Dr. Hoskins and the T-word

By **Mitch Shannon,** for THE CHRONICLE OF HEALTHCARE MARKETING

"TRANSPARENCY" IS A FAMILIAR WORD THAT SHOULD BE COMMONLY understood. However, the intended meaning behind transparency can sometimes be far from transparent—in the sense that invoking the term can be used as a ploy to distract or deflect, thereby allowing the continuation of practices cloaked in obscurity. In the field of linguistics, such usage is known as an auto-antonym" or a "Janus phrase."

So it is that the Government of Ontario, facing an election next year and trailing in the polls, just introduced the idea of new legislation aimed at compelling therapy-makers to publicly disclose most financial exchanges with healthcare professionals. These would include honoraria, speaker and advisory board fees, travel grants, and likely even coffee and pastry receipts from working sessions.

Dr. Eric Hoskins, the province's health minister, says: Its important to have this level of *transparency* and accountability. It creates even more confidence in our health-care system." A spokesman for his federal counterpart chimes in that Ottawa will continue to look at ways to increase openness and *transparency* for Canadians. Brian Lewis, head of the device-makers' lobby adds that his group supports Ontario's objectives towards greater *transparency* in health care."

Dr. Hoskins' hijacking of the T-word came, regrettably, during a week when several individuals linked to his party were tied up in a courtroom, defending their alleged criminal act of intentionally destroying records relating to a 2011 mishap that cost taxpayers $1.1 billion. (The trial continues as this issue of *The Chronicle* goes to press.)

As an added curiosity, the Ontario government a few weeks earlier announced the conclusion of a process aimed at determining the best choice to operate a retailing monopoly for the sale of recreational cannabis products to the public. Queens Park considered submissions from established pharmacy organizations, along with proposals from other interested groups. Then they calculated the lucrative potential of running the sole legal marijuana enterprise serving a population of 14 million. And what do you think they decided? The government deliberated (not all that transparently), and then awarded the prize to… itself!

These coinciding incidents serve to illustrate that the meaning of transparency may be regarded in different ways, at least in the minds of Dr. Hoskins and his cabinet colleagues. They appear to believe that plenty is required for thee, but semi-transparency should suffice for me.

In truth, the proposal for a registry of financial relationships between HCPs and Big Pharma is far from that big a deal. In the US—hardly a beacon of progressive healthcare policy—legislation known as the Physician Payments Sunshine Act has been in place since 2010, and it is this law that Dr. Hoskins apparently wishes to replicate. The proposed implementation date in Ontario would follow the Americans by a full decade, if anyone is keeping score. (Several EU nations, Australia and Japan have introduced similar registries along the way.)

It's possible to argue against the need for such measures, but why bother? In an age characterized by the existence of Wikileaks and the hacker culture, it's safest to assume that all manner of information will eventually be disclosed, come what may. In 2017 and beyond, the only prevention against having indefensible practices come to light is not to engage in indefensible practices in the first place.

But why listen to us? Just ask J. Michael Pearson if he still thinks Philidor was a good idea.

That is not to revisit the old philosophical discussion of whether a senior physician will change his or her prescribing behaviour if presented with a $10 Tim Horton's gift card as a gratuity. In all likelihood, they will not, and maintaining a public database of how many $10 gift cards Dr. Hypothetical received from Brandi-the-drug-rep is not that much of a meaningful contribution toward public discourse on the critical subject of health policy and the emerging need for care rationing.

However, it should not take long for anyone to suspect that Dr. Hoskins and his colleagues and counterparts fear the political risk of encouraging an open conversation about the real-world challenges faced by the province's health system.

Among such threats must be included the long tradition of ineptitude and worse in Queen's Park. (For more as applied to the life sciences, Google the term "MaRS Bailout".) Hence, this pre-election distraction: *Hey, let's all get transparent! You go first.*

It may be understandable in a cynical political context, but what is especially galling about Dr. Hoskins' announcement is his typical self-congratulatory ministerial flourish, tinged with the inevitable implied blaming of the private sector.

Introducing this scheme now is not at all about finagling his government's slim re-election chances; goodness, no. Rather, he says, "it's about empowering patients and giving them tools and information so that they can make better, more informed decisions about their own healthcare."

Really, doctor? Because if you're truly a fan of transparency, we've got to disclose our opinion that the floating of this plan at this juncture represents a megadose of phar-

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My Turn

Proposed changes could reduce access to therapies

By **Dr. Nigel Rawson and Bacchus Barua,** Special to THE CHRONICLE OF HEALTHCARE MARKETING

While well-intentioned, changes to Patented Medicine Prices Review Board (PMPRB) could stop companies from launching new drugs. In a speech in May, federal Health Minister Jane Philpott talked about rising prescription drug prices and announced the launch of consultations on proposed changes to the PMPRB designed "to protect Canadians from excessive drug prices."

The proposed changes may be well-intentioned, but could delay access to medications in Canada or deter companies from launching new drugs. This would significantly impact the ability of health-care providers to treat patients with new, innovative and potentially life-transforming medicines.

Many new drugs, in particular biologics and genetic therapies, are more expensive and more effective than the traditional "small-molecule" drugs that public and private insurers historically cover, which raises additional concerns about affordability. Consequently, insurers want pharmaceutical companies to demonstrate the value of their drugs before considering them for coverage. All stakeholders, including patients, would like to see drugs that are cost-effective. However, what's sometimes forgotten is that the only thing worse than an expensive drug is an inaccessible one.

For 30 years, the PMPRB, an independent federal organization, has sought to strike a balance between ensuring Canadian prices for patented medicines are not excessive while recognizing the importance of pharmaceutical innovation by allowing companies to recoup the immense cost of researching, developing and testing new life-saving and life-improving treatments. The PMPRB does this by comparing the price that a company proposes to charge for a new drug in Canada with prices in seven comparator countries (France, Germany, Italy, Sweden, Switzerland, the United Kingdom and the United States) and with the Canadian prices of similar, older drugs.

NEW ANALYSIS REQUIREMENTS WOULD EFFECTIVELY DUPLICATE CADTH SUBMISSIONS

Now, the federal government wants to require pharmaceutical companies to submit pharmacoeconomic (cost-effectiveness) analyses of their drugs in the health-care settings of Canada and other countries to the PMPRB to demonstrate the value of their products. Currently, companies submit these assessments, based on Canadian health-care data and prices, to the Canadian Agency for Drugs and Technologies in Health (CADTH) for recommendations regarding reimbursement in public drug insurance plans. While CADTH does not set prices, it frequently recommends price reductions to improve the cost-effectiveness of a drug. Importantly, CADTH's negative drug reimbursement recommendation rate is close to 50 per cent, which could have serious consequences for patient access.

So even if the PMPRB simply used the analysis submitted to CADTH, it would be inappropriate for it to set a price based solely on a cost-effectiveness analysis of the public insurance market because CADTH's analyses do not account for patient preferences (such as

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