Episode 4 Transcript – Judith Glennie

Michelle:
Who pays for treatments in Canada? How do they decide which ones to pay for? The answers to these questions aren't simple, but they are important for people living with cancer to know because patients can help in making those decisions. Our guest on this episode of My Time, My Voice is just the right person to help us make sense of this process and provide some tips on how to get involved.

Judy Glennie:
My name is Judy Glennie. I'm a clinical pharmacist by background and I've worked in a wide range of practice areas in patient care, primarily in the teaching hospital environment and some community pharmacy. And then ended up in teaching at universities and then eventually in government where I was primarily, as it relates to our topic today, responsible for all of the evidence, evaluation, and administration of the Ontario Public Drug Program.

Michelle:
So this is a very interesting niche that you have found yourself in through all of your hard work and all of your experience and I think it might be a bit of a complicated subject for some people, which is why we are very glad to have you on hand to walk our listeners through a little bit more about this subject. How would you explain to someone what it is that you do, imagine that you were at a dinner party and they asked you. How would you explain that?

Judy Glennie:
I guess the best way to explain it is that I help sometimes drug companies, sometimes patient groups understand how government bodies, government decision makers are going to make decisions as it relates to a specific new medication. So, which really means how the evidence will be evaluated, the scientific data from the clinical trials and how that drug is going to fit into the treatment of that particular disease.

Michelle:
So as a potential treatment makes its way from the lab to your local clinic or the hospital, Health Canada has to decide whether or not to authorize it for sale which is a huge step in this process. So why don't we start our conversation there? What does Health Canada evaluate, particularly when it comes to a new treatment?

Judy Glennie:
When Health Canada makes a decision to authorize a treatment for patients in Canada, it bases that decision on the safety of the treatment, and then it also bases the decision on the efficacy or how well the new treatment works. And then finally on the quality of the treatment, which really relates to how the drug is manufactured and all of the chemistry, et cetera behind it. So it's very much an evaluation of the clinical trials and then how the drug is made.

Michelle:
And just to add another layer to things, Health Canada decides whether or not a treatment can be sold in Canada but it's the so-called payers who actually pay for it. So when people in your world talk about payers, who exactly are they referring to?

Judy Glennie:
for the most part in Canada, we have two types of payers or two buckets of payers. We have private, what we call private payers, who have private drug plans that many people have as a result of their employment. So they get it as part of their benefits package. And then there are public payers, which are really the government drug programs, who provide funding for medications, sometimes only for elderly, over 65 elderly patients, or sometimes for special pockets of patients. Patients who have disabilities, those kinds of things.

Now, when it comes to oncology treatments, for instance, it's primarily the public payer who is funding those cancer therapies. And then there are some patients who do pay for their medications out of pocket that's not, by no means the majority, it's a small proportion. It's really is the primarily the private plans and then the public panel plans who pay for cancer treatments. And my expertise and my focus really is on the public drug plans.

Michelle:
Thank you for explaining that for us. Now, why don't we move back a step actually from there because there are important layers of decision-making between Health Canada authorizing a drug for sale and then the payers actually paying for them on the patient's behalf. What is the first step after Health Canada authorizes the treatment.

Judy Glennie:
In Canada, once a drug has been authorized by Health Canada, the manufacturer, if they want public funding, make a submission to one of the national, either the national health technology assessment body, which is called CADTH, that's the acronym, which stands for the Canadian Agency for Drugs and Technologies in Health. And then Quebec has its own HTA body, which is called INESSS, which stands for Les Institut national d'excellence en santé et en services sociaux. And both of these bodies pretty much fulfill the same purpose though, where they do health technology assessments or what we call HTAs to evaluate the evidence and then make a recommendation on whether the province should pay for the new treatment in question or not.

Judy Glennie interview:
Within that abroad HTA body CADTH, there are actually two streams. There's an oncology stream and then a non-oncology stream. So the oncology specific process or stream is called the Pan-Canadian Oncology Drug Review or pCODR. And that focuses purely on oncology medications and their evaluation. And they have specialists to look at the evidence submitted for those oncology drugs. And that's primarily because oncology drugs are very specialized and the treatment of different cancers is becoming more and more complex, and you really do need specialists looking at the data. So the expert review committee (known as pERC) then makes the recommendations for most of the provinces, except, apart from Quebec. Quebec does their own evaluation again, within INESSS.

Michelle:
When it comes to comittees like pERC, how did they make their recommendations and what are the HTA looking at specifically?

Judy Glennie:
First and foremost, they look at the clinical data. So that means the clinicals trials and how much additional benefit is there using the new drug compared to the existing therapies. They also look at the safety of that new medication, and then the impact on the quality of life of the patients, which is usually a measure that is captured, or at least should be captured in these clinical trials. The second component that pERC (or CADTH) looks at is the patient input process. And there is a very defined process that we can talk about a bit more, but a defined process for patients to articulate what they're looking for in a new cancer treatment.

Michelle:
So say I am a patient and you mentioned that there are ways that patients can get involved and give their input. How do we go about doing that?

Judy Glennie:
Well, I think first and foremost, joining a patient group, I think is probably one of the most effective ways.

Judy Glennie interview:
Patients both at in INESSS as well as at CADTH under the pCODR process have formalized patient input processes. And so what happens is that when a new drug submission is made to CADTH, CADTH turns around and puts out a call to patient groups relevant to the therapeutic area to provide input. And they really try to fundamentally ask

four questions or three or four questions, but really it's around what their experience is with treatments that are currently available for the disease in question, the good, the bad and the ugly.

Judy Glennie:
So, as I said, it's usually the patient groups that collate all of this input, sometimes through surveys or focus groups, and then they provide that information to the health technology assessment body. pERC takes that information and integrates it into its decision process and, and really compares it to the clinical data to see whether there's an alignment there.

Michelle:
So in your opinion, how much, I want to look for a different word than power but how much pull or how much input do the patients have individually or as a group and how much input do they have in this overall process and what's the importance of that input?

Judy Glennie:
These patient groups over the years have really developed a very high level of expertise in patient input submissions and they really know very well what kind of information is needed. So they have developed really good processes and systems to make sure that the patient voice is heard and heard effectively through the patient input at the HTA process.

Judy Glennie:
I think the other piece within these patient input activities, there certainly are a lot of individual patient stories that are collected as part of it, and they can be extremely impactful in the HTA process. So again, that's where individual patients sharing their story based on their experience and sharing that with the patient groups so that they can integrate it into that patient input submission, can be very powerful and really make that patient input submission very powerful at the expert committee table.

Judy Glennie:
And so I'm very happy that pCODR, when it launched, integrated this patient input process into its overall way of doing business, right from the beginning. And was really committed to ensuring that the patient voice was a strong and integral part of the process.

Judy Glennie:
There also is a clinician input process. And again, the clinicians who have firsthand experience sometimes with the drug, and obviously with the patients who may have this disease also have that opportunity for input. So both of those sources of input really provide a lot of important context around the real world experiences of patients in particular and the real world expectations of patients.

Michelle:
Okay. Thank you for clarifying that. And let's move on to the next step before the treatment gets to the payers. So what happens if the drug is recommended for funding?

Judy Glennie:
Well, assuming that pERC does make that recommendation to fund the new medication, the next step is the negotiation process. And that takes place within an organization called the pan-Canadian Pharmaceutical Alliance or pCPA. This world is chock-full of acronyms.

Judy Glennie:
And it is the job that organization represents all of the provincial payers. And they get engaged in a negotiation with the company to determine what the final price, the final criteria for use of the drug, what that will be. And then once the price is negotiated, the province, individual provinces sign a formal agreement that we call a listing agreement. And that really is just a contract between the manufacturer and the drug plan to fund the drug on the

formulary. And the formulary primarily it really is just a list of drugs that are paid for by a drug plan, that's all that really means.

Michelle:
Because, all of these things are different from province to province in Canada, does each province have its own formulary? And if so, do they list the same drugs or different drugs. How does that work?

Judy Glennie:
Each province does have its own drug plan and it does have its own formulary. And so there is no one formulary for all Canadians. It is province by province. The challenges — and it still exists; it's better than it was, but it still exists — is that there even once a drug has gone through this process of HTA and then price negotiations, not all drugs necessarily get listed or become available to Canadians all at the same time, province by province.

Michelle:
If you find out that a treatment that might help you is authorized by Health Canada but it's not reimbursed through the public drug plans and this is where it starts to get complicated. In your province, particularly what can you do? You're familiar with Ontario specifically. So let's talk about that as an example for starters.

Judy Glennie:
In Ontario, we have what we call the Exceptional Access Program or EAP, and it is intended for access to medications where a drug that's not necessarily on the formulary. And it's what we call a special authorization process, where a clinician makes a request to the Ministry of Health Drug Programs Branch Drug Programs Branch under the EAP to get funding for a specific patient. And that patient has to meet very specific criteria for the use of the drug. And so what happens is that the physician, or sometimes a nurse really submits a request, a written request, describing the patient's disease state and why the patient needs access to that medication

Michelle:
And do other provinces have similar types of programs as we do here in Ontario?

Judy Glennie:
I'm not an expert in every province, but it certainly really is a patchwork across different provinces.

Michelle:
I'm thankful that we have you here for your insight because I think when it comes for a lot of people, these regulatory processes might seem a little bit dry or over our heads. So it's helpful to get someone with your level of expertise to break all this down for us. When you're working in this world as a pharmacist as someone with that background, how often are you thinking about cancer patients as individuals, as people and how to help them?

Judy Glennie:
It is easy, to be honest, to get very mired down in the minutia of the clinical trial data, but at the end of the day, we, when we're looking at these data, do you have to ask the question, so what? So what difference does this make to the patient, to their quality of life, to their survival or whatever else the objectives are of the clinical trial and the introduction of a new medication. And frankly, that's what payers do too, to be honest with you. As a former payer, ultimately, that's the question we want to have answered is so what, how much better will patient outcomes be, if I fund this new drug? Both in terms of survival, quality of life, lower side effects, all those kinds of factors.

Judy Glennie:
It may surprise people to hear this, but what payers are looking for when they're looking at whether or not a new drug should be funded, or frankly not all that different from what a clinician and a patient are looking for.

Michelle:
And this all comes back to how important the patient input is really and the patients having a voice.

Michelle:
Dr. Glennie, thank you so much for being here today and speaking to us, I think you've given us a lot of insight into processes that might be a little bit mysterious for many of us and I feel like I know a lot more after chatting with you. So thank you so much for that.

Michelle outro:
And finally for our listeners, thank you so much for being with us today. We hope you'll come back for our conversation with Chad King, a cancer researcher who works in British Columbia. Best of health, until then.