SUBMISSION TO THE ADVISORY COUNCIL ON THE IMPLEMENTATION OF NATIONAL PHARMACARE

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The Canadian Health Coalition (CHC) was formed in 1979 with the goal of protecting and extending public health care in order to improve the well-being of the population. For nearly 40 years the CHC has advocated for a national public drug plan as a necessary addition to hospitals and doctors.

The CHC is a public advocacy organization dedicated to the preservation and improvement of public health care. Our membership is comprised of national organizations representing nurses, health care workers, seniors, churches, anti-poverty groups, students and trade unions, as well as researchers and affiliated coalitions in 10 provinces and one territory.

Neither the CHC itself, nor any of our affiliated organizations, receive financial or other support from companies that sell drugs, provide insurance for drugs or dispense drugs. The opinions of the CHC are independent of any influence due to financial self-interest.

Who should be covered?

All residents of Canada should be covered by a national public drug plan and this coverage should be portable from one part of the country to another. There should be no co-pays or deductibles, since even at modest levels they have been shown to prevent patients from receiving the medication they need. We do not require co-pays for visits to the doctor or treatment at a hospital. It has long been a central tenet of our health care system that good health should not be based on a person's ability to pay. This principle should also be applied to prescription medications.

We recognize the need for discussions with indigenous and first nations populations in order to ensure their full coverage under a national drug plan.

What drugs should be covered?

The drug formulary should be comprehensive, meaning it should cover the drugs necessary for a healthy population. Drugs should be reviewed for inclusion on the formulary by an independent body of medical experts and researchers with no connection to the interests of pharmaceutical companies. All drugs on the formulary should be safe and effective. **While this may seem self-evident, it has not been the case to date. Drugs which have been proved to be dangerous (such as Vioxx) or ineffective (such as Diclectin), have been approved in the past under pressure and influence from drug companies and in the absence of independent review.**

It is important that this review process be transparent and doctors and medical researchers have access to the research information necessary to adequately assess drugs. Likewise, the preparation of guidelines for doctors concerning their central role in prescribing drugs must also be free of influence from drug companies. There should be an effective and adequately resourced national database for drug reactions, so that any unexpected adverse reactions can be tracked and remedial action taken.

The best approach would be an independent federal-level body that would be responsible for assessing drugs, placing them on the formulary and reviewing their safety and effectiveness over time. A Canadian model for independent drug review would be the Therapeutics Initiative at the University of British Columbia, and there are many international examples from countries that have decades of experience with formularies for national drug plans.

These measures would assist doctors in improving their prescribing practices.

How should the drug plan be financed?

We are currently burdened with a vast patchwork of 100 public and over 100,000 private drug plans.[1] This system of drug coverage is rife with excessively high drug prices, unnecessary administration costs, and overprescribing. It is inefficient and needlessly costly.

By contrast, universal public drug coverage will lead to much lower drug costs by consolidating bargaining power at the national level and reducing the excessively high administration costs charged by insurance companies and benefit consultants.

The greatest beneficiaries would be employers and households. Had a public drug plan been in effect in 2015-2016, the savings for employers would have been a remarkable **$9 billion in that year alone**[2], according to the Parliamentary Budget Office (PBO). The elimination of the burden of this pointless overhead would enhance the competitiveness of Canadian business by lowering its costs. Like any other reduced cost, this would be an incentive to business growth and increased employment. The automobile industry has pointed out the value of public health care covering doctors and hospitals to their Canadian facilities; this effect will be further enhanced by the addition of pharmacare.

But the burden is not only financial. A public plan would also allow businesses to get on with running their firms rather than dealing with the drug needs of employees and managing their drug plans.

An officer of a very large company once informed us that she supported a public plan because, rather than deal with pressing business issues, she often had to deal with employees who were unhappy with the company's drug plan. She had no knowledge in the area, whereas a public plan would have specialists who could determine which drugs to cover based on the evidence and who, we would add, should be free of financial or other conflicts.

In 2015-2016 savings for households would have been **$7.1 billion in just that year**, when premiums are included.[3] Instead of wasting money on overpriced medications and administration, people could have used it to invest in themselves, their small businesses, to improve their material standard of living, or pay down their debts. On this last point we draw the Council's attention to the concerns expressed by the Bank of Canada about excessive household debt, something pharmacare could help reduce.[4]

As noted above there should be no co-pays of any kind as they increase non-adherence to medications due to cost. They also add a needless layer of complexity to a system that should be simple and straightforward. In addition, they raise insignificant sums of money once the administrative costs are taken into account.

The CHC supports public funding for a national drug plan shared by the federal, provincial and territorial governments. Leadership by the federal government will be critical. It must pay a significant share of the cost of the program to induce the provinces to participate and to follow national standards.

How much then should the federal government pay? When Medicare began 50 years ago the federal government covered one half the cost of doctors and hospitals.[5,6] Accordingly, the federal government should fund at least fifty percent of the new pharmacare program. The provinces should fund the rest.

Regarding the magnitude of the additional spending required by the federal government, let us consider the experience of single payer Pharmacare plans in Europe as well as the estimate made by the PBO last year. According to OECD numbers, on a per capita basis for 2015, Norway spent about one half what we did, Sweden and the U.K. one third less and Australia about 20 percent less.[7] Accordingly we can reasonably expect a decrease in cost for Canada somewhere in the range of 20 to 50 percent.

Last year the PBO estimated the savings resulting from of a universal pharmacare plan for Canada in the 2015-16 fiscal year based on the Quebec public formulary. An overall decrease in cost of 17 percent was calculated. It was based on an estimated cost of pharmacare of $20.4 billion versus the cost for the same coverage without pharmacare of $24.6 billion[8]. Cautious assumptions were made. The most critical was that drug prices would decrease by 25 percent under Pharmacare. However months after the report was released much larger price decreases for generic drugs were negotiated by the provinces for their public plans. In addition, savings are also likely for patented drugs, due to the expected revision of Patented Medicine Prices Review Board (PMPRB) regulations[9,10].

Under Pharmacare, negotiations with the pharmaceutical drug industry would be for the entire Canadian market and would build on these recent price reductions. Lower prices would continue to be achieved as negotiators for Pharmacare introduce competitive bidding and use the inducement of including drugs under universal public coverage to their advantage. Furthermore, it is likely that dispensing fees and mark-ups charged by pharmacies which amounted to 36 percent of total drug costs under pharmacare[11] would also be lower. In Quebec dispensing fees under the public plan are considerably less than those charged under private insurance.

These considerations make it clear to us that the PBO estimate for savings from Pharmacare was overly cautious. We expect Canada to attain savings similar to the 33 percent achieved under European single payer Pharmacare. Under that scenario the total cost for Pharmacare would have amounted to $16.4 billion (0.66 x $24.6 billion) in 2015-16.

Accordingly, if the federal government covered 50 percent of total pharmacare costs it would have spent $8.2 billion (one half of $16.4 billion).

Given the federal government already spent $2.3 billion on drug related matters (including tax credits and direct spending on First Nations peoples, RCMP, etc.[12]) net new funding would have been even less at $5.9 billion (i.e. $8.2 billion minus $2.3 billion). These figures for 2015-16 would probably need to be adjusted somewhat higher for 2019-20.

This modest additional spending by the federal government will be money very well spent when it is compared to the estimated yearly savings by employers and households noted above of $9 billion[13] and $7.1 billion respectively[14].

The federal government should pay for pharmacare only through its general spending. An increase in the GST should not be considered as it is unfair, especially to people with low incomes. It is also unpopular. It would be a serious mistake to associate a positive new program with a negative and

unfair tax increase. Neither should there be a payroll or targeted tax applied to workers or employers. Such taxes amount to a tax on jobs and hinder job creation by increasing their cost to employers. The advantage of lower overhead for employers would be negated if a pharmacare payroll tax were implemented.

If money does need to be raised to cover the cost of pharmacare it should come only from a small increase in personal and corporate income taxes. These are the fairest sources of taxation.

Public health care should be thought of as part of Canada's social infrastructure much as roads, bridges, ports and railways are part of our physical infrastructure. Efficient and fair drug coverage will add to our country's overall productivity and competitiveness. It will lead to a healthier population, less time away from work, and reduce the burden on the health system caused by at least 100,000 needless admissions to hospital every year that result from non-adherence to required medication due to cost.[15]

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[1] Government of Canada, *Towards the Implementation of National Pharmacare*, June 2018, p.4.
[2] Parliamentary Budget Office (PBO), *Federal Cost of a National Pharmacare Program,* p.1.
[3] PBO, p. 19.
[4] Stephen S. Poloz, Governor, Bank of Canada, *Canada's Economy and Household Debt: How Big Is the Problem?,* May 1, 2018.
[5] PBO, p.26. Author's note: other expenses include long term care, public health, capital expenditures, etc.
[6]Hugh Mackenzie, *The Canada Health Transfer Disconnect: An Aging Population, Rising Health Care Costs and a Shrinking Federal Role in Funding,* Canadian Federation of Nurses Unions, 2015, pp.2-4.
The commitment by the federal government referred to doctors and hospitals. The federal share of overall provincial health spending was 37% in the 1970s; in 1977 tax points were transferred to the provinces lowering the cash transfer to 25%, which then declined to 10% by 1998, then slowly rose to 23% by 2015.
[7] OECD (2017), Health at a Glance 2017: OECD Indicators, figure 10.2, p.187, and calculations by the author.
[8] Office of the Parliamentary Budget Officer (PBO)*, Federal Cost of a National Pharmacare Program*, Sept 2017, p.2.
[9] Government of Canada, p.5.
[10] Geoffrey Mowat, DLA Piper Insights*, Drug pricing in Canada: Changes for the PMPRB with proposed amendments to the Patented Medicines Regulation,* December 19, 2017.
https://www.dlapiper.com/en/canada/insights/publications/2017/12/changes-for-the-pmprb/
[11] PBO, p.42. The estimated total of mark-ups and fees was $7.4 billion of a total of $20.4 billion, or 36 percent.
[12] PBO, p.11. The sum of direct spending: 0.645B; medical tax credits: 1.480B and 0.150B.
[13] PBO, p.1.
[14] PBO, p.19. This number includes premiums.
[15] Michael R. law, et al., The Consequences of patient charges for prescription drugs in Canada: a cross-sectional survey, CMAJ open, February 13, 2018 vol. 6 no. 1 E63-E70; accessed at
http://cmajopen.ca/content/6/1/E63.abstract?cited-by=yes&legid=cmajo;6/1/E63#cited-by