lung health starts now

lung health foundation

Drug Reimbursement

managing costs without compromising health and access

In partnership with

AstraZeneca

October 2017

About the Lung Health Foundation

The Lung Health Foundation is the leading health charity dedicated to improving lung health through a uniquely integrated approach that identifies gaps and fills them through investments in groundbreaking research and urgently needed programs and supports; policy and practice change; and promoting awareness about lung health issues affecting all Canadians.

About the Breathing Policy Forum Series

Bringing together thought leaders from the public and private sectors, the Breathing Policy Forum Series tackles some of the most urgent and pressing issues facing healthcare today,

Each forum provides strategic opportunities to develop creative and actionable solutions - facilitating collaboration on health and policy issues of growing provincial and national concern, exploring innovative ways of controlling skyrocketing medical costs, improving access to healthcare, and managing the growing burden of chronic disease.

Contents

Letter from the President & CEO

The Lung Health Foundation is very excited about our ongoing Breathing Policy Forum series aimed at developing creative and actionable solutions that are needed now, more than ever, to improve the healthcare system in Ontario.

As our population grows and ages, those pressures will only rise as we face an unprecedented level of demand for services and supports.

Maintaining the accessibility and availability of necessary medicines remains an emerging challenge. It accounts for 14 per cent of total healthcare spending nationally.

Then there's the emergence of precision medicine that treats small numbers of people. While the costs may be considered high relative to traditional medications, these treatments also provide us with an improved ability to get the right drug to the right person at the right time, thereby increasing the likelihood of successful treatments.

The number of drugs that cost more than $50,000 per patient has grown by 50 per cent and the usage of prescription drugs is growing especially amongst our seniors. Forty per cent of Canadians take a prescription drug regularly. For those over 65, that number grows to 80 per cent. In addition to these challenges, Canada has several public and private drug plans with varying formularies for reimbursement which can be seen as a roadblock to equitable access.

The goal of this forum will be to explore reimbursement policies in Ontario, identifying ways of ensuring that patients have equitable access to the necessary and appropriate medicines they need and that the required supports are put in place.

Our series of Breathing Policy Forums are a way for the Lung Health Foundation to play a deeper, more profound role in policy, bringing relevant players together to tackle some of the more pressing issues facing us here in Ontario, but also nationally. It's not about point fingers and putting the onus on others. It's about working together in partnership and honest dialogue.

To address these challenges within the context of competing priorities and the limited ability on the part of governments to continually increase health care spending, we need to work together to develop innovative and creative solutions.

George Habib
President & CEO
Lung Health Foundation

Setting the Context

Ross Wallace
Principal, Santis Health

A Complicated and Multi-Faceted Problem

The single greatest question facing the healthcare system today is how to price drugs at a point where they are accessible to as many patients as possible without deterring innovation in the Canadian system. If a drug price is set too high than the number of people with access to it will be limited. Whereas if a price is set to low, innovative drug companies will seek jurisdictions with more favourable conditions to test drugs that have the potential to be live-saving.

A further complication to this problem is that expensive innovative drugs can save the system money in the long-run, whereas other times overall impact on the system is minuscule (regardless of the impact on quality of life for the patient).

Tensions in solving the problem

In order to understand this issue further, the following tensions need to be explored:

- Tension between costs and access
- Tension between orders of government and sub-governments including provincial health systems, pan-Canadian negotiating frameworks and federal regulatory bodies
- Tension between the importance of demonstrating value and the challenges in measuring value
- Tension between drugs as a singular form of intervention, a piece of what patients get, a piece of what the system pays for, but benefits that are often accrued and identified and valued by other people within the system.

The notion of value

Of the tensions mentioned above, the one underlying theme that is common throughout is the articulation of value for a particular intervention or product. As there is no standard way of measuring value across the system, it is often hard to find a consensus of what value looks like because there are different ways to interpret and measure quantitative and qualitative results.

Ways to address the problem

The problem is often addressed from a very high-level, which, if done frequently, can result in broad solutions that do not have any tangible outcomes or results. However, taking a therapeutically focused approach to search for ways to answer this question allows a more concrete focus on the challenges - in particular, assessing the problem through the lens of the patient perspective, the clinical role and the system role.

Having broad conversations that include experts in these roles helps to address the problem in a way that allows for practical recommendations to be made that complement the broader solutions.

The Patient Perspective:

Living with Asthma

Jennifer's Story

Often times a patient is not properly diagnosed with asthma. They are put on medications without undergoing the testing required to make an accurate diagnosis. The ramifications of misdiagnoses are that a person is either underdiagnosed or over diagnosed, both of which cause a preventable burden on the healthcare system.

For years, Jennifer Falkiner would have chronic respiratory infections. She would be prescribed antibiotics, inhalers and even Prednisone in extreme circumstances. None of these worked, so eventually she was tested to see if certain allergens were a trigger for her asthma. When the test came back negative, her doctor was at a loss for what to do.

Jennifer eventually saw a respirologist who prescribed her Symbicor to manage her asthma. Approximately every two months her asthma would become so unmanageable that she would require a round of Prednisone to get it under control. At this point in her life, Jennifer was on very strong medications to control her asthma, which contained steroids and came with a variety of unwanted side-effects.

But, seeing a properly trained respirologist meant that Jennifer had access to more innovative medicines than she has prior. After the two steroid based medications were not able to control her asthma, it was suggested by her respirologist that Xolair might help.

However, Xolair was an expensive drug that was not widely covered by insurance companies. Her insurance company eventually covered a portion of it (on the basis that there was no generic option available) and the rest was fortunately covered by the drug company.

After Jennifer tried Xolair for seven months, her asthma was still not under control and it became so unmanageable that performing her job as a Canada Post worker became too difficult. She was also not able to do many activities she used to be able to do with her grandchildren. At this point she was on a variety of different drugs that included Singulair and a daily dosage of Prednisone.

Eventually, a biologic drug trial was presented to her and her quality of life began to

improve almost immediately. She was weaned off Prednisone and put on half the dose of Symbicort. Eventually she was taken off Singulair and hasn't had to use Ventolin in about two and a half years.

In addition to reducing or being taken off several medications (which has reduced costs to her and her insurance provider), Jennifer's performance on the job significantly improved and she was able to once again enjoy active time with her family.

However, the question remains: Once the trial is done, who will cover the cost of the drug that has radically improved Jennifer's quality of life? Jennifer wants to retire in under two years, but with a fixed income, she doesn't know if she'll be able to afford it.

What's next?

Jennifer's story highlights both the tensions of cost versus access and the difficulty in demonstrating and measuring value.

Both Xolair and the trial biologic drug are extremely expensive, which means that the average citizen cannot afford it without the proper coverage. Even though Xolair did not work for Jennifer, she was fortunate her insurance company and the drug company came to an agreement. However, that is not always the case for patients who require the same treatment as Jennifer.

Although this particular trial drug may be expensive, the overall value calculation is difficult. From a purely quantitative perspective, Jennifer is able to produce more economic outputs and is less of a strain on the public health system. However, the cost is extremely high and the incentives for the private insurance company to pay the entire bill may not exist. For this to be covered under a public drug program, the calculation of value becomes even more difficult in a time of limited public funds.

Jennifer's story illustrates the importance of defining a universally accepted method of measuring the value of a drug when deciding whether or not it will be covered by a private or public insurance plan. It also highlights the important issue of pricing drugs at a cost that allows them to be accessible to patients, but doing so without compromising innovation.

The Health Perspective:

Dr. Alan Kaplan

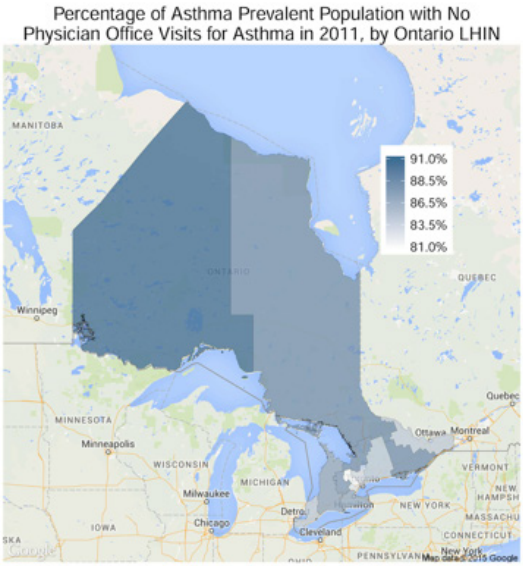
Asthma is the most common chronic respiratory disease in Canada, affecting approximately 2.2 million adults and close to one million children. Although asthma can be fatal, almost all of asthma deaths are theoretically preventable (Stanbrook & Kaplan). In the past 20 years, Canada has made significant strides in asthma management and can now claim one of the lowest asthma mortality rates globally (Stanbrook & Kaplan).

The Importance of Diagnosis

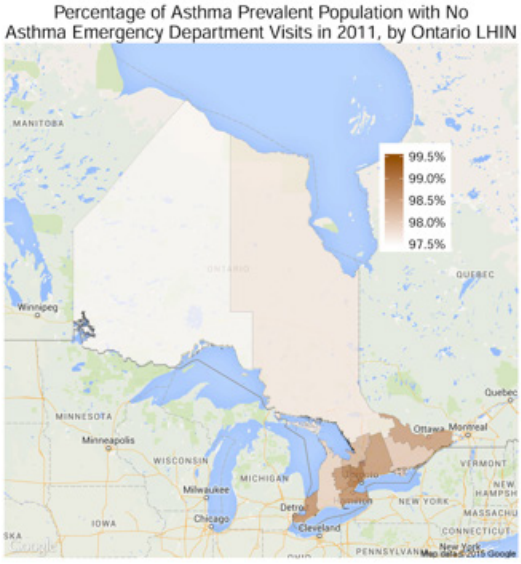
The first step in controlling asthma is the correct diagnosis, which should involve a spirometry test. Although performing a spirometry test will help formally diagnose asthma, nearly 50 per cent of those who have been diagnosed with asthma have not undergone a spirometry test (Kaplan & Stanbrook, 2010). Moreover, a 2016 study found that 30 per cent of individuals who had been diagnosed with asthma by their physician did not have active asthma. What is more troubling is that over 90 per cent of these patients were able to stop their asthma medications and remain off their medications for a year (Aaron, Vandemheen, & Fitzgearld).

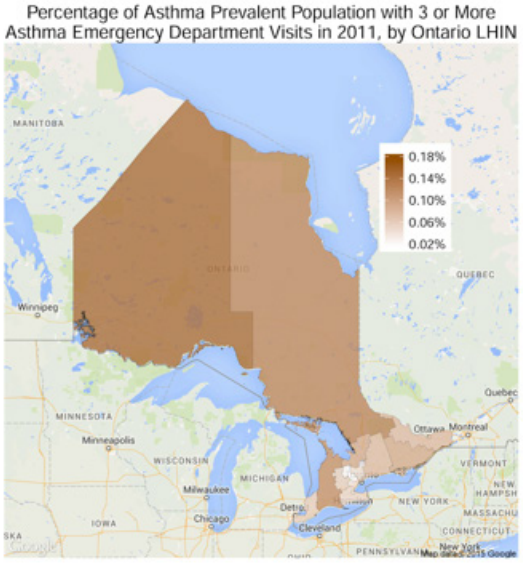
The importance of a proper diagnosis cannot be over stated. Individuals who have been over-diagnosed receive unnecessary medication, which is a cost to both an individual and to the public and private insurance systems. These individuals may also suffer from the unnecessary side effects of asthma medications, putting an even greater strain on the system. There are also those who have been undiagnosed or not diagnosed at all. In these cases, individuals who are not deemed to have their asthma under control not only experience a decline in quality of life, but also create a much larger load on the system than necessary. Poor asthma control imposes a significant burden on the healthcare system with the annual direct and indirect costs estimated at between $504 million and $648 million in Canada (Kaplan , Balter, Bell, Kim, & McIvor).

Diagnosis is important because the only way to control asthma is through the right treatment for right person at right time.



Government of Ontario, Ministry of Health and Long-Term Care (2011)





Government of Ontario, Ministry of Health and Long-Term Care (2011)

Systematic Issues

In addition to diagnostics, there are also a number of systemic issues that need to be addressed in order for asthma and other lung diseases to be managed properly:

- Disparities across Local Health Integration Networks (LHINs) for resources and respiratory educators: Areas that are near large urban centres have greater access to a family doctor, thereby are more likely to have their asthma under control and use the hospital less.
- Electronic health records to provide easy access to healthcare providers - however, there is no notification that someone may be overmedicating e.g. someone using their bronchodilator too often. There is also no burden on pharmacists to keep track of this either.

Who is responsible?

Patient: It is up to the patient to make sure they are taking their medication correctly and that they understand their condition, what their triggers are and how to avoid them.

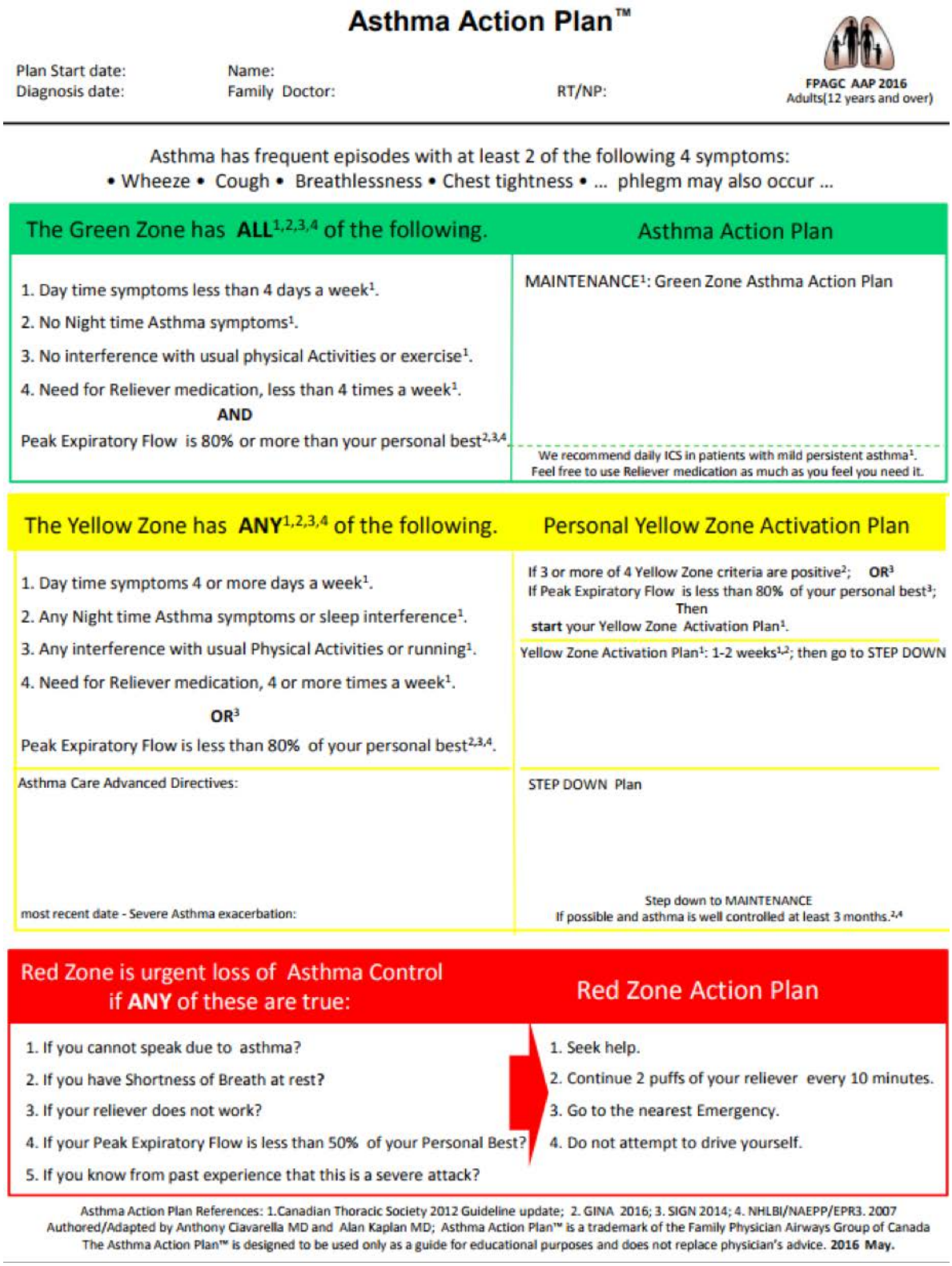
Doctor: It is the responsibility of the doctor to make the right diagnosis and decide on the right treatment for the patient.

System problems: In order for the patient and doctors to be fully accountable, inherent systematic issues need to be addressed e.g. if there is no funding for diagnostic tests, like spirometry, then it will not be done.

Action Plans

An Action Plan is a personalized plan prepared by a healthcare professional for an asthmatic patient that provides resources such as education and how to manage worsening symptoms in a traffic light confirmation: (actionplan)

Green	describes adequate control and corresponding baseline medications
Yellow	describes loss of control and corresponding instructions for therapeutic intensification
Red	indicates severe symptoms that should prompt immediate medical assistance



Asthma Action Plan™

Plan Start date:
Diagnosis date:
Name:
Family Doctor:
RT/NP:

FPAGC AAP 2016
Adults(12 years and over)

Asthma has frequent episodes with at least 2 of the following 4 symptoms:
• Wheeze • Cough • Breathlessness • Chest tightness • … phlegm may also occur …

The Green Zone has **ALL**[1,2,3,4] of the following.	Asthma Action Plan
1. Day time symptoms less than 4 days a week[1]. 2. No Night time Asthma symptoms[1]. 3. No interference with usual physical Activities or exercise[1]. 4. Need for Reliever medication, less than 4 times a week[1]. **AND** Peak Expiratory Flow is 80% or more than your personal best[2,3,4].	MAINTENANCE[1]: Green Zone Asthma Action Plan We recommend daily ICS in patients with mild persistent asthma[1]. Feel free to use Reliever medication as much as you feel you need it.

The Yellow Zone has **ANY**[1,2,3,4] of the following.	Personal Yellow Zone Activation Plan
1. Day time symptoms 4 or more days a week[1]. 2. Any Night time Asthma symptoms or sleep interference[1]. 3. Any interference with usual Physical Activities or running[1]. 4. Need for Reliever medication, 4 or more times a week[1]. **OR**[3] Peak Expiratory Flow is less than 80% of your personal best[2,3,4].	If 3 or more of 4 Yellow Zone criteria are positive[2]; **OR**[3] If Peak Expiratory Flow is less than 80% of your personal best[3]; Then **start** your Yellow Zone Activation Plan[1]. Yellow Zone Activation Plan[1]: 1-2 weeks[1,2]; then go to STEP DOWN
Asthma Care Advanced Directives: most recent date - Severe Asthma exacerbation:	STEP DOWN Plan Step down to MAINTENANCE If possible and asthma is well controlled at least 3 months.[2,4]

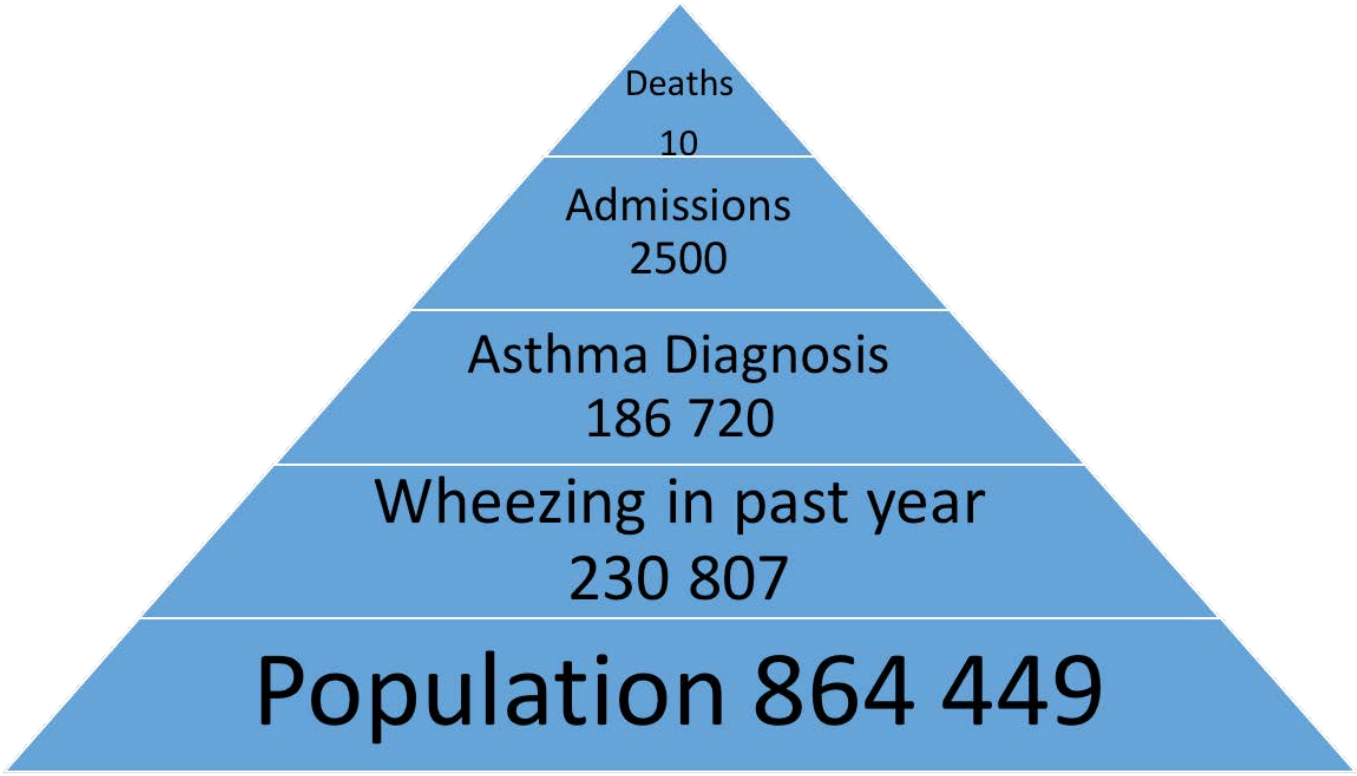
Red Zone is urgent loss of Asthma Control if **ANY** of these are true:	Red Zone Action Plan
1. If you cannot speak due to asthma? 2. If you have Shortness of Breath at rest? 3. If your reliever does not work? 4. If your Peak Expiratory Flow is less than 50% of your Personal Best? 5. If you know from past experience that this is a severe attack?	1. Seek help. 2. Continue 2 puffs of your reliever every 10 minutes. 3. Go to the nearest Emergency. 4. Do not attempt to drive yourself.

Asthma Action Plan References: 1.Canadian Thoracic Society 2012 Guideline update; 2. GINA 2016; 3. SIGN 2014; 4. NHLBI/NAEPP/EPR3. 2007
Authored/Adapted by Anthony Ciavarella MD and Alan Kaplan MD; Asthma Action Plan™ is a trademark of the Family Physician Airways Group of Canada
The Asthma Action Plan™ is designed to be used only as a guide for educational purposes and does not replace physician's advice. **2016 May.**

A review of randomized control trials demonstrated that the use of a written Asthma Action Plan (AAP), combined with patient education, significantly reduced healthcare system utilization. Troubling though is the fact that only 20 per cent of Ontarians with asthma have an AAP.

Assessing Value and Costs

In order to manage costs related to lung disease on the healthcare system there needs to be a broad discussion surrounding value.



The question surrounding what medications government or health plans decide to cover is extremely complex, as it requires placing value on a patient's life. Although biologics can be a life-changing medicine, they are also expensive, treat fewer people and may not be the most efficient use of limited funds.

To better asses this, public and private plans should assess value through the population/risk pyramid. At the bottom is the population at risk of contracting asthma. Each level of the pyramid contains less people, but represents both a more serious condition and cost to the system. In order to make a significant change for the costly small group at the top, there need to be changes as to what is covered for the large and relatively inexpensive group at the bottom.

For example, these individuals should be provided with vaccinations and over-the-counter smoking cessation products, which are inexpensive, but save the system money in the long-run because it limits the mobility into the upper tiers of the risk pyramid. Less individuals at the upper end of the risk period mean that there are more funds available to cover expensive medications such as biologics.

Moving Forward

- Government needs to invest funds to make spirometry more accessible. The more people that are correctly diagnosed with asthma and provided with an accurate AAP will offset system costs.
- Patients need to understand their condition and how to properly take their medication.
- Biologics can be life-changing, but their current price point makes it difficult for public and private plans to justify covering them. Systemic issues need to be addressed in order to make coverage more palatable.

Payer Perspective: Opportunities, Challenges and Implications

Suzanne McGurn
Assistant Deputy Minister, and Executive Officer, Ontario Public Drug Programs, Ministry of Health and Long-Term Care

Ontario's Public Drug Programs

The Ontario Public Drug Programs (OPDP) provide access to medications through six main programs. The largest program, the Ontario Drug Benefit (ODB) program provides access to over 4,400 drug products to eligible Ontarians. Since January 1, 2018, the number of Ontarians covered under the ODB has doubled to approximately 60 per cent of the population with the addition of children and youth aged 24 years and under. The ODB program also provides coverage for seniors, those receiving social assistance, residents of long-term care and special care homes, recipients of professional home and community care services, and people registered under the Trillium Drug Program, a program to help those facing high prescription costs relative to their household income.

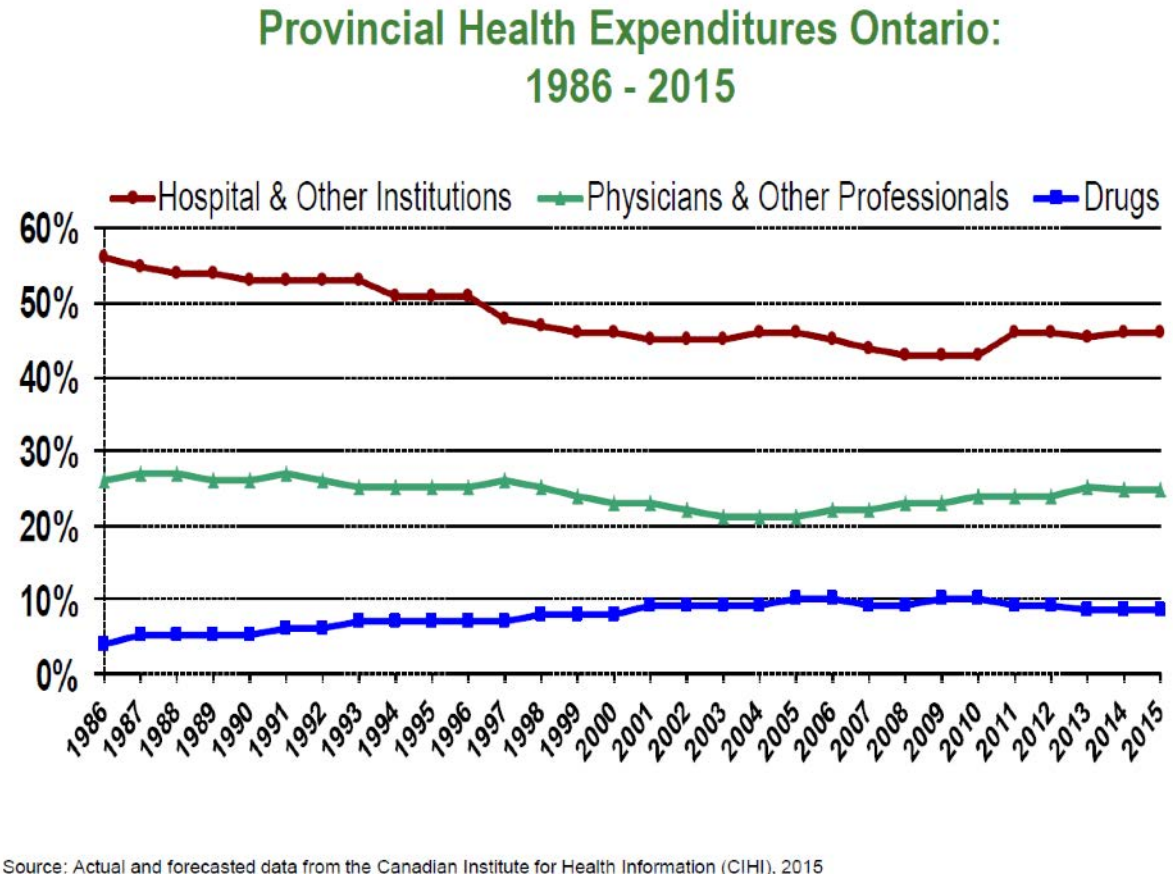
Increasing Costs, Limited Resources and the Importance of Value

The expansion of public drug coverage to children and youth, the aging of the baby boomer generation and the increase in prices for innovative medicines have made the discussion of value-for-money and sustainability extremely critical. Between 2007 and 2016, the number of Ontarians using the healthcare system increased by 16 per cent, while the cost of medications through the ODB program increased by 48 per cent. The pace at which the cost of medicines has outstripped healthcare system growth underscores the importance of understanding and considering what value truly is.

The OPDP understands the importance of engaging others within the healthcare community to learn how they define value. In addition to the OPDP, there are many other stakeholders who have to consider what value is, including employers, third party insurance providers, the government, tax payers, patients and their families, and other stakeholders.

We need to understand the real value of medicines– not just the marketed cost - and be able to a make a determination to add, adjust or potentially remove products that do not provide value-for-money. Each dollar spent by public drug programs on medicines, is a dollar not spent elsewhere. These are difficult decisions to make to ensure that Ontarians have improved access to newer and better medications that demonstrate value-for-money, while maintaining the sustainability of our overall healthcare system.

Over the past three decades, the public drug budget has grown more than the hospital budget. Public drug spending is an important component of preventative medicine and can help reduce hospital visits, however, there is also value in having state-of-the- art hospitals. It is trade-offs like this that the public payer must weigh every day.



Source: Actual and forecasted data from the Canadian Institute for Health Information (CIHI), 2015

Canadian Institute for Health Information

Challenges and the Way Forward

Communication

A key requirement for addressing issues facing the healthcare system is communication. This is critical to properly understand the needs of those within the system and the issues they face. Stakeholders from across the healthcare system should be brought together to discuss what terms such as access, equity, evidence and choice mean in relation to real value - not the marketed value.

There also needs to be a baseline understanding of key definitions and questions amongst all stakeholders. What is added therapeutic value? What are improved endpoints? Is survival the only important endpoint? What are reductions in side effects worth? How important is patient convenience and what does and patient-centred care look like in the pharmaceutical space? What is an appropriate incremental cost-effectiveness ratio? How do countries take into account the severity of a disease? How do we determine what a price premium should be? Should there be a maximum price public drug payers are willing to pay?

Pressures of Pricing

Prices for medications are continually increasing, with the industry using their market position as the price setter and being rewarded for setting high prices every time a drug is funded. Prices for some new and innovative medicines may not be indicative of their clinical-effectiveness. The province's spending on drugs now amounts to approximately nine percent of all provincial healthcare expenditures. Rising costs can also be particularly challenging for those who are uninsured, or whose coverage is inadequate. People, are forced to make very difficult decisions about what they can and cannot afford.

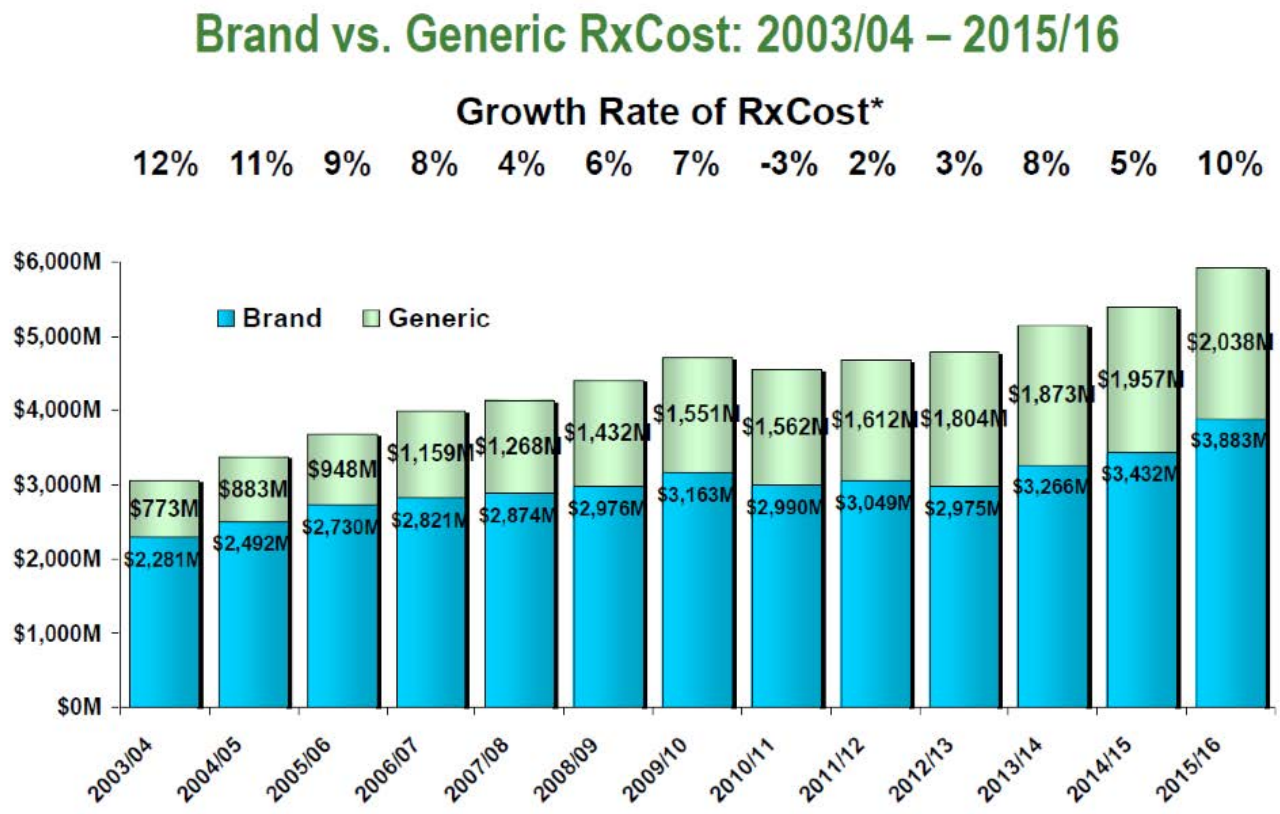
There has been a focus on bending the healthcare cost curve. As much as it may often be said that we do not take into account the impact on other parts of the healthcare system, we really do.

The pan-Canadian Pharmaceutical Alliance (pCPA) has been a critical component in reducing drug prices across the country, and bringing provinces, territories and federal drug plans together to pursue other collaborative efforts. This includes a recent agreement between the pCPA and the Canadian Generic Pharmaceutical Association which resulted in price reductions of an additional 25 to 40 per cent off prices for 70 of the most commonly prescribed drugs. The pCPA on its own is not the solution, its existence is a symptom of the problem. How fast can we get products into the market? How fast can competitors come into the market? A lot of investment money is required at the front end of getting a product introduced, but what happens the rest of the time? We also need to examine prescribing rules, not only in relation to clinical criteria, but also in regards appropriate prescribing to reduce the misuse, abuse and diversion of prescribed medicines.

Systematic

At the crux of understanding the systemic issues is a better understanding of the new product pipeline. For example, certain drugs can be life-changing, yet are very expensive. While some of these products are only required by a very small subset of the population, funding these products can be challenging for the long term sustainability of the public drug programs. In these situations, difficult decisions need to be made regarding what will and will not be covered. Discussions on value, as previously mentioned, will be very important.

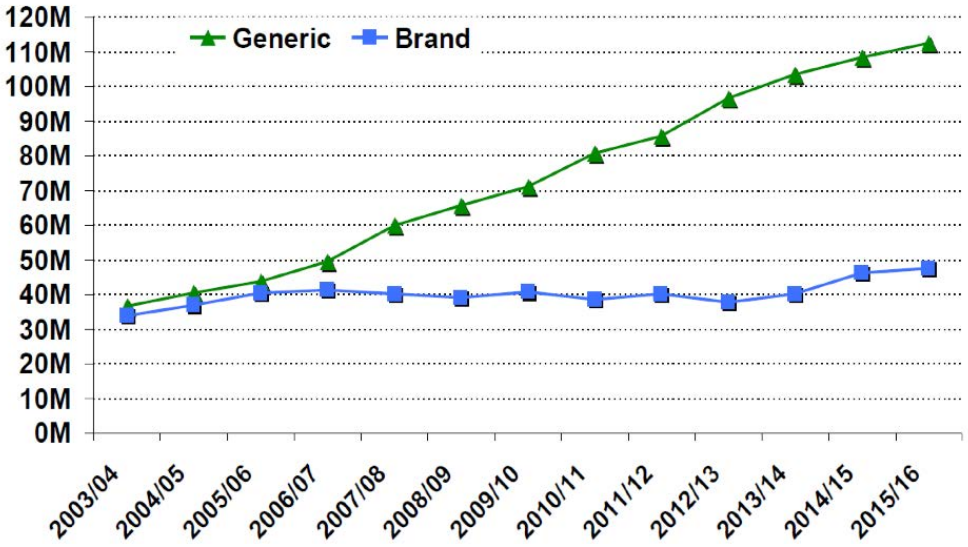
A way to ease this pressure is through generics, biosimilars and managed entry agreements. Generics and biosimilars create value because they make room in the system, and getting an innovative product to market quickly can be transformative. Yet, if managed entry agreements are not handled properly, then the system can be adversely affected. A balance needs to be struck that allows for innovation to flourish and competition to enter the market to maximize access. However, managed agreements that are based on evidence and endpoints also need to ensure they can determine how to make decisions about taking patients off medicines or when to stop paying for them.



* Drug cost is based on the publicly available list prices and may not reflect actual prices paid by the ministry under confidential listing agreements with manufacturers.

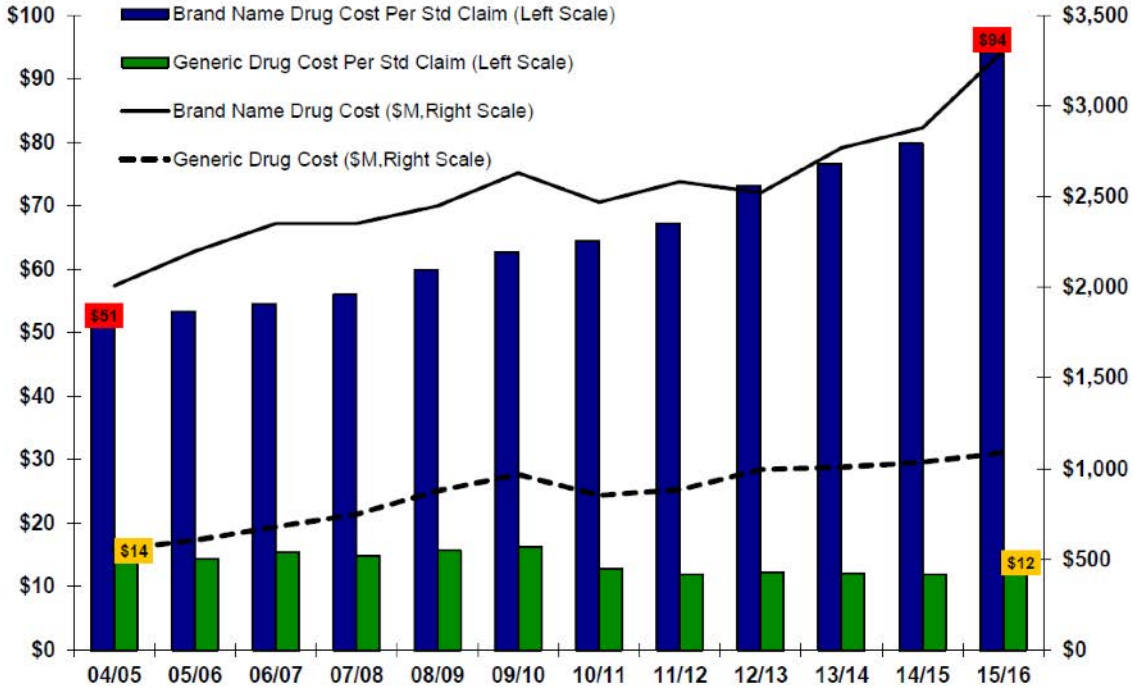
Ontario Ministry of Health and Long-Term Care

Brand vs. Generic Claim Count: 2003/04 – 2015/16



Ontario Ministry of Health and Long-Term Care

Comparison of Brand and Generic Drug Costs*: 2004/05 to 2015/16



* Drug cost is based on the publicly available list prices and may not reflect actual prices paid by the ministry under confidential listing agreements with manufacturers.
Note: Std Claims = claims standardized to 30 days supply

Government of Ontario, Ministry of Health and Long-Term Care

Recommendations

1 Encourage and create the right conditions for patients to receive a proper diagnosis through a spirometry test

A correct diagnosis is at the core of managing costs and extracting value from the healthcare system. When a patient is given the correct diagnosis, they receive the correct medication (if any) and a proper action plan to help manage symptoms, if necessary.

However, roughly half of the time, asthma or COPD is diagnosed without the use of a diagnostic tool known as a spirometry test. Without a proper spirometry test, patients are often misdiagnosed, which results in an undue financial and administrative burden on the healthcare system.

Often, a spirometry test is not performed when diagnosing patients with either asthma or COPD due to a lack of training for doctors and healthcare professionals, as well as a lack of resources to administer testing. The latter is especially true in rural and remote communities.

To encourage healthcare professionals to use spirometry testing more often, there needs to be an attempt to close the knowledge gap by providing better training to doctors and healthcare professionals.

For example, the London Family Health Team recently:

- Created and shared a flow chart for the process of referring patients for spirometry testing.
- Promoted training sessions to demonstrate best practice in spirometry technique.
- Encouraged capacity building by training registered nurses on spirometry testing.

The Credit Valley Family Health Team:

- Introduced tear-off referral pads to book an appointment for spirometry screening.
- Provided yearly COPD education days.

Both family health teams should be used as examples of how to train doctors and health professionals on spirometry testing, and how to increase administrative capacity for the test.

At the London Family Health Team, the percent of smokers and ex-smokers over 40 years of age screened for COPD increased from 72.2 per cent in September 2010 to 98 per cent in August 2011. For the Credit Valley Family Health Team, it increased from 25.2 per cent in August 2011 to 69 percent in March 2012 (Health Quality Ontario).

2 Consider the role of biologics and biosimilars in effective disease management

A biologic is a unique cohort of drugs.

A traditional drug is chemically synthesized which means that, in theory, with the right ingredients and equipment it could be replicated by anyone. A biologic is made from medicinal living organisms and their products, which makes it very difficult and expensive to re-create.

The cost of biologics is considered one of the most significant obstacles in accessing it. For example, many traditional drugs continuously did not work for Jennifer Falkiner. But once she was put on a trial for a biologic, her asthma became manageable. However, Jennifer, like many individuals, does not know if her private insurance company will cover biologics in the future due to their high cost.

In order for public and private payers to embrace biologics, there are systemic issues in the healthcare system should be addressed. The work done by the London and Credit Family Health Teams to encourage and educate healthcare providers on spirometry testing addresses some of these issues.

Addressing the systemic issue of proper diagnosis also helps to determine if a biologic can work for an individual, as they are not for everyone. For example, biologics are only intended to be used by people with severe asthma, which is defined as asthma that is difficult to control with standard reliever and controller medications. The only way a doctor can truly know if you have severe asthma is through the use of a proper diagnostic tool.

A second avenue that should be explored is the role of biosimilars. A biosimilar is a medication that is made to be as close as possible to a reference biologic medication. Biosimilars are different from generic drugs in the sense that the active ingredients in a biosimilar medication and a reference medicine will never be exactly the same, unlike generics which are identical copies of brand name drugs (Health Canada).

Switching a patient from a biologic to a biosimilar is not as easy as switching someone from Advil to a generic version. Since few clinical studies have been done, there are still questions of whether human bodies might respond differently to biosimilar. Moreover, due to the regulatory requirements and complexities of developing, manufacturing and monitoring biologic drugs, the percentage price difference between biosmilars and their reference products are not as high as the price difference between generic and brand name drugs. However, there are still significant cost savings to be had given the high costs of innovator biologics. In the European Union, for example, biosimilars are priced 20 per

cent to 30 per cent lower than their respective innovator products (Health Canada).

Despite their potential benefits, biosimilars have had not had a lot of uptake in Canada to date. Providing education and information to relevant stakeholders may help to increase confidence in biosimilars. Encouraging the use of biosimilar's when possible can also help free up resources for biologics that do not have a biosimilar alternative.

A competitive and sustainable market for biosimilar and innovator drugs could offer many benefits to the healthcare system, including broadening access to effective biologic treatments, reducing the cost burden and enabling savings to be re-directed across all areas of healthcare including funding of new innovative therapies. In order to do so, governments, industry and patients must all work together to make sure that they are embraced (Health Canada).

3 Importance of evaluation: Clinical guidelines versus real-world experience, and measuring "value"

The value of a drug, especially a biologic, can only be determined if there is a rigorous evaluation that includes both clinical guidelines and patient submissions.

Clinical guidelines are high level, research based and representative of the trial group, whereas patient submissions assess the everyday impact of a drug or a biologic. Currently, Health Quality Ontario (HQO) provides guidelines and frameworks for both clinicians and patients, but does not provide one for drugs.

Part of the issue, however, is that there is no universal definition of "value." Interjurisdictional inconsistencies exist in terms of the need for, and type of, economic evaluation required for biosimilars. Moreover, patient value also needs to be taken into account. The current system of pharmacoeconomics does not do a good job of measuring metrics such as spending more time with family, more time at work and improvements to mental health.

A recommendation for the Ontario context is that HQO provide a comprehensive guideline for drugs, which would help streamline the definition of "value" within its jurisdiction, including patient value.

4 Importance of Communication

Patients, physicians, pharmacists and healthcare providers need to improve communication, as better communication helps identify issues with adherence, technique and comorbidities.

Patients especially need to understand what their triggers are and how to manage their condition on a day-to-day basis.

Physicians need to provide patients with an Action Plan that outlines triggers, biology, severity and prognosis of their condition.

Pharmacists need to monitor patient prescriptions to ensure they are adhering to an Action Plan and to look for troubling patterns e.g. they are only refiling their short-acting bronchodilator.

At the London Family Health Centre, patients were engaged through a clear action plan that identified one goal to achieve (Health Quality Ontario).

Moving Forward

How to maximize access to innovative medicines, while fostering the right conditions for them to flourish is one of the single greatest questions currently facing the healthcare system.

In the case of chronic lung disease, the most important thing that can be done is encouraging the wide-spread use of spirometry testing to ensure that all patients who have been diagnosed with asthma have been done so properly. A proper diagnosis makes sure that the patient is receiving the right treatment, limiting the strain that under and over diagnosis places on the healthcare system.

In addition to the wide-spread use of spirometry, there also needs to be a movement towards a universal definition of value. The tensions between orders of government and sub-governments can hinder this discussion, but can be alleviated through improved communication and the standardization of performance measurement frameworks.

Biologics are an important form of intervention, but given their composition, it is difficult to measure and evaluate their value. A correct diagnosis can help alleviate this tension and maximize the chance that the correct individuals are given biologics, which, when combined with proper communication, has the potential to have a transformative impact on our healthcare system.

Canada does a tremendous job in the way it manages healthcare. There are a lot of commonalities even though various players may execute them differently, even within the many formularies that exist. But, we also must remember that medicines are not magical.

We need to stop overprescribing. We do not carry out surgeries that are unnecessary, and, therefore, need to do the same with inappropriate prescribing. As well, the number of medicines we have on the market and the number that people have access to does not actually matter. What matters is getting the right medicines to the right people in the right circumstance. This is where Canada can make tremendous leaps and bounds in the delivery of its healthcare.

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About Our Partners

Santis Health

Santis Health is a Toronto-based public affairs, strategic advisory, public policy, marketing and communication consultancy that is dedicated to providing first-class counsel and support for clients exclusively in the health care sector. Our approach is strategic by design, with a focus on leveraging a deep understanding of the sector in order to develop a tailored plan to help organizations, associations and companies achieve measurable, lasting outcomes.

Jennifer Faulkner, Patient Advocate

Jennifer Faulkner is a mother of four and grandmother of four. She has worked at Canada Post for more than 30 years, being a letter carrier for the past 17 of them. And, she lives with severe asthma.

It was in her early 30's that Jennifer developed asthma, which became progressively worse over the years. Fortunately, things have changed over the past few years. Jennifer is now able to do her very physical job again to the best of her ability, but more importantly, she can fully enjoy her grandchildren, without asthma holding her back.

Suzanne McGurn

Suzanne is the Assistant Deputy Minister (ADM) and Executive Officer (EO) for the Ontario Public Drug Programs. In this role, she oversees one of the largest drug programs in North America, providing access to prescription medications for nearly 4 million Ontarians.

Suzanne also plays a significant leadership role within the pan-Canadian Pharmaceutical Alliance (pCPA). Through its efforts the pCPA is bringing improved value to the publicly funded drug plans across Canada, harnessing the negotiating power of 14 participating jurisdictions with its emphasis on not only affordability, but also greater consistency in access and appropriateness.

Dr. Alan Kaplan

Dr. Alan Kaplan is the Chair of the Family Physician Airways Group of Canada and Immediate past-Chairman of the Respiratory Medicine Special Interest Focus Group, College of Family Physicians of Canada. He is a family physician practicing in Richmond Hill.

Among many other titles, he is a board member of the Respiratory Section of the College of Family Physicians of Canada, as well as the Chair of the Council of Organizing Members of the Canadian Network for Respiratory Care.

Notes

lung health foundation