Mr. Dave Van Kesteren: Wouldn't that just increase the indebtedness of Canadians overall? Is that a fair assumption?

Mr. Mostafa Askari: Well, it's a transfer of those costs from the private sector to government. The portion that we don't know—and this was the question that was raised a little earlier—is how much of that private insurance that is provided is actually paid for by the governments or public entities. That we don't know yet. We haven't really looked at that breakdown.

That will tell you on a net basis how much overall the taxpayers have to bear as a result of this, but it's certainly a transfer of those.... It's like health care. If we didn't have a national health care system, employers would have provided national health care through insurance. Now that we have national health care, they don't have to provide that, obviously.

It's a reduction of the burden and the cost for businesses that are providing that kind of insurance. There will be some additional cost for taxpayers, because we are assuming the public sector would accept all the responsibility, certainly. How governments are going to finance that is a different issue, because then you have to get into the issue of whether the government can find that money somewhere within the envelope it has, or if it has to borrow more money to pay for that. That's another issue.

The Chair: Thanks very much.

On behalf of the committee, I really want to thank you for the good work you did on this and to tell you how helpful it is. This is certainly going to have a big impact on our report to Parliament. We appreciate it very much.

I also want to say that today I think we've had the clearest answers we've ever had in this committee—ever. There is no room for misunderstanding. The answers were very clear, specific, and precise. On behalf of the committee, thanks very much.

We will now adjourn.