Recommendations on Proposed Amendments to the Patented Medicines Regulations

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Endorsed By:

CONECTed

Collective Oncology Network for Exchange, Cancer Care, Innovation, Treatment Access & Education

A. INTRODUCTION

Our health care system is complex; no one would argue to the contrary. There are many key decision makers at either federal, national or provincial levels that are responsible for the health care services Canadians receive from coast to coast to coast. Health Canada holds different responsibilities influencing the landscape of our health care system, including drug safety, quality and effectiveness. In addition, they play an important role with respect to drug pricing. We, as patient organisations, recognise the regulations overseeing drug pricing need to be re-evaluated, especially given the changes in our ecosystems since the inception of these regulations. Moving forward, changes are necessary to ensure Canadians get the best possible and timely access to health care resources while ensuring sustainability of our health care system for generations to come. We know the people who work at Health Canada also have the same vision. We are grateful to all those involved in seeking the input of groups like ours and other stakeholders on protecting Canadians from excessive drug prices through the consultation on the proposed amendments to the patented medicines regulations. We believe our health care system must prepare for a significant paradigm shift and welcome opportunities to share our thoughts on what needs to be done by collaborating with all stakeholders involved in making our health care system the best it can be.

Background

Drug Systems Structure in Canada

Canada has a unique health care system because of the division of responsibilities between the federal and provincial/territorial governments. The federal *Canada Health Act* promises eligible people in Canada access to doctors and hospitals. Incidentally this means free drugs in hospitals but only for those determined by hospital drug formularies. The provinces and territories have the responsibility to create public drug funding mechanisms and each has done so based on relevant criteria for each, including the economic engine of the province, competing interests for public funds, population demographics and needs and other relevant factors. Thus, public plans are different across each province/territory.

The collective public systems cover approximately 60 per cent of drug expenditures and the private sector covers the rest, mainly through employer-sponsored benefit plans provided through private insurance companies. Some people purchase individual private plans, while others have no coverage (sometimes referred to as “the working poor”), are underinsured (people with inadequate private coverage) or are “theoretically insured” (those who are eligible for public reimbursement plans but cannot afford the deductibles or co-pays to access them).

Recent Trends in Health

While health costs have always been a large part of every provincial/territorial budget, the cost of the drug portion of the overall health budget is growing as we discover the causes of new “rare” diseases, learn how to cure diseases such as Hepatitis C, manage a disease like HIV with lifetime treatments and more recently make huge breakthroughs in cancer treatment, referred to as personalized medicine, precision medicine and immuno-oncology.

While science is making headway by leaps and bounds, the economic engines of our country are not keeping pace. There are also increased competing demands on public dollars, our population is aging and the number of people working is declining. There are other factors

including global competition, the environment and new work paradigms. This problem is not unique to Canada but as stated at the outset, the federal/provincial/ territorial split in the health mandate is unique.

Thus, governments are talking more than ever about health care sustainability, affordability and public/private partnerships in health. Specifically, the federal government has adopted the three "A"s of health policy: affordability, accessibility and the appropriate use of prescription drugs.

Regulatory Roles in Health including the Patented Medicine Prices Review Board's (PMPRB) Role

There are several regulatory checks and balances in decisions about health interventions. The federal role through Health Canada includes ensuring that products entering Canada are safe, effective and of good quality. PMPRB monitors that the proposed ex-factory price at which a drug will enter Canada is not excessive, as part of its consumer protection role. The Canadian Agency for Drugs and Technologies in Health (CADTH) recommends to public payers whether a product is of value to be paid for out of the public purse for eligible people. L'Institut national d'excellence en sante et en service sociaux (INESSS) has the same mandate for Quebec. The pan-Canadian Pharmaceutical Alliance (pCPA) negotiates a price for the public plans. Cancer agencies provide advice on cancer drugs. Each province determines whether and/or when to add a product to its public reimbursement plan. Private insurers recommend and offer plan designs that are competitive for employers. They work from the PMPRB price but have also negotiated lower prices with pharmaceutical companies in several cases. Individuals pay for drugs they can afford but are not covered for them by private or public plans.

Health Canada and PMPRB have determined within this environment that it is time to do a review of drug prices based on a mandate from the federal Minister of Health to make recommendations about what to do about the fact that drug prices in Canada are "too high". This conclusion is based primarily on an analysis that says that Canada is paying the second highest drug prices overall of the seven countries with which it has been comparing itself. The drug budget is generally quoted as being 16 per cent of the total health budget including generic drugs and over-the-counter medicines. Depending on whose numbers you accept, innovative drug prices have been rising, stable, or declining. Another reason for this review is the fact that research and development has been going down, notwithstanding a commitment when the *Patent Act* sections on pricing were introduced that it would be at 10 per cent and has dropped to about 4 per cent. There are numerous reasons for this also based on whose narrative you accept.

The above-signed patient groups have analyzed the proposed regulatory changes and have the following recommendations to make:

Summary of Recommendations

- Removal of the pharmacoeconomic evaluation analysis as a mandatory process from the Regulations and to move it to the Guidelines along with other listed relevant factors to be considered. We believe this is appropriate because the "willingness to pay" as defined in the document provided by Health Canada and the PMPRB for the use of pharmacoeconomic analysis varies among, and within, public payers, private insurers and individual payers. The decisions relevant to pharmacoeconomics must be left to those stakeholders who focus on specific patient populations and not be centrally

mandated by the federal government. The Regulations should therefore delete the use of a pharmacoeconomic analysis as mandatory but rather should move it to the Guidelines along with other discretionary factors that may be pertinent depending on the circumstances of the product being reviewed as being an excessive price to enter the Canadian market.

- The definition of "size of the market" needs to be clarified to clearly differentiate between current number of patients versus expected patients to be put on the patented medicine.

- While we have no objection to Canada considering GDP to determine an excessive ex-factory market entry price, we submit that including other measures such as overall percentage of dollars spent on prescription medicines relative to health outcomes, reduction of hospitalization or other metrics are also relevant and useful. Unfortunately, the issue of silo budgeting, and looking at each piece of the health budget relative to outputs rather than holistically in relationship to their impact on health outcomes, is a serious fundamental flaw with our entire health care system vision and structure.

- pCPA should be mandated by the Council of the Federation to negotiate agreements based on such innovative contract approaches as pay for performance, risk sharing agreements and other innovative contractual designs, rather than solely on a negotiated price, since that approach will truly reduce prices and the overall drug budget.

- Government policies should be created that ensure that all savings from drug pricing reductions are returned to the public health budget, or become an automatic rebate to employers in the case of private group insurance plans for use to augment drug coverage for employees with life-threatening or serious illnesses, or become an automatic rebate to individuals with private individual coverage.

- During the consultations, we suggested other relevant factors be included. With respect to the proposed list of 12 comparator countries, the federal government should ensure that all factors are considered and compared and that these be made transparent. These include: private/public insurance drug split, health care delivery mix in each country, whether they have a robust Health Technology Assessment (HTA) process, overall health care system structure in each country, demographics of comparator country, price control strategy e.g. free price, maximum price or reimbursement price or a combination of these (we understand that all but Germany have a list price and all but Sweden, Norway and Japan have net prices), price control tools e.g. IRP, TRP, cost per QALY, Cost-plus /cost calculation, cost comparison, tendering or pricing negotiations, health systems data collection, monitoring and evaluation, time to market , what drugs are actually covered in those countries and the importance of wide and universal access, access to research and clinical trials and commitment to innovation and last but not least a measure of health outcomes (perhaps that from the WHO) in these countries need to be used in selecting comparator countries.

- Drugs for life-threatening diseases should receive special attention. The federal government should not use any comparator countries for drugs for life-threatening and serious diseases or conditions in the Regulations that delay market entry longer than Canada's present time to entry as Canadian patients cannot wait any longer than the

already lengthy delays experienced to obtain access to badly needed treatments. Thus, some or all of the comparator countries should be removed and replaced by more appropriate comparators. The federal government should not use any comparator countries for drugs for life-threatening and serious diseases or conditions in the Regulations that have less clinical trial access in these areas as clinical trials are an important means for access in Canada.

- The federal government should only select comparator countries that have comparable or better market entry times than Canada and comparable or better access to clinical trials as Canada.

- All analyses done in support of the Regulations should be made public.

- Additional factors that should be taken into account in selecting comparator countries include private/public insurance drug and health care delivery mix in each country, whether they have a robust HTA process, the entire health care system structure in each country, demographics of the country, price control strategy i.e. free price, maximum price or reimbursement price or a combination of these (we understand that all but Germany have a list price and all but Sweden, Norway and Japan have net prices), price control tools e.g. IRP, TRP, cost per QALY, cost-plus/cost calculation, cost comparison, tendering or pricing negotiations, time to market, health systems data collection, monitoring and evaluation, time-to-market, what drugs are actually covered in those countries and the importance of wide/universal access, access to research and clinical trials and commitment to innovation.

- There should be a clarification added to the proposed patented generic drug process explaining that the complaints process can be accessed by anyone.

- The definition of “indirect” discounts and rebates should be defined in the Regulation. The Regulation should clearly state how the information about indirect discounts and rebates will be used.

- Patient values must be added in the Regulation as an equally important factor for the PMPRB to consider as any others when determining whether a drug price is excessive since all Canadian governments have expressed that their health policies are based on patient-centred care.

- PMPRB and Health Canada should develop a rigorous monitoring and evaluation framework for the federal regulation of drug pricing designed with patient groups and reviewed annually and modified as required.

- An efficient, effective and mandatory dispute resolution mechanism within PMPRB for excessive pricing in the breakthrough drug category should be created within PMPRB such as a mandatory Alternative Dispute Resolution process with publicly published reasons for the decision as well as regular re-evaluation of a well-defined class of breakthrough drugs. These will address the core affordability problem of PMPRB.

- The *Patent Act* should be amended to delete the Consumer Price Index (CPI) as an automatic increase mechanism for therapies.

- The federal government must ensure that there are no unintended and unforeseen adverse consequences to public payers of a lower entry price into Canada for public and private payers by reducing the overall amount available to provincial/territorial payers for price negotiations before promulgating these Regulations. Such an adverse impact will mean less access to necessary medicines for eligible people in Canada and this is surely not the intention of the federal government.

In conclusion, we strongly believe when looking at drug pricing policy changes, the federal government should do so in the context of overall health outcomes, the impact on the entire health care system and employers. The real issue for many people in Canada is lack of access or inadequate access to necessary medicines. This is a problem worth solving. The main problem for the poor is the lack of funds to buy drugs or the inability to pay the deductibles, co-pays and other costs associated with being uninsured or underinsured. The federal government should set up a fund that these people can access across Canada to deal with this inequity in access. The federal government must recognize that where the impact of lowering the drug entry price in Canada by 20 per cent or more is less access or delayed access for patients, the above-signed patient groups and the patients they represent will not support it.

The federal government must show leadership in health by convening a multi-stakeholder group including meaningful patient group representation to find a common vision for the health care system founded on value-based health outcomes and to determine how to collaborate to achieve that goal together.

B. REVIEW OF THE QUESTIONS POSED BY HEALTH CANADA

1. Introduction

Drugs treat chronic conditions, improve, and save lives. Having access to drugs, new and old, should not be considered a privilege, but a right of every Canadian. Our health care system, although not perfect, is one of the most important characteristics of our country, of who we are, and what we represent.

The goal of our collective governments should be to look at ways to improve how we provide and pay for health care with a view to improving health outcomes and making our system sustainable for generations to come.

Protecting consumers from excessive drug prices is a critical part of ensuring this goal is attainable. Through the PMPRB, we believe the federal Minister of Health has played, and should continue to play, an important role in ensuring that drugs are not brought into Canada at an excessive price.

The ecosystem for pharmaceutical therapies in Canada has changed since the adoption of Bill C22 (the *Patent Act*) and since the creation of the PMPRB in 1987. Amending these *Regulations* is necessary to modernise our drug pricing system. However, we firmly believe that the following principles developed by patient groups must be maintained when considering or making changes to drug pricing regulations to protect all Canadians:

- **Protect** or **improve** existing individual access to therapies at or above their current level.
- **Safeguard and improve access** to medically necessary therapies for all residents of Canada regardless of ability to pay or place of residency.
- **Ensure universality and equality** that recognizes diversity in all its forms and accommodation for disability.
- **Brings cutting-edge pharmaceutical research** to Canada so Canadians can benefit from these research programs that would otherwise not be accessible.
- **Recognize** the discrete needs of people with life-threatening and serious debilitating illnesses that significantly impact their and their caregivers' quality of life.
- **Accept, assess and value** real-world evidence in determining therapeutic value.
- **Reinvest** pharmaceutical system savings back into the pharmaceutical budget to provide increased access to therapies.
- **Build** on the foundation of health care mechanisms and systems already in place.
- **Develop** value-based drug pricing contracts, including systems for sharing data and other relevant information.
- **Analyze** the overall value and broader socio-economic impact of a drug, including cost savings in other parts of the health care budget.
- **Expand** health technology assessment processes to measure the value of all components of the health care budget.

With these principles in mind, the above-signed patient organisations are pleased to provide feedback to the proposed amendments to the Regulations promulgated pursuant to the *Patent*

Act. We appreciate Health Canada for reaching out to stakeholders to be involved in a meaningful way in this consultation process.

2. **General Comment**

The *Patent Act* is the governing federal legislation under which all Regulations and Guidelines related to excessive drug pricing are made. They are "handmaidens" to the *Patent Act*, defining how the Act will be administered. Thus, when looking at each Regulation and Guideline an overarching question is whether the Regulation and Guideline proposed enable the law as defined in the *Patent Act*. If not, the Regulation or Guideline is *ultra vires*, outside the jurisdiction of the legislator or quasi-judicial administrative body to enact.

In addition, it is important to place the legislation in the context of other health regulatory systems in place in the public domain, i.e., Health Canada, CADTH, pCPA, cancer agencies and provincial/territorial drug plans. Each has its own mandate and PMPRB should not be duplicating the mandate of other systems.

It is also always important when reviewing solutions to a problem to ensure that the problem itself is clearly defined. There is much stated concern that Canada has the second highest drug pricing of the present seven comparator countries in the present Regulations. An April 2017 report by the PMPRB's National Prescription Drug Utilization System reports that for brand name drugs launched from 2009-2014, Canada was second lowest among the seven countries in the present Regulations.

Our understanding from PMPRB is that the main problem it faces is the ability of a patentee to use its monopoly position in the marketplace to charge prices that are very high and often outside the reach of payers. It has stated that this generally occurs for a very small number of the products it reviews, between 5 per cent and 10 per cent, those that are considered "breakthrough", also referred to as "blockbuster" or "niche buster". The Hepatitis C cure drugs are a recent example of this. This percentage may grow over time as this is where health care is heading, into the world of breakthrough cures through stem cells, biologics, immunotherapy, personalized medicine, biomarkers and away from dying in hospitals and long-term care homes, but their numbers will still be limited. In other cases, market forces naturally drive down the price of new drugs coming into Canada. Yet, the Regulation changes target all drugs, even those where the present system regulates price effectively. Thus, if this is the crux of the problem, the solution should address that problem.

It is also paramount in addressing the affordability portion of the three "A"s that there not be negative impacts on either or both of the other two: access or appropriate prescribing. In our submission, creating Regulations that address the real affordability problem, i.e., "excessive" prices for breakthrough drugs, will avoid these potential negative impacts.

3. Comments on Proposed Amendments

Proposal #1

I. The Pharmacoeconomic evaluation for the medicine and other medicines in the same therapeutic class in Canada and in countries other than Canada.

Consultation Question

Do you agree that a pharmacoeconomic evaluation is an important factor for the PMPRB to consider when determining whether a drug is priced excessively? If so, how should the evaluation be considered?

We can only answer this question provisionally given that the scope of current pharmacoeconomic evaluation in Canada has been developed solely to provide advice and guidance to public payers and does not include private payers or people who pay out of pocket. In our submission, even if a pharmacoeconomic evaluation is one pertinent factor for consideration, it is by no means the only "important" factor (undefined and therefore subjective). Our general recommendations in addressing this question would be:

Recommendation:

1. Removal of the pharmacoeconomic evaluation analysis as a mandatory process from the Regulations and to move it to the Guidelines along with other listed relevant factors to be considered. We believe this is appropriate because the "willingness to pay" as defined in the document provided by Health Canada and the PMPRB for the use of pharmacoeconomic analysis varies among, and within, public payers, private insurers and individual payers. The decisions relevant to pharmacoeconomics must be left to those stakeholders who focus on specific patient populations and not be centrally mandated by the federal government. The Regulations should therefore delete the use of a pharmacoeconomic analysis as mandatory but rather should move it to the Guidelines along with other discretionary factors that may be pertinent depending on the circumstances of the product being reviewed as being an excessive price to enter the Canadian market.

Additional comments for consideration:

- PMPRB regulates drug list prices for all consumers, including employees and their dependants under health benefit plans offered by their employers or unions and managed by insurance companies, as well as individuals covered under public drug plans and people who pay out of pocket across Canada. Currently, pharmacoeconomics and the use of quality-adjusted life year (QALY) is used by CADTH to make recommendations to provincial drug plans under the lenses for which these provinces/territories reimburse drugs. These reviews are based on comparisons between the new technology and best practices already reimbursed in these provinces for defined and sometimes targeted populations (e.g. seniors, children) and other factors. This proposal for regulatory change incorporates the reviews/recommendations provided by CADTH which uses it solely for one sector of the consumer population while PMPRB is charged with providing a consumer protection service for all consumers. Will they be looking at one pharmacoeconomic evaluation for the public reimbursement population, one for the private payer population and one for the uninsured? If so, is that appropriate?

- The pan-Canadian Oncology Drug Review (pCODR), a programme of CADTH, is responsible for making coverage recommendations about cancer drugs to provincial and territorial drug plans. The pCODR review process is designed "to bring consistency and clarity to the assessment of cancer drugs" and emphasizes four dimensions of value in their decision criteria: clinical benefit, economic evaluations, patient-based values, and adoption feasibility.[1] The pCODR guidelines state that there is no weighting scheme for the criteria and no threshold that must be met for any single element of the review. Rather, decisions should be made based on the individual drug, disease, and context. In that regard, pCODR could be described as taking an implicit approach to decision-making. While there is no formal framework for the Common Drug Review (CDR), the CADTH programme for non-oncology drugs, there is similarly no weighting scheme to the criteria looked at through the CDR process. Proponents of implicit approaches to decision-making argue that some ambiguity is necessary to address the inherent complexity of priority setting, allowing for individual decision-makers to exercise appropriate contextual judgment.[2] It is not relying solely on a pharmacoeconomic assessment itself. In a recent study in Current Oncology a comparison of preferences from pCODR and from the Canadian public found that both groups were willing to forego some degree of efficiency (which QALYs alone provide) to prioritize specific patient characteristics. Thus, even pCODR recognizes that a pure pharmacoeconomic analysis based on QALYs is not appropriate across the board for all disease states and all populations and that some discretionary factors must be available to determine value in each situation.[3]

- Benefits of a drug can also vary between populations it is designed to treat. This is true for many disease states. This requires an examination of how the currently proposed Regulations will take that reality into account. For example, in the mental health area, response to psychiatric medications is highly individualized, variable and related to several factors such as genetics, age, sex and socio-economic factors. As a result, individuals often must try several medications before they find an effective treatment. The Regulations appear too rigid to take this into account.

- The proposed Regulations do not address cost benefit to determine an appropriate price for drugs that treat children, rare diseases and cancers. As presented, it has been conceded that it does not address children or rare diseases and in our submission, the same is true of cancers. In fact, given what we are learning about the complexity of each of the more than 200 cancers and the difference at each stage even within the same disease site of cancer, all cancers may well be defined as rare diseases.

- Determining a fair price for a drug is not a simple process. It implies that one must put a cost or value on human life. The introduction of a fixed cost per QALY threshold is very concerning for many reasons including:

    1. QALY measurements vary significantly between diseases (like cancer), patient population (pediatric vs elderly) and rare diseases. How could a fixed QALY threshold (line in the sand) reasonably address the value a drug can bring to a patient or his/her family. Patient values are totally divorced from such a process. From a patient's perspective, using QALYs is problematic as the methodology used to determine QALYs all too often fails to represent the real value a drug brings to a patient's health outcomes.

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[1] "The prioritization preferences of pan-Canadian Oncology Review members and the Canadian public: a stated-preferences comparison", *Curr. Oncol.* 2016 Oct.23 (5): 322-328, C. Skedgel PhD, p.322

[2] Ibid., p.322

[3] Ibid., p.327

2. In the case of people with disabilities, QALYs could create discrimination against their health status because treatments that restore people to their "normal" disabled states could be undervalued relative to those who return to a "healthy" state.

3. In Canada, as described above, QALYs are used by CADTH in its review process to make reimbursement recommendations to public provincial and federal drug plans. These recommendations are then used by the pCPA to negotiate listing agreements, presumably by reducing the QALYs to a more acceptable threshold, which is accomplished by reducing the drug price. These are non-transparent negotiations. PMPRB has said that "willingness to pay" is a relevant factor in the price of a drug. While we agree, each stakeholder's willingness to pay is different. In fact, even within the public payer group, each province/territory and the federal plans will have a different answer about willingness to pay depending on discreet factors within each jurisdiction including its tax base, its population base, its economic base, population demographics, other opportunity costs inside and outside health. Thus, the willingness to pay criterion is pertinent at the payer level not at the PMPRB level. Patient organisations believe that more power should be given to the provinces/territories to negotiate more acceptable drug prices by negotiating prices down, introducing pay for performance schemes, and investments in better disease management programs.

4. QALYs are calculated based on data obtained through clinical trial studies undertaken by drug manufacturers. These trials are highly controlled and patients are chosen with much care through strict inclusion and exclusion criteria. There should be more emphasis placed on what happens in the real world, once a drug has been used in a broader population. If QALYs are to be used in the decision-making process to determine an appropriate drug price entry into Canada, we urge Health Canada and payers to use real-world evidence to adjust price according to the value they provide as further evidence is gathered over time.

- The use of QALYs or other pharmacoenonomic methodologies as proposed in the consultation document, does not give us confidence that they will result in more equitable resource allocation or deliver better health care to Canadians. There must be a mechanism by which every dollar saved goes back to pay for better health care and access to treatments. This is achievable in the public sector but requires a change in government policy and processes. It is far more problematic in the private sector where there is no mechanism nor incentive nor commitment to reinvest drug plan cost savings into an employer-sponsored health plan.

- We do not understand how the drug pricing that assumes a reduction in list price would affect negotiations undertaken by the pCPA on behalf of the public drug plans. We do not know the extent to which private plan prices subsidize public plan prices. Given the lower prices for private payers, will pCPA have less of a buffer to negotiate listing agreements? If so, having lower prices would benefit private payers more so than the public drug plans. We are not privy to the information that would answer this question as it is in the purview of the pharmaceutical manufacturers. We strongly recommend that the federal government do its due diligence to ensure that there are not unforeseen unintended negative consequences for public payers in its price negotiations by starting at lower prices since patients will be the ultimate losers in that scenario as fewer drugs may well be available on public plans. If so, this would be exacerbated in provinces like Saskatchewan, British Columbia and Manitoba, where the design of their public plans is more broadly encompassing than in other provinces.

II. The size of the market for the medicine in Canada and in countries other than Canada and the Gross Domestic Product in Canada.

Consultation Question

Do you agree that the size of the market for the drug in Canada and other countries is an important factor for the PMPRB to consider when determining whether a drug is priced excessively? If so, how should the size of the market be considered?

No matter what, Canada will always be a small market for international pharmaceutical companies compared to many other countries. The smaller market opportunity we represent plays a significant role in what industry may or may not do when it comes to launching a drug in Canada. Of the 12 countries proposed for comparison, based on sales and price per product in 2012-2013, Canada will be compared to four bigger and eight smaller pharmaceutical markets. Thus, if size is an important factor, how well will this basket of countries represent good comparators?

In addition, there is lack of clarity about the definition of "size of the market". Does it refer only to current number of patients or does it refer to expected number of patients or both?

Recommendation:

1. The definition of "size of the market" needs to be clarified to clearly differentiate between current number of patients versus expected patients to be put on the patented medicine.

Additional comments for consideration:

- Market size is only one of the many factors that should be considered when determining whether a drug is priced excessively. It is not logical or feasible to assume that every time a new patented medicine comes into the market, everyone with the condition will suddenly switch to that new patented medicine (because patented and/or generic of same/similar therapeutic classes often already exist for current patients). Hence, market demand/value will likely stabilize the costs of newly patented medicines to market value, especially at the negotiation level, including pCPA and provincially.
- However, in the case of breakthrough medicines, such as hepatitis C (HCV) drugs, market size, especially the potential sudden increase in demand due to significant increased efficacy (i.e. a cure) or significant decrease in serious adverse events was apparently not anticipated. Many provinces and private payers arbitrarily put a non-evidence based requirement before providing treatment coverage. It is only very recently that negotiation of HCV drugs by pCPA broadened the coverage in some, but not all, of the provinces. As Canada's health care delivery is at the provincial level, an initially set high price without consideration of the sudden increase in demand across Canada significantly reduced coverage and access to an HCV cure. Nevertheless, other factors such as timely access to safe and effective medicines, as mentioned previously in the submission, need to be considered.
- Not only market size but also access to safe and effective treatments in a timely manner is very important. Historically, Canada has benefited from a regulatory and economic environment where drugs are submitted to Health Canada, approved and launched by industry within its first-tier launch countries. Any changes to the PMPRB Regulations, through market size factors or other economic factors must not impact the launch sequence of new drugs or the access to clinical trials as these might negatively affect our current environment. We, as patient organisations, do not want to be relegated to a lower-tier launch country

where we must wait even longer to get access to effective therapies. Looking at the seven new countries proposed for the comparator countries, all have delayed market entry compared to Canada. This is unacceptable to cancer patients and patient groups in Canada. We do not know if this is directly related to market size or not, but clearly they must be removed. Regulatory programmes are already delaying access to drugs in Canada creating potentially negative health outcomes. For example, in oncology, regulatory bodies delayed access to 14 cancer drugs for metastasized solid tumours. Similarly, for mental health medications, including antipsychotics, the average coverage waits for drugs in all public drug plans was 1,173 days, ranging from 290 to 4,146 days, assuming they were listed at all. It is easy to take the logical steps to the resulting detrimental health outcomes to patients requiring access to these medicines. Further delays cannot be permitted to occur.[4]

- It makes sense that cost of drugs be adjusted based on changes in the market size, but these adjustments should also consider the level of innovation and improvement to patient outcomes and savings in other areas of the health care system in addition to other social systems including the criminal justice system, the child welfare system and the disability support system.

III. Gross domestic product in Canada

Consultation Question

Do you agree that Canada's GDP and GDP growth are important for the PMPRB to consider when determining whether a drug is priced excessively? If so, how should GDP be considered?

GDP is a measure of a country's economy. Thankfully Canada's GDP ranks high in the developed world. Hence using GDP seems to be a good measure to be used by PMPRB as it is focussed on our ability to pay. Relative to the 12 comparator countries proposed for comparison in the Regulations, Canada is "in the middle", with 7 countries with lower GDP per capita than Canada.

Recommendation:

1. While we have no objection to Canada considering GDP to determine an excessive ex-factory market entry price, we submit that including other measures such as overall percentage of dollar spent on prescription medicines relative to health outcomes, reduction of hospitalization or other metrics are also relevant and useful. Unfortunately, the issue of silo budgeting, and looking at each piece of the health budget relative to outputs rather than holistically in relationship to their impact on health outcomes, is a serious fundamental flaw with our entire health care system vision and structure.

Consultation Question

Are there any other factors that should be considered by the PMBRB when determining whether a drug is priced excessively? How should these factor(s) be considered and what information should be required from patentees?

Recommendations:

1. pCPA should be mandated by the Council of the Federation to negotiate agreements based on such innovative contract approaches as pay for performance, risk sharing agreements

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[4] **"**Economic cost of delayed access to 14 new cancer medicines in Canada's public drug plans", *chp* 2016 May 31, rev.Aug.24, Nigel Rawson, p.9

and other innovative contractual designs, rather than solely on a negotiated price, since that approach will truly reduce prices and the overall drug budget.

2. Government policies should be created that ensure that all savings from drug pricing reductions are returned to the public health budget, or become an automatic rebate to employers in the case of private group insurance plans for use to augment drug coverage for employees with life-threatening or serious illnesses, or become an automatic rebate to individuals with private individual coverage.

Additional comments for consideration:

- Another factor is the fact that Canadians in many disease areas have access to industry-sponsored clinical trials and these are considered important treatment options. If the countries proposed have more limited access to clinical trials, they should be removed.

- Another important factor is the impact that availability and cost of drugs in the health care system can have to drive down costs in other areas of this system. How will these be measured and re-invested under the new regulatory regime?

- One could also argue that economic improvements, because of the increased productivity of employees in the private sector, should be a factor in drug price determination and adjustments. These are not presently being measure and how this would be done remains to be determined.

Proposal #2: Amending the list of countries used for international price comparisons

Consultation Questions

1. **Are there other countries that should be considered in revising the Schedule?**

It is difficult for the above-signed groups to provide a complete response on what other countries should be included in a new basket of countries without a more fulsome understanding for the rationale for choosing the current 12 countries and the reasoning for excluding other potential candidate countries. We have been told that economic factors, i.e., GDP, and a strong commitment to consumer protection in those countries were primary factors in selecting them. What are these consumer protection mechanisms and how relevant are they to the Canadian system?

Recommendations:

1. During the consultations, we suggested other relevant factors be included. With respect to the proposed list of 12 comparator countries, the federal government should ensure that all factors are considered and compared and that these be made transparent. These include: private/public insurance drug split, health care delivery mix in each country, whether they have a robust Health Technology Assessment (HTA) process, overall health care system structure in each country, demographics of comparator country, price control strategy e.g. free price, maximum price or reimbursement price or a combination of these (we understand that all but Germany have a list price and all but Sweden, Norway and Japan have net prices), price control tools e.g. IRP, TRP, cost per QALY, cost-plus /cost calculation, cost comparison, tendering or pricing negotiations, health systems data collection, monitoring and evaluation, time to market, what drugs are actually covered in those countries and the importance of wide and universal access, access to research and clinical trials and

commitment to innovation and, last but not least, a measure of health outcomes (perhaps those from the WHO) in these countries need to be used in selecting comparator countries.

2. Drugs for life-threatening diseases should receive special attention. The federal government should not use any comparator countries for drugs for life-threatening and serious diseases or conditions in the Regulations that delay market entry longer than Canada's present time to entry as Canadian patients cannot wait any longer than the already lengthy delays experienced to obtain access to badly needed treatments. Thus, some or all the comparator countries should be removed and replaced by more appropriate comparators. The federal government should not use any comparator countries for drugs for life-threatening and serious diseases or conditions in the Regulations that have less clinical trial access in these areas as clinical trials are an important process for access in Canada.

3. The federal government should only select comparator countries that have comparable or better market entry times than Canada and comparable or better access to clinical trials as Canada.

4. All analyses done in support of the Regulations should be made public.

Additional comments for consideration:

- We were advised that some, if not all, of these factors had been considered but were offered no firm assurance that we would have access to these analyses: including private/public insurance drug and health care delivery mix in each country, whether they have a robust HTA process, the entire health care system structure in each country, demographics of the country, price control strategy e.g. free price, maximum price or reimbursement price or a combination of these (we understand that all but Germany have a list price and all but Sweden, Norway and Japan have net prices), price control tools e.g. IRP, TRP, cost per QALY, Cost-plus /cost calculation, cost comparison, tendering or pricing negotiations, time to market, health systems data collection, monitoring and evaluation, time to market entry, what drugs are actually covered in those countries including the importance of wide and universal drug coverage, access to research and clinical trials and commitment to innovation.

- We have reviewed these broader factors in relation to the proposed basket and there are numerous relevant differences between our health care system and aspects of each of these. We will mention a few as examples but there are numerous others that are undoubtedly already part of Health Canada's and PMPRB's analyses of them.

    1. One striking difference is that public spending is by far higher in many of these countries than in Canada e.g. France, Sweden, Norway, United Kingdom, South Korea.

    2. Some of these countries have mandated varying forms of risk sharing agreements with the pharmaceutical industry e.g, Germany, Netherlands, other EU countries.

    3. In Korea, there is no incentive for innovation or the allocation of clinical research, something that is important in our country.

    4. Japan has a system of revising drug pricing downwards for new drugs selling in greater volume than expected and for brand name drugs when generic equivalents hit the market.

5. The point is that each country has an interdependent health care ecosystem and we cannot cherry pick the drug pricing model only, without looking at other relevant aspects of the system to find those that most closely align with our values and our structure. Perhaps this has been done but without seeing the government's analysis, we have no way of determining this.

2. Are there other criteria that should be considered in revising the Schedule?

We would submit all the factors set out in in this submission should be considered. For example, comparability of health care systems is important because of the principle of universality; the type of different delivery systems across regions is relevant; reimbursement of drugs either by the public or private systems is also relevant.

Recommendation:

1. Factors that should be taken into account in selecting comparator countries include private/public insurance drug and health care delivery mix in each country, whether they have a robust HTA process, the entire health care system structure in each country, demographics of the country, price control strategy e.g. free price, maximum price or reimbursement price or a combination of these (we understand that all but Germany have a list price and all but Sweden, Norway and Japan have net prices), price control tools e.g. IRP, TRP, cost per QALY, Cost-plus/cost calculation, cost comparison, tendering or pricing negotiations, time to market, health systems data collection, monitoring and evaluation, time-to-market, what drugs are actually covered in those countries and the importance of wide/universal access, access to research and clinical trials and commitment to innovation.

Additional comments for consideration:

- Our health care system is not uniform across provinces, and how it would be standardized, not to the lowest common denominator but to best practices not only within Canada but also in comparison to these countries, must be considered.

- Health outcomes measurements must also be comparison factors, as these play a critical role in determining the value of a drug treatment in any HTA analysis. If PMPRB is to include HTA in its pricing determination, health outcomes must also be included. Additionally, it would be wise to compare health outcomes within the new basket of countries looking for possible correlations between drug expenditures and outcomes as compared to other cost drivers, like hospitalisation, disability. For an excellent discussion of health care based on outcomes, read the World Economic Forum on Africa 2017 Paper[5] and "The Patient Will See You Now", a recent book by Dr. Eric Topol.[6]

- Additionally, health outcome measurements cannot be disassociated from real-world evidence data collection and analysis. It is part of the continuum of health outcomes measurement. Currently the responsibility to oversee, collect, analyse and implement solutions derived from these analyses does not reside with any one government stakeholder e.g. Health Canada, PMPRB, CADTH, pCPA, CAPCA. These agencies as well as registries held by disease groups and health data collection agencies, and the private sector, have a

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[5] https://www.weforum.org/reports/value-in-healthcare-laying-the-foundation-for-health-system-transformation

[6] "The Patient Will See You Now", *Basic Books*, 2015, Eric Topol

stake in real-world evidence generation. It is imperative that there is a common accepted consensus on the definition of real-world evidence, how to collect and analyze it and the purposes for which it will be used.

- Cultural factors should be considered when comparing Canada to other countries. It is important that we, as a culturally diverse country, find our own comfort levels in making value judgments about what we are willing to pay for the value we are seeking in exchange for better health outcomes.

- Lastly, the issue of how we see our role as a world leader in subsidizing prices and access to necessary medicines in the developing world has not been addressed at all. This was a question often asked when combination therapies were developed for HIV that were out of the reach of people in developing countries. Cancer is arguably comparable.

3. Please provide any other comments you may have on the Schedule of comparator countries?

Until we can do a more in-depth analysis of comparator countries and the factors they bring to the comparator basket, we cannot provide comprehensive comments on this question. We reserve further comments until more information becomes available to us from various sources.

We also request that more details be provided on market entry for new products in the new basket countries, as this will undoubtedly influence how new drugs will be introduced in Canada, which could result in longer wait times for patients to gain access to these drugs.

When examining the OECD countries chosen as the new basket of 12 comparator countries, it seems that the average price ratio from these countries are at, or close to, the median OECD price ratio. This begs the question: why not just use this median price ratio as one of the factors going forward? In the document provided the number for this median is about 22 per cent below that of Canada. Why do the proposed guideline changes not acknowledge this?

Proposal #3: Reducing regulatory burden for generic drugs with a patent

Consultation Question

Do you agree that patentees of generic drugs i.e. drugs that have been authorised for sale by Health Canada through an ANDS should only report information about the identity of the drug and its price in the event of a complaint or at the request of PMPRB?

This seems like a reasonable approach and a way to be more efficient with the resources at the disposal of the PMPRB. Clarification that the complaints process can be made by anyone should be added.

Recommendation:

1. There should be a clarification added to the proposed patented generic drug process explaining that the complaints process can be accessed by anyone.

Proposal #4: Modernizing reporting requirements for patentees

Consultation Questions

1. Is the information sought in relation to the new factors relevant and sufficient?

2. Is this information generally available to patentees?

This question is directly related to Question #1. See our comments under that section.

Proposal #5: Providing information related to third party rebates

Consultation Question
Are there any reasons why patentees should *not* be required to disclose to the PMPRB information on indirect discounts and rebates provided to third party payers?

First, the question is not clear and needs to be revised since the definition of "indirect" discounts and rebates is not defined. We were told that it referred to rebates to pCPA, private payers and cards provided to individual payers by companies to cover deductibles and prescribing fees. If so, this should be made clear.

It should also be clearly stated how this information will be used. Unless there is a purpose for it, there is no point asking patentees to do more work than required.

Recommendation:

1. The definition of "indirect" discounts and rebates should be defined in the Regulation. The Regulation should clearly state how the information about indirect discounts and rebates will be used.

Additional Comments and Recommendations:

Patient values are not discussed to any extent in the consultation document. We find this antithetical to the goals of increasing affordability for medicines to Canadians and to the stated aims of all Canadian governments to ensure patient-centred care in this country.

Recommendation:

1. Patient values must be added in the Regulation as an equally important factor for the PMPRB to consider as any others when determining whether a drug price is excessive since all Canadian governments have expressed that their health policies are based on patient-centred care.

2. PMPRB and Health Canada should develop a rigorous monitoring and evaluation framework for the federal regulation of drug pricing designed with patient groups and reviewed annually and modified as required.

Other recommendations for consideration:

1. An efficient, effective and mandatory dispute resolution mechanism within PMPRB for excessive pricing in the breakthrough drug category should be created within PMPRB such as a mandatory Alternative Dispute Resolution process with publicly published reasons for the decision as well as regular re-evaluation of a well-defined class of breakthrough drugs. This will address the core affordability problems of PMPRB.

2. The *Patent Act* should be amended to delete the Consumer Price Index (CPI) as an automatic increase mechanism for therapies.

4. Conclusions

In every pricing review, there is always room to reduce drug costs through negotiation but, if the impact of lowering the drug entry price in Canada by 20 per cent or more is less or delayed access to treatments for patients, patients and their organizational representatives will not support it.

Our stated concerns about the basket of countries leading to increased delays in access is not without an evidentiary basis. We have done an analysis of launch times and drug prices in several countries, and there appears to be a direct relationship. For instance, Switzerland launches new medicines 142 days after market access while Canada launches such products 357 days after market authorization. Launch times in Germany and the UK were on average within 4 to 6 months while France, Spain and Italy took more than a year.

As the federal government looks at drug pricing policy changes, they should do so in the context of overall health outcomes, the impact on the entire health care system and employers. The real issue for many people in Canada is lack of access or inadequate access to necessary medicines. This is a problem worth solving. The main problem for the poor is the lack of funds to buy drugs or the inability to pay the deductibles, co-pays and other costs associated with being uninsured or underinsured. The federal government should set up a fund that these people can access across Canada to deal with this inequity in access.

Final recommendation:

1. The federal government must ensure that there are no unintended and unforeseen adverse consequences to public payers of a lower entry price into Canada for public and private payers by reducing the overall amount available to provincial/territorial payers for price negotiations before promulgating these Regulations. Such an adverse impact will mean less access to necessary medicines for eligible people in Canada and this is surely not the intention of the federal government.

The federal government must show leadership in health by convening a multi-stakeholder group including meaningful patient group representation to find a common vision for the health care system founded on value-based health outcomes and to determine how to collaborate to achieve that goal together.