Canadian Health Coalition / Coalition canadienne de la santé

MYTHBUSTER

A National Public Drug Plan

There is a growing movement in Canada to finish some of the left-over business of ensuring everyone has public health care coverage from cradle to grave. The first step is to ensure everyone can afford their prescription medication through the creation of a comprehensive National Public Drug Plan (NPDP).

In Canada, one in ten people can't afford to adhere to their prescription medications and 10 per cent have no public or private drug insurance. In a study comparing eleven developed countries, Canada has the second highest rate of people reporting that they cannot afford to take their medications as prescribed.1 Canadians are resorting to skipping pills, sharing medication or going to emergency rooms to access medicine for which they already have a prescription. In this mythbuster we examine common myths about a NPDP.

1. CANADA CAN'T AFFORD A NATIONAL PUBLIC DRUG PLAN

In fact, Canada can't afford to not have a NPDP. We pay the second highest price for brand name pharmaceutical medicines in the world and the highest price for generic medicines. The federal government, provinces, territories, and hospitals all negotiate separately with pharmaceutical companies for the price of medicines. This ignores even the most basic understandings of economics of scale by saving costs. Bulk purchasing and combined purchasing power allows for the negotiation of better prices from pharmaceutical and generic manufacturers.

The increase in drug prices often outpaces all other health care spending. In 2014, forty-three per cent ($12.5 billion) of prescription drug spending was paid by the public sector, an increase of 9.2% from the year before. This means more and more tax dollars are being spent every year on prescription medication and not on other needed social services.2

Payments for medication made through private insurers totaled $10.4 billion in 2014. Most private insurance is provided by employers. This leaves workers with lower wages and the constraints on negotiating other benefits. Twenty-two per cent ($6.5 billion) of prescription medication costs were paid directly out-of-pocket that year.3

If Canada had a single purchaser for medications who shared the cost with provinces, territories, employers, and tax payers, collectively we would save $11.5 billion a year and we could provide medicines to everyone.

2. NEW MEDICINE IS BETTER MEDICINE

Current research shows that only about 1 out of every 10 drugs marketed offer therapeutic advantage over medicines currently on the market.4 Pharmaceutical companies can charge high prices for all new medicines with no market competition for the length of their 20-year patent. This provides a strong incentive for companies to develop drugs that are very similar to ones already on the market and find a new use for them. A small change to the ingredients in a drug or its use results in a new 20-year patent.

New medicines do not need to be an improvement on those already on the market, they just need to be better than a placebo. New medicine is often not better than medicine already available, it just costs more money.

3. I WOULD NOT BENEFIT FROM SUCH A PLAN AS MY MEDICINE IS ALREADY COVERED FOR FREE BY MY EMPLOYER

Work based drug plans in Canada cover 60% of Canadians.5 Few of these plans cover 100% of the costs, most have deductibles and co-pays, often with maximum payout limits. Those are the costs workers see. What is not transparent is the increases to salaries and other benefits that workers miss out on because of the rapidly rising costs of drug benefit plans.

With a NPDP people will also have more freedom to change jobs without worrying about losing drug benefits for them and their family. When workers get laid off, couples separate, or people retire, they won't have to worry about losing access to needed medicines.

ACKNOWLEDGEMENT

This document was supported by a grant from the Ken and Debbie Rubin Public Advocacy Fund. It summarizes the presentations made at the Canadian Health Coalition's policy conference A Prescription for Equity: A National Public Drug Plan, held in Ottawa in April 2017.

4. A PUBLIC PLAN WILL DENY PEOPLE ACCESS TO IMPORTANT NEW DRUGS

Between 1990 and 2009, 4-5% of new drugs in four different five- year periods (1990-94, 1995-99, 2000-04, 2005-09) were pulled off the shelf after being approved by Health Canada.6 As we mentioned in myth #2 new drugs are often not better than medicines already available. Prescribers in Canada are often unable to access complete information on new drugs because Health Canada deems the information proprietary. In order to assess which medications have significant therapeutic benefits and are safe for patients, prescribers need more information.

A group of prescribers and patients should be established to review new medications and using evidence decide if those medicines should be recommended to Health Canada for inclusion on a national formulary.

A NPDP will not deny people access to new medication, but it will make sure people have access to safe medication.

5. IF WE DON'T PAY THE HIGHEST PRICES, WE MIGHT NOT HAVE ACCESS TO MEDICINES WHEN THERE ARE SHORTAGES

A NPDP can help prevent prescription drug shortages in Canada. Countries with a NPDP like New Zealand have built clauses into their contracts with pharmaceutical companies that ensure they receive priority access to medications when shortages occur. Canada currently has no arrangement for priority access.

6. WE SHOULD MODEL A NATIONAL PUBLIC DRUG PLAN AFTER QUEBEC'S PROVINCIAL PLAN AND INCLUDE PRIVATE INSURANCE

Quebec's pharmacare system relies on private insurance plans. These plans often have high deductibles, co-pays, caps on remittances, and they only want healthy subscribers lowering their odds of having very expensive plan members. Those with pre-existing conditions have challenges getting private coverage, and if they can get insured, it is often at unaffordable rates.

Despite having mandatory prescription insurance, 12 per cent of Quebecois cannot afford to take their medications as prescribed.7 A NPDP needs to be modeled like access to hospitals and doctors in Canada — everyone has access to the medicine they need with no private fees.

7. IF WE PAY DRUG COMPANIES LESS MONEY, WE'LL LOSE RESEARCH AND DEVELOPMENT (R&D) JOBS IN CANADA

This has long been argued by pharmaceutical companies. In 1987, Canada struck a deal with pharmaceutical companies that we would increase the length of patent exclusivity to 10-years. In exchange, pharmaceutical companies had to increase their investment in Canadian R&D from 5-10% of their profits. In 1993, Canada again extended patents, this time to 20 years.8 But since 1987, pharmaceutical expenditure on R&D in Canada has actually fallen. In 2014, R&D investments from pharmaceutical profits hit an all-time low of 4.3%. They rose by just 0.1% in 2015.9 Longer patents have not meant increased R&D expenditure in Canada.

The United Kingdom has a universal pharmacare program. They also have two global pharmaceutical companies who invest at least 4 billion pounds in R&D in the UK every year.10 In fact, in 2016, GlaxoSmithKline and AstraZeneca invested 7.5 billion pounds in R&D which accounted for 45 per cent of all corporate R&D in the UK that year.11

8. WITH CATASTROPHIC COVERAGE IN EVERY PROVINCE AND TERRITORY, EVERYONE IS COVERED IF THEY NEED IT

While all provinces and territories offer catastrophic drug programs, coverage varies widely across the country with differences in premiums, co-payments, and deductibles. This leads to large inequality across Canada with different accessibility and affordability depending on where you live, and still leaves many people unable to afford their medication.

9. MAKING PEOPLE PAY A SMALL FEE WOULD HELP FUND SUCH A PLAN AND DISCOURAGE OVERUSE

A co-payment of just $2 has been found to deter people from accessing needed medication.12 Northern Ireland, Scotland, and Wales have pharmacare programs with no co-pays or deductibles. Ensuring everyone can access the medication they need requires removing as many financial barriers as possible.

10. WE CAN JUST CHANGE OUR COMPARATOR COUNTRIES TO SAVE MONEY, WE DON'T NEED A UNIVERSAL PLAN

Canada looks to the highest paying comparator countries (like the US and Germany) when setting our own prices for medicines. Using cheaper comparator countries would lower the price of medicines in Canada by about $4.5 billion. But this is a far cry from a universal system which makes medicine accessible to all. The implementation of a full NPDP could result in nearly triple those savings while ensuring everyone has the medication they need.

11. ACCESS TO MEDICINE IS A PRIVILEGE

The World Health Organization declared access to medicine a human right in 2000.13

12. FREE DRUGS WILL LEAD TO AN OVERMEDICATED POPULATION

A similar argument was made in Canada when public health care was first introduced: if physician and hospital care is free, everyone will use it all the time. For the vast majority of the population, going to the doctor or the hospital is not something they look forward to. We trust prescribers to be the gatekeepers of the health care system and ensure those who need it have access. We need to do the same with prescription medication and expect prescribers to prescribe responsibly.

More than anecdotal, studies of systems that have eliminated financial barriers to prescription medication have shown little increase in use. As of 2007, Wales eliminated all copayments for medication. Since then Wales has experienced a minimal increase in drug prescription and researchers say this increase may not be a direct result of the abolition of copayments.14

If a NPDP were implemented correctly Canada could experience a decrease in prescriptions. Currently populations like senior population are over prescribed.15 Giving prescribers better information and using evidence to inform drug use can decrease inappropriate prescribing. An example of more knowledge leading to fewer prescriptions can be found with the BC Therapeutics Initiative.16

13. PROVINCES AND TERRITORIES CAN DO IT TOGETHER, THE FEDERAL GOVERNMENT DOESN'T HAVE A ROLE

The provinces and territories are working together now on creating a common drug formulary and bulk purchasing some drugs. But to make the extensive changes that are needed, to bring in new drug safety measures and to apply the principles and criteria of the Canada Health Act in ensuring everyone has equal access, the provinces and territories need federal leadership. The federal government is also a major purchaser of prescription medication in Canada covering medicine for first nations, RCMP, federal inmates, military and veterans, and refugees. To capitalise on our economies of scale, all provincial, territorial and federal governments should be involved.

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LEXICON

Catastrophic drug programs
Government insurance models that protect individuals from drug expenses that threaten their financial security or cause "undue financial hardship." Each province/territory sets their own threshold.

Co-pay
A common feature of many health insurance plans where the insured pays out-of-pocket amount for medicine or health care services, usually around 20% of the cost of medicine.

Common drug formulary
A list of commonly prescribed and available medications.

Deductible
The amount of money an individual pays for expenses before their insurance plan starts to pay.

Payout limit
The insurance company often sets a maximum amount it will refund over a one year period.

Pharmacare
Term used to describe universal coverage of prescription drugs in Canada.

Placebo
A substance that has no therapeutic effect, used as a control in testing new drugs.

ABOUT THE CANADIAN HEALTH COALITION

Since 1979, the Canadian Health Coalition advocates for the preservation and improvement of universal public health care across Canada. We're a coalition of national organizations representing nurses, health care workers, seniors, churches, social justice organizations, women, and trade unions, as well as affiliated coalitions in 9 provinces and 1 territory.

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