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POLICY BRIEF

A National Public Drug Plan For All

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The purpose of this policy document is to argue the case for a national public drug plan for everyone. Such a plan would be similar to the protection that we now enjoy under Medicare, that is the right to see a doctor or go to the hospital without having to pay for those services. The situation is very different for prescription drugs, because many have to pay for their drugs, in whole or in part, and as a consequence some people cannot take the drugs prescribed by their doctors.

The following discussion will argue that a national public drug plan is necessary for three reasons: the lack of access to prescription drugs under current plans, the need to control the high price of drugs and the important question of drug safety. The last section discusses the critical role of the federal government in establishing a national public drug plan.

1. Access to prescription drugs

Prescription drugs are left out of our national public Medicare plan, so there are three groups of Canadians with different levels of coverage and non-coverage for drugs. A joint report from the provincial governments called "Pan Canadian Drugs Negotiations Report" points out the following levels of drug coverage.

Three Different Levels of Drug Coverage

1. **Public plans**
   "Altogether approximately 10 million Canadians are covered by publicly funded drug plans, nine million through the provincial plans and another million through the federal plans".[1] This means that approximately 29 percent of 35 million Canadians, less than a third, have access to public drug coverage.

2. **Private insurance plans, mainly work based**
   The report also says: "…the majority of the population (about 66 percent) obtained drug coverage through private insurers, either through their employers or purchased individually."[2]

3. **No drug coverage**
   "10 percent of Canadians lack basic drug coverage."[3] This means that 3.5 million people have no drug coverage.

The public drug plans that include approximately 29 percent of the population are a patchwork of different provincial, territorial and federal plans. In some provinces, only seniors, those on social assistance and people suffering from certain illnesses are covered, while in others people pay for drugs based on an income assessment. The federal government covers specific groups under its jurisdiction, including First Nations and Inuit, refugees, the military and veterans, the RCMP and federal prison inmates. It is important to bear in mind that those included in public drug plans are not necessarily receiving their drugs free of charge. Often part of the cost must still be paid by the individual which may create a barrier to obtaining prescription drugs.

Approximately two-thirds of the population rely on private insurance, provided primarily through a wide-ranging assortment of work-based plans. Thousands of plans provide different levels of coverage at each workplace, sometimes including spouses and children. Employers and

employees pay the cost of these plans in the form of premiums charged by insurance companies. Since benefit plans are part of negotiations in the work place, workers may also be paying for their drug coverage in the form of lower wages. Many plans also require that individuals pay part of the prescription cost at the pharmacy counter since they cover only 80 percent or 70 percent or 60 percent of the cost. A survey of work-based drug plans in Ontario found that just 38 percent of them covered 100 percent of the cost of drugs.[4] As well, private plans are in difficulty because the high and increasing price of drugs threatens their sustainability, so the trend is towards reducing benefits and requiring individuals to pay a larger portion of the costs.

The amounts paid by individuals can be very considerable, depending upon the cost of the drug. In other words, just because people have private drug insurance does not mean that they can access the drugs that they are prescribed. Also, since these plans are attached to the work place, they are not reliable. If you change jobs or get laid off, you no longer have coverage through the drug plan. In the case of retirement, only a minority of retirees continue to be covered by their work-based plans.

Access to prescription drugs through work-based private insurance plans varies widely. So, men are more often covered by private health insurance than women, unionized workers more often than non-unionized, residents of some provinces more than others, older workers more often than young people.[5] It all depends on where you work and the type of private drug plan available to you. None of this is related to medical need.

Many people simply have no drug coverage, either public or private. According to the report from the provinces quoted above, 10 percent of Canadians, that is 3.5 million people, have neither a public nor a private drug plan. For example, there are 2.8 million workers who are self-employed, fully 15 percent of the total employed work force.[6] These workers are not covered by work-based health benefits and, depending on where they live, many would not be eligible for provincial public drug coverage. People with low-income jobs are the worst off since they are the most likely not to have drug benefits as part of their jobs, but would often earn too much to be eligible for the public plans.

The end result is that 22 percent of all drug expenditures is paid by individuals out of their own pockets.[7] This includes those who have no drug coverage and also the co-pays required by both private and public plans. However, this figure does not include contributions to premiums for work-based coverage, nor the amount spent by those who buy individual insurance plans.

The problems with this patchwork of coverage and non-coverage are predictable and disturbing. In any one year 10 percent of Canadians are unable to obtain the drugs prescribed by their doctors because they cannot afford it, and this figure increases to 36 percent for those with no insurance and low incomes.[8] An Angus Reid poll conducted in 2015 found that the previous year almost one-quarter of Canadians (23 percent) "did not take medicines as prescribed because of cost", meaning that they either did not fill their prescriptions, cut the dosage or did not renew a prescription.[9] And so, there are the horror stories: the man with diabetes who needs to retire early but cannot because he would lose his work-based drug plan; the young woman with cancer trying to pay off a $26,000 debt for her drugs; the couple planning to sell their house in order to pay for their prescriptions.[10]

As André Picard, health reporter to the Globe and Mail, has pointed out: "The fact that a person with $20,000 out-of-hospital drug cancer treatment will pay nothing out-of-pocket in Nunavut, $3,000 in British Columbia and $20,000 in Prince Edward Island offends the principles of Medicare and Canadian values."[11]

A unified public drug plan would provide proper access to care for everyone. It must therefore be a federal initiative that provides a significant proportion of the costs to the provinces to ensure the same basic standard of service across the country. While the provinces have autonomy in health care spending, the federal government needs to establish priorities backed by funding in order to ensure that access is fair and equal for all. In other words, drug coverage should be provided on the same basis as the provision of doctors and hospitals under Medicare.

Such a national public drug plan is not a new idea. Indeed, Canada is both out-of-step and behind the times when compared with other comparable countries. Many European countries, as well as Australia and New Zealand, have implemented national public drug plans. Commonly, these plans provide drugs to a significant part of the population entirely free of charge, for example children, students, those on social assistance, seniors and people with chronic diseases. Others pay a small contribution for each prescription, often limited by both monthly and annual caps. Wales and Scotland have eliminated all individual contributions and provide drugs free of charge to their entire populations.

Many countries introduced national drug plans in the 1940s as part of their national health plans. Indeed, every country that has a national public health plan includes drugs as part of that plan, with the sole exception of Canada. A national public drug plan for Canada is not a bold new experiment. In many other comparable countries, three generations of citizens have already benefited from such a plan.

2. Cost control of prescription drugs

Our chaotic hodgepodge of public and private plans, with unsatisfactory health results and large contributions by individuals, is not cheaper than the public plans in other countries. It is in fact much, much more expensive.

Thanks to groundbreaking work by Marc-André Gagnon of Carleton University, we now have a clear idea of just how much we might save by introducing a properly regulated national public drug plan. The answer is a staggering 41 percent reduction in costs. In 2013, we paid $27.7 billion for prescription drugs and we could be paying just $16.3 billion for a universal public system with improved coverage for everyone.[12]

Why are Canadians paying more for less? How can it be that providing a national public drug plan for the whole population would be less expensive than our current partial arrangements? The most serious issue is inflated drug prices, followed by the cost of private drug plans, and high dispensing fees.

Inflated Drug Prices

In Canada, the most serious waste of money is in the high prices paid for drugs. This is a combination of setting high prices for new drugs and the lack of competitive pricing for drugs. We pay an additional $9.9 billion per year, because we do not have population-wide bargaining and competitive prices.[13]

When new drugs are approved for sale, the maximum introductory price of those drugs is set by a federal body called the Patented Medicine Prices Review Board (PMPRB). This board looks at the prices of drugs in other countries and takes the median price (i.e. the mid-point price) for the price in Canada. But the countries chosen for comparison are those with among the highest prices in the world, so the price here is set unnecessarily high.

This approach was developed on purpose as an industrial policy to increase pharmaceutical investment in research and development (R&D) and create jobs. However, this policy has been a complete failure. Over the years from 1998 to 2013, there has been a decline in R&D investment in relation to sales from 11.5 to 4.5 percent.[14] Indeed, the PMPRB itself has now admitted that this policy does not work.[15] As a result of this ineffective industrial policy, we pay an

unnecessarily high price for drugs under patent. This is costly because patented drugs account for 62 percent of total prescription drug sales.[16]

Brand name drugs come to the end of their patent price protection after 20 years, when the drug can be produced by other drug manufacturers and sold at cheaper prices, called generic drugs. However, this period of 20 years is commonly extended by several years as drug companies fight in the courts to prevent the introduction of cheaper generics. This process means that we often continue to pay the high prices set by the PMPRB for several more years.

Generic drug prices are also very high in Canada compared with other countries. In 2011 the price of 82 generic drugs was 54 percent higher in Canada than in the UK, Germany, France, Sweden, Italy and the United States.[17] The reason for this difference is the lack of negotiation over drug prices.

In countries with national public drug plans, prices are negotiated with the drug companies for both brand name and generic drugs, and they do this with the strength that comes from purchasing drugs for the whole population. Depending on the plan, they bargain the price for bulk purchasing, establish budgets, require companies to present competitive bids, consider bundling of more than one drug and so on. The results are impressive. Countries with national public drug plans have much lower prices than Canada and are more successful in restraining price increases.[18]

In the absence of a national drug plan, only 43 percent of all expenditure on drugs is government funded, but that amount is then divided between different federal, provincial and territorial drug plans, as well as hospitals and hospital groups, which all purchase drugs separately.[19] This situation means that the bargaining power of public sector drug purchases is severely limited.

Moreover, the majority of spending on drugs is by thousands of private insurance plans and by individuals, with no bargaining strength at all to negotiate lower prices. Private plans also have no incentive to negotiate lower prices, since it is workers and employers that pay for the drugs and not the insurance companies. Indeed, since the premiums charged by insurance companies for their services are often calculated as a percentage of the drug costs paid under the plans, there is even an incentive not to obtain lower drug prices.

Provincial public plans have made some attempts to control prices by negotiating confidential rebates from drug companies. This means that the official drug prices remain the same, but some provincial plans receive an undisclosed discount. Since the official prices remain unchanged, individuals and work-based plans continue to pay the higher prices. So, while some public provincial plans cut costs, these costs are actually shifted to individual patients, to private work-based plans and to smaller provinces unable to negotiate the same rebates.[20]

In 2010, the provincial and territorial premiers announced their intention to negotiate drug prices together, now called the pan-Canadian Pharmaceutical Alliance (p-CPA). The p-CPA website states: "As of March 31, 2015, these collaborative efforts between provinces and territories have resulted in 63 completed joint negotiations on brand name drugs and price reductions on 14 generic drugs. This has resulted in an estimated $490 million in combined savings annually."[21] While this seems like progress, it's a small amount compared to what we could be saving with a national plan for everyone. Also, only the public plans are involved, covering an estimated 29 percent of the population and again leaving individuals and work-based private plans continuing to pay the high and ever-rising official prices.

Hospital groups have also tried to negotiate lower drug prices, but the results have been limited and prices vary widely from one group to another. In 2015, the Quebec Auditor General examined the cost of medications for five different hospital groups. He declared himself shocked to find that there was generally a difference of more than 10 percent in prices paid for the same drugs. In the case of one drug, some hospitals were paying 9 times more than others. He also pointed out that some pharmaceutical companies simply refused to negotiate.[22]

Clearly, the fragmented nature of drug plans in Canada works against negotiating reduced prices with pharmaceutical companies. Moreover, negotiations by the provinces for the public plans have caused higher prices for the rest of the population, including the most vulnerable who have no drug coverage at all.

Pharmaceutical companies are private profit-making businesses, not a public service. Indeed, they are very successful businesses in that the profits they make are extraordinarily high. In the United States, drug company profits have steadily outpaced those of other companies for many years, although the gap has grown even larger since the mid-1980s. As of 2010, the profits of drug companies were three times higher than those of the Fortune 500 (the 500 American companies with the largest revenues).[23]

Until we start to discuss producing drugs for the public good with public non-profit drug manufacturers, the best option open to us is to expand our public plans to cover the whole population. A national public plan would then have the strength to negotiate reduced prices with the pharmaceutical companies, as so many other countries have already done.

Wasted Money in Private Plans

The private insurance plans that cover two-thirds of the population waste a great deal of money. As already noted above, they do not negotiate cheaper drug prices and by their very existence undermine attempts to do so by our partial public plans. They also entail additional costs compared to public plans.

Thousands of private plans cover millions of individuals in many different ways. Each plan has its own arrangements, restrictions and co-pays and every time an individual needs a prescription, it must be checked for coverage under that plan. Insurance companies must analyze the costs for each group of workers, make adjustments in the premium charges to employers and seek new customers. This vast amount of administration is expensive. And in addition to these costs, most insurance companies, unlike the public drug plans, are in business to make a profit.

A study by Michael Law looked at the administrative costs and profits of private for-profit insurance plans. He showed that these costs have rapidly increased in recent years and now stand at a remarkable 23 percent of total costs.[24] This means that close to a quarter of the money paid to for-profit private insurance drug plans is spent, not on prescription drugs, but on administration and profits. Law points out that this would be illegal in the US, where such charges are constrained to a maximum of 20 percent. Some insurance companies are non-profit and when these are included with the for-profit companies, the combined percentage of administrative costs for all private health plans stands at 16 percent. By comparison, the cost of administration for public drug plans is just 1.8 percent.[25] We are therefore paying an additional $1.3 billion for administration and profits that would be saved in a public plan.

Another issue related to work-based plans is that the federal government subsidizes these plans with reduced taxation. The employer's contribution to the drug plan is expressed as part of the employees' salaries and is tax free. This is an advantage to employers and an encouragement to provide drug coverage. It is also a regressive tax measure, because the more an employee earns and therefore the higher the marginal tax rate, the less tax they pay as a result of this policy. The cost to the federal government of this subsidy was $1.2 billion in 2009.[26]

High Dispensing Fees

The third reason for the high cost of drugs in Canada is the high price of dispensing fees paid to pharmacies. Pharmacies determine which generic drugs to stock and sell, so drug companies have provided rebates to pharmacies in return for stocking their products. This benefited the pharmacies but not the provinces, so the provinces tried to undermine this practice of rebates. Since the provinces set the price of generic drugs at a percentage of the brand price, they reduced the percentage. Between 2010 and 2012, Ontario dropped generic prices from 50 percent to 25 percent of the brand name drug price. Other provinces followed suit and in Alberta and Quebec generic prices were dropped to 18 percent of the brand price.[27] Given that 60 percent of prescriptions in Quebec are for generic drugs, it would be reasonable to expect an impressive drop in the overall cost of prescriptions. This did not happen and in some cases the average price of a prescription actually increased. Why? The answer is cost-shifting.

Pharmacies recouped the loss from the lower priced generics by increasing the dispensing fees for drugs covered by private insurance. For example, in Quebec between 2010 and 2012, the average cost for a public plan prescription decreased by 5.5 percent, but the cost for prescriptions covered by private plans increased by 6.4 percent. A survey of pharmacies in Quebec showed that for a sample of brand name and generic drugs, public plans paid an average dispensing fee of $8.44 per prescription, while private plans paid $25.76, more than three times the cost.[28] In some cases the dispensing fee costs more than the drug. In the western provinces and territories, dispensing fees increased by 5.5 percent in one year. Again, private plans are an easy target with no controls over prices.

Under a single national public drug plan, there could be no cost shifting between public and private plans. With more standard coverage and therefore faster dispensing processes, Gagnon concludes that we would save 2 percent of total costs.

The Results

Expenditure on drugs in Canada is out of control. We pay pharmaceutical companies inflated prices, our fragmented plans prevent us from negotiating prices effectively, and the financial burden is being shifted from public plans to individuals and to private work-based plans. As spending continues to increase, bargaining in the work place for drug benefits becomes harder, co-payments for individuals get higher and benefits get smaller. One way to cope has been the

introduction of "flexible plans", where each worker must choose between different levels of coverage and pay accordingly, essentially guessing what their drug needs might be.

In all this, there is cause to wonder at a situation in which employers, workers and unions are haggling over appropriate drug coverage for two-thirds of the population, rather than medical professionals and public policy experts.

With a national public drug plan covering the whole population for all their drug costs, Gagnon has estimated total savings of $11.4 billion, that is 41 percent of the current expenditure of $27.7 billion.[29] Moreover, this reduced amount includes a 10 percent increase in the use of prescription drugs to allow for providing drugs to those who are currently unable to afford their prescriptions.

3. **Drug safety**

We are caught in a situation in which drugs are a crucial element in health care and a life-saving necessity for many people, while at the same time there are serious concerns about the safety of prescription drugs. Research has shown that the pervasive influence of pharmaceutical companies in the research, approval and prescribing of drugs leads to both the overuse and misuse of drugs. Note that this reflects back upon the high cost of providing prescription drugs. If we are overusing and misusing drugs then we are paying for unnecessary drugs, increasing costs with no health improvement or even health impairment.

Health Canada reviews the efficacy and safety of new drugs and approves their sale and use. This process is not independent of the pharmaceutical companies. Starting in 1994, a new "cost-recovery" approach meant that drug companies began paying fees for the approval process. Pharmaceutical companies now pay half the costs of the agency that approves their drugs.[30] Clearly, this is not an independent process. The Canadian Medical Association Journal has stated that Health Canada is biased towards approving drugs too quickly and without adequate proof of safety.[31]

Research trials for new drugs financed by pharmaceutical companies have been found to be biased in favour of the product that the company makes.[32] The research required of drug companies for the approval process is not made available either to the public or to medical

professionals and researchers. This secrecy means that further analysis of the safety of drugs put on the market is difficult, and medical professionals are denied the opportunity to make their own assessment of the relative effectiveness and safety of drugs.

The threshold for drug approval is low. A drug does not have to be better than an existing drug to be approved, but only better than a placebo. Health Canada therefore approves new brand name drugs that are more expensive than existing drugs but provide no additional therapeutic value, or even less therapeutic value than drugs already on the market. Less is known about the safety of these "me-too" drugs because they have only been subject to clinical trials in controlled environments, while existing drugs have been used in the real world on a wide population with the opportunity to identify any problems. At least 85 percent of the drugs approved by Health Canada are these me-too drugs, more expensive and of questionable therapeutic advantage.[33]

We need a national formulary (the list of approved drugs) that would consider cost effectiveness. This means not just comparing a new drug to a placebo, but considering whether it is any real improvement over existing drugs that are less expensive because they are no longer under patent. This is often also a safer choice, because existing drugs have been used in the population generally and there has been time to consider any adverse drug reactions. Paying high prices just because a drug is new is not only costly, but also often a less safe approach.

Once on the market, drug companies sell their drugs by influencing doctors to prescribe them. It is estimated that drug companies spend $60,000 per doctor per year on drug promotion.[34] This means that sales representatives visit doctors' offices, providing wall charts and free samples, plus paying for doctors to attend conferences and give papers. It also means advertising drugs in medical journals and to the public at large. Nothing about this process is objective. Indeed, studies have found that sales representatives fail to provide information to doctors about the negative side effects of drugs[35] and that doctors are indeed influenced by this sales process in what they prescribe.[36]

We have every reason to be worried about the influence of drug companies. In 2011, GlaxoSmithKline paid $3 billion in the US to settle criminal and civil proceedings. The company pleaded guilty to promoting drugs for unapproved uses, failing to disclose safety issues and "providing doctors with European hunting trips, high-paid speaking tours and even tickets to a Madonna concert".[37] The company is now facing new allegations in China that doctors are

being bribed to prescribe drugs. Glaxo is not alone. Over the last 10 years, all the large drug companies have pleaded guilty to a range of illegal activities. For example:

- Pfizer paid $2 billion in 2009 for illegally promoting four drugs, as well as paying bribes and providing "lavish hospitality" to health care providers to encourage them to prescribe their drugs.
- Novartis paid $423 million in 2010 for illegally marketing drugs and paying kickbacks to healthcare professionals to encourage them to prescribe their drugs.
- Sanofi-Aventis paid $95 million in 2009 for defrauding public health agencies by overcharging for medications.
- AstraZeneca paid $520 million in 2010 for illegally marketing an anti-psychotic drug to children, the elderly and veterans, uses not approved by the US Food and Drug Administration.
- Johnson & Johnson was fined $1.1 billion in 2012 for downplaying the potentially life-threatening side-effects for children and the elderly of a drug called Risperdal.
- Eli Lilly paid $1.4 billion in 2009 for illegally marketing its top-selling anti-psychotic drug, Zyprexa, for unapproved uses for the elderly and children including Alzheimer's, dementia and depression.[38]

There are many more such cases. To summarize, pharmaceutical companies are regularly and repeatedly in the American courts for misleading statements about negative and sometimes life-threatening side-effects, failing to disclose safety data, making false statements about drug safety, promoting and selling drugs for illnesses and for patients that they have not been approved for, providing financial incentives to doctors and hospitals to induce them to prescribe drugs, and defrauding public drug programs.

To improve this situation we must take back control of drug approval and information from the pharmaceutical industry, because there are clear contradictions between the goals of public health and those of private drug companies. The first concerns itself with the welfare of patients, while the goal of pharmaceutical companies is to increase their profits.

We need an independent and transparent assessment of drugs and a national formulary that covers necessary and effective drugs at the best prices available. We need to provide independent information and education for doctors based on research rather than sales quotas.

A national plan would also make possible a Canada-wide database on drugs so that adverse effects could be tracked and reported to doctors. There could be other advantages. For example, in Australia, there is a program called NPS MedicineWise that focuses on improving prescribing by doctors and the use of medicines by consumers. It is government funded, but independently run, and provides information to both doctors and the public. A research study has now shown that this program has improved the health of patients with cardiovascular disease.[39]

The question of drug safety is clearly linked to the issue of drug expenditures. Because we are consuming drugs unnecessarily and because we are consuming high-priced drugs when much less expensive and often safer drugs are available, we are overspending on prescription drugs. This is in addition to the unnecessary costs outlined above. If we were to improve the independence and therefore the safety of drug research, approval and information, we would not only be providing better health care, but also saving the cost of unnecessary and damaging drugs.

4. Moving to a national public drug plan

The role of the federal government is critical in any initiative towards providing everyone with access to necessary prescription drugs. As with services from hospitals and doctors, the provinces and territories cannot ensure standards for everyone across the country. Provincial and territorial variations in wealth, population and geography make it far more difficult to provide services in some parts of the country than in others. In order to ensure equal services for all, federal financial support is essential. It is also important to establish national standards for services, so that everyone receives equal treatment regardless of where they live.

In the case of prescription drugs, a national program is also necessary in order to reduce prescription drug prices. Negotiations on drug prices need to be at the national level for the whole population in order to wield effective bargaining power. National negotiations for a public plan covering all drugs is also the only way to prevent pharmaceutical companies from shifting costs from one plan or group to another.

The federal government provides significant financial support to the provinces for the cost of health care services from hospitals and doctors. In 2014-15, this cash transfer amounted to $32.1

billion.[40] The various provincial public plans for prescription drugs receive no federal financial support.

The Canadian Health Coalition (CHC) proposes that a national public drug plan be financed by the federal government at a minimum of 25 percent of total costs. As pointed out above, Gagnon estimates that the cost of a national public drug plan would be $16.3 billion, based on 2012-13 figures. A federal contribution of 25 percent would therefore entail an expenditure of approximately $4 billion.

Given current federal government responsibilities for drugs, this amount is not entirely or even primarily, an additional expenditure. This requires further explanation. The federal government currently spends money on prescription drugs in four ways:

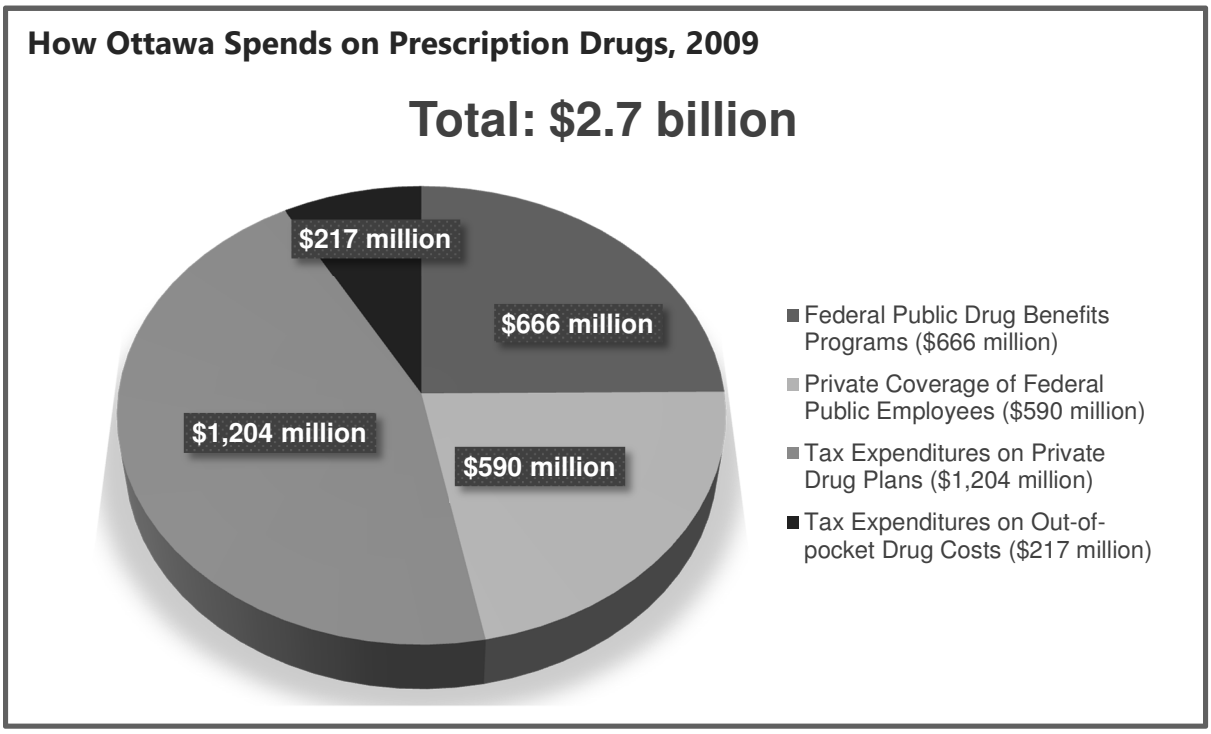
1. The federal government is directly responsible for providing prescription drugs to approximately one million Canadians: First Nations and Inuit, inmates of federal prisons, refugees, members of the military, the RCMP and veterans.

2. As an employer, the federal government provides a health benefits plan called the Public Service Health Care Plan (PSHCP), which includes drug coverage for federal government employees and retirees. Including spouses and children, the plan covers 1.4 million people and is the largest private work-based health plan in the country.[41]

3. Through taxation the federal government provides two types of tax reductions. First, as mentioned above, private work based plans that cover employees for dental and health benefits are considered as non-taxable income for employees.

4. The second type of federal tax reduction is that individuals may claim the Medical Expenses Tax Credit for out-of-pocket medical expenses, including prescription drugs.

For 2009, Gagnon estimated that the total of these expenditures for drugs was $2.7 billion[42], as shown below:



The information to update this figure is not available, but spending on drugs has certainly escalated since 2009. As well, the 2009 figure for the number of employees and retirees covered by the federal drug plan was 603,572. In 2015 this number was expressed in rounded figures as "over 630,000 members".[43] In the absence of more detailed information, it seems reasonable to estimate the federal government's contribution to the current mix of drug plans and tax exemptions as between $2.7 and $3 billion.

Gagnon found that the cost of a national public drug plan to cover the whole population without co-pays was $16.3 billion for 2013. If the federal government were to finance 25 percent of that cost, that contribution would be approximately $4 billion. However, the federal government already spends approximately three-quarters of that amount on drugs, namely between $2.7 to $3 billion. The additional federal funding required would be in the range of $1 billion to $1.3 billion.

In Prime Minister Trudeau's mandate to the new Health Minister in November 2015, he lists "improve access to necessary prescription medications" as one of ten priorities. He elaborates on this point, stating: "This will include joining with provincial and territorial governments to buy drugs in bulk, reducing the cost Canadian governments pay for these drugs, making them more affordable for Canadians, and exploring the need for a national formulary."[44] It is very

encouraging to see the question of prescription drugs raised at the federal level and we appreciate the intention to look more closely at the issue.

However, joint action to reduce only "the cost Canadian governments pay" is likely to be counter-productive. This suggests that it is only public plans covering just 29 percent of the population that would benefit from negotiations to reduce drug costs. The issue here is that drug companies can and do shift the cost of drugs from one part of our patchwork to another, as has already been demonstrated. If governments negotiate price reductions in their limited public plans, there is nothing to prevent pharmaceutical companies from raising prices for private plans and individuals. As pointed out above, these two groups involve the large majority of the population. It means that the cost of private work-based plans would rise, resulting in further reductions in benefit coverage and throwing higher payments onto individuals. Such a strategy will also mean moving costs onto those with the least protection of all, the 3.5 million people with no drug plan who must pay whatever they are asked at the pharmacy counter.

The CHC calls upon the federal government to initiate discussions with the provinces with the goal of establishing a national public drug plan. Given that the federal government is already spending an estimated $2.7 to $3 billion per year for the current inefficient, costly and partial provision of drugs, this amount could be redirected to support the cost of a national public plan.

The federal government also has important responsibilities in the following areas, which would both increase safety and control drug expenditures:

- ensure that research into new drugs is transparent and open to independent analysis;
- tighten the drug approval process at Health Canada so that it is independent of pharmaceutical companies;
- review and improve the work of the PMPRB which sets the prices of new brand name drugs artificially high;
- establish a national formulary based on therapeutic advantage rather than allowing expensive me-too drugs onto the market;
- review the process that allows the drug companies to extend their patents beyond the 20 year limit;

- ❖ review the national database of adverse drug reactions and improve the collection of information, so that doctors and medical researchers have access to adequate data on the negative effects of drugs.

We know that a national public drug plan would be enormously popular. A 2015 poll by the Angus Reid Institute found that a striking 91 percent of Canadians supported such a plan.[45] These proposals would also bring Canada into the 21st century and align our public health plan with other comparable countries. The federal government would complete the public provision of health care envisioned by Tommy Douglas and ensure safe and effective drug coverage for everyone.

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