Meeting Name: Best Medicines Coalition Conference - Pharmaceutical Care For Patients: Today's Challenges, Tomorrow's Vision, Toronto ON, November 17-18, 2014

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Meeting Overview/Background

A wide range of topics from personal genetics to public attitudes on the Canadian health care system were covered at this two-day conference.

Daily breakdown of activities/sessions

Gail Attar, chair of the Best Medicines Coalition and Mr. Bill Dempster of 3Sixty Public Affairs Inc. opened the conference. Gail is the President and CEO of the Gastrointestinal Society of Canada. Bill is CEO of 3Sixty Public Affairs Inc. He develops and implements high impact government relations as well as policy and business strategies, for clients in the health and life sciences sector.

Demspter spoke about current thoughts and trends about health care in Canada and future Pharmacare Issues. In 2014, more than $215 billion has been spent on healthcare in Canada. Hospitals get the lion share of the spending, followed by doctors while medication costs are rising and Pharmacare coverage is declining.

Due to a lack of leadership at the federal level, the provincial premiers have banded together to co-ordinate health files, he noted. The upcoming federal election may see a change in leadership for the health file, he added.

Canadian health care spending is 11% of Canada's Gross National Product and is the 8th highest in the 34-member Organization of Economic Development and Cooperation. Generally, provincial healthcare spending is up slightly but down in BC.

Recent public opinion polls have showed health care privatization is “less polarized" while there is a focus on improving home care, he said. Access to health care is a Canadian top priority.

Across Canada, provincial governments, which control health care spending in their respective provinces, are striving to find efficiencies and cost-savings across their healthcare regimes. Reducing the time patients spend in hospitals is a key concern.

Due to an increasing alignment across public health programs, there is a push to adopt a national Pharmacare program while the Federal government is focused on controlling spending and the economy, Dempster said.

Dr. Brian O'Rourke provided a Canadian Agency for Drugs and Technologies in Health (CADTH) update on health technology assessment. He is President and CEO of the organization. CADTH is a not-for-profit organization and has links with other similar organizations around the world. They approve medications and medical devices in Canada.

CADTH is on track to clear up a backlog of 7 drug submissions by March 2015, commonly referred to as the “queue”. Approval has been given to charge an application fee for a Common Drug Review (CDR) to offset review costs O'Rourke said, adding that a similar fee will apply to pan-Canadian Oncology Drug Reviews (pCODR) next spring. CDR is composed of most Provinces and Territories while pCODR involves 9 provinces and not the federal government.

pCODR is designed to bring consistency and clarity to the assessment of cancer drugs. In April, 2014, the organization was transferred to CADTH to consolidate policy direction across Canada's drug review programs.

CADTH is studying ways to continually improve patient engagement as well as determine what are the important outcomes of drug assessments.

The scientific advice program will provide advice to drug companies early in the development of new drugs. A physician and a patient representative will be included in this process

Confidentiality is of prime concern to the pharma companies when developing new medicines. The program is slated to start early in 2015 and go into effect by next July for new drug submissions.

CADTH's strategic plan from 2015-2018 makes patient engagement a top priority compared to public input. In the past, only 50% of 30 drug trials had some form of patient involvement.

Senior Pharmacist Sherry O'Quinn is with the Ontario Public Drug Program at the Ministry of Health and Long Term Care. She provided insight into the work of the Pan Canadian Pharmaceutical Alliance formerly called the Pan Canadian Pricing Alliance (PCPA) as well as price negotiations and drug listing.

Provinces and Territories have worked together under the pan-Canadian Pricing Alliance and the Generic Value Price Initiative to achieve greater value for brand name and generic drugs for publically-funded drug programs. They are now known collectively as the PCPA.
All brand name drugs coming forward for funding through the national review processes of CDR and pCODR are now considered for negotiation through the PCPA.

Product Listing Agreements (PLAs) are negotiated between the pharma company and government. The benefits of these agreements include increased access to drugs, government spending more tightly controlled and improved value to the taxpayer, she said.

Challenges to this process include confidentiality, time-consuming negotiations and "patchwork coverage across Canada."

It can take up to six weeks to approve a new drug. Once that happens, negotiations begin with the pharma company to agree on price and availability. Each province decides whether to fund a particular drug.

Challenges the PCPA face include making their role more explicit, funding, greater transparency and patient input. Also developing a process of clear time lines for each step of the approval process would be beneficial to all parties involved, O'Quinn further commented.

Since 2010, there have been 49 completed negotiations which have led to price reductions on 10 generic drugs at 18% of the cost of the equivalent brand name product. Usually there are 10-12 negotiations ongoing at any one time.

The first day closed with comments and discussion regarding formulary management -- delisting, and substitution of certain drugs as well as a round table discussion of all participants.

Attara noted that therapeutic substitution (TS) refers to reducing the cost of medicine in a particular drug class and NOT generic substitution.

There is a false assumption in government that drugs in the same therapeutic class are medically interchangeable, she noted, adding that patients, because of genetics, may react differently to various drugs in the same class.

Patients do not have a choice when it comes to taking a recommended drug. If another drug works fine but it is not covered by the government plan, then the patient is responsible for the total cost.

Delisting of certain drugs is another concern, Attara said. Delisting of a drug is made for budgetary concerns and not for the drug effectiveness.

"The government looks at one-size that fits all" which does not always work to the benefit of the patient. These cost control initiatives have been primarily BC focused but the other jurisdictions watch closely what happens in other regions.

Discussion followed on different means by which the BMC and patient groups can lobby health officials and government representatives for improved patient input into formulary management.

The morning of the second conference day was devoted to an overview and trends in private health care plans. Suzanne Lepage is an independent private plan consultant with more than 20-years experience in the industry.

Employers view a group health plan as part of a compensation program and not as health needs, she commented. Unlike government health programs, a private plan has no transparency. Plan sponsor, the employer, decide what type of benefits are offered. Usually more than one quote is obtained and the competition is fierce. The type of industry, the number of employees and plan design all form part of the underwriting process.

On behalf of their members, unions can negotiate details of a private plan.

A "pooling charge" is sometimes part of a plan. This extra charge is designed to share higher claim costs in the plan among all participants, keeping premiums steady. Generally, if claims for health benefits increase above a certain level, then premiums paid by the employee will move higher at plan renewal.

Many plans have a deductible before a member can access coverage. Common benefits include: the plan paying 80% of drug costs, a lifetime maximum limit, a yearly claim amount for certain items such as smoking cessation and a yearly maximum drug claim. With a "flex plan", different levels of coverage may be offered.

Group insurance shares the risk among all participants in the plan and is based on age, gender, occupation, province of work and any previous claim experience. It is Canadian law that an individual who loses group insurance has 30 days to convert to an individual plan.

Most important, Lepage noted, when a plan sponsor switches plans, benefits in the new plan may not be the same as the old plan.

With insurers and plan sponsors facing huge cost pressures, the Canadian Life and Health Insurance Association is pushing for a national policy on drug prices. Unfortunately, private plans face higher drug costs compared to government-run plans. Since insurance companies need to be profitable to stay in business,

these higher costs are reflected in premiums charged to the employer and employee.

Some trends impacting private health plans include a Preferred Provider Network (PPN), forcing the plan member to buy medications or services from a specified provider. The insurance company has negotiated lower costs. The provider hopes to make up the difference in their fees by generating a greater volume of business.

Also, when disability is involved, an insurance company case manager works with a disabled individual and his/her health provider to get the individual back to work as soon as possible.

The plan can also have mandatory generic drug pricing. Usually a generic drug is prescribed unless it is not available. If a specific drug is not available in generic form, then a doctor's certificate may be needed to obtain coverage. Or the plan may cover a similar drug not prescribed by the doctor.

In some plans, government coverage has to be used first before the private plan benefits can be accessed, Lepage said. Because of high costs, access to specialty drugs may be limited or a series of "hurdles or steps" need to be completed before the drug cost is covered under the plan.

Lepage concluded her presentation by offering tips on what to do when a specific drug is not covered by a private health plan.

Ask the insurer why a specific drug is not covered, if it is under review, when will the review be completed. Develop a strategy to appeal a plan formulary manager decision not to cover a specific drug or a "step therapy" which eliminates access to the drug. Sometimes the plan requires the individual to apply for alternate coverage.

When the employer chooses a provincial formulary which does not cover the specific drug access will be denied. In some cases, the plan member has received the maximum benefit under their plan and no longer has coverage, Lepage said.

Dr. Jeffrey Pollard, of 23and Me, was the keynote speaker on the last day of the event. The company, based in California, aims to advance the integration of personal genomics into the modern health care environment.

For $200, an individual undertakes a simple saliva test which is sent to the company's US head office for testing. All results are confidential and protected against genetic discrimination. The report will contain information on over 100 health conditions and traits.

Dr. Pollard stressed the results may cause concern when the individual shares personal DNA information with family members but it does not appear to be a large problem at this time. Personal response to medications, genetic risk factors, inherited conditions such as cystic fibrosis as well as interesting personal traits i.e.-response to the smell of cooked asparagus, are some of the results from the test. He noted that this information can help to "provide guidance" for improving personal lifestyle choices.

Discovering ancestry traits is another benefit and can prove to be very interesting for the individual and family members.

23andMe has successfully completed more than 750,000 tests which include 20,000 in Canada. More than 80% of respondents have authorized their results to be used in company research. Over the past four years, the Californian company has published 22 papers.

"In a matter of years, our research has saved decades of time and saved money," Dr. Pollard concluded.