THE ECONOMIC CASE FOR UNIVERSAL PUBLIC PHARMACARE

By Keith Newman, Board Member
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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.

Contact for follow up:

Melanie Benard
National Director, Policy and Advocacy
Canadian Health Coalition
251, Bank Street, suite 212
Ottawa, Ontario K2P 1X3
613-688-4973
policy@healthcoalition.ca

Public health care is part of Canada's social infrastructure, much as public roads, bridges, and railways are part of our physical infrastructure. But a key component of that infrastructure is currently missing: a national drug plan that is public, universal, comprehensive, accessible and portable.[1] This is what is meant by the term "pharmacare" in this paper.

This document provides a roadmap for Canada's investment in such a plan. The economic case in favour of pharmacare is overwhelming. A national public drug plan is affordable, it would improve the health of Canadians, and it would be good for business.

The Advantages of a Universal Public Plan

Canada's complex network of 100 public and over 100,000 private drug plans[2] is rife with excessively high drug prices and overprescribing. A national public drug plan will lower drug costs by consolidating bargaining power for drug prices at the national level. It would also reduce the high administration costs and eliminate the profit margins charged by insurance companies.

Fair and efficient public drug coverage will also increase our country's productivity and competitiveness.[3] It will relieve employers of the financial burden of providing coverage and allow them to focus on their business operations. A healthier population would also mean less time away from work.

Universal drug coverage will also reduce the burden on the health care system by ensuring that people don't go without treatment. Currently, non-adherence to prescriptions due to cost results in 303,000 additional doctor visits, 93,000 visits to the emergency department, and about 26,000 admissions to hospital.[4]

Disadvantages of the "Fill in the Gaps" Model

Coverage of prescription drugs has overwhelming support among Canadians. Fiscal conservatives don't oppose an expanded public drug plan per se, but they call for a "fill in the gaps" model. This means leaving the thousands of different drug plans in place and just adding a public plan for those who lack adequate coverage. Some claim this would be "fiscally responsible". However, all the evidence contradicts this.

For example, Quebec adopted a "fill in the gaps" model in 1997. Drug costs in that province are the highest in Canada and in the developed world (with the sole exception of the United States).[5]All this money doesn't even buy adequate care since up to twelve percent of Quebecers report that they can't afford their prescription drugs.[6]

The "fill in the gaps" model falsely assumes that workers are adequately covered under private work-based plans, which is not the case. These plans are linked to specific employers, so if people change jobs or get laid off, they lose their drug coverage. Work-based plans also commonly require premiums, deductibles and co-pays that vary from one employer to another. Many people can't afford these out-of-pocket costs and are therefore unable to fill their prescriptions. Coverage under a plan therefore doesn't mean a person actually has

access to their medicines. This problem is getting worse as the cost of drugs increases and employers look for ways to lower costs by reducing benefits.

Coverage is also uneven and unfair. It is typically better for men than for women, for higher-paid workers than lower-paid workers, for full-time workers than part-time workers, and for workers in the public sector than those in the private sector.

Who Will Benefit Financially from Pharmacare?

1. Employers will benefit.

According to a study by the Parliamentary Budget Office (PBO), if a public drug plan had been in effect in 2015-2016, the savings for employers would have been **$9 billion in that year alone**.[7] The elimination of these overhead costs would enhance the competitiveness of Canadian business. Like any other reduced cost, this would be an incentive for business growth and increased employment. The automobile industry has pointed out the value for their Canadian facilities of having pubic coverage of doctor and hospital services;[8] this value will be enhanced by the addition of pharmacare.

2. Households will benefit.

In 2015-2016, savings for households would have been **$7.1 billion**.[9] Instead of spending money on overpriced medications, people could invest this money in themselves, in their small businesses, in improving their material standard of living, or in paying down their debts.

3. All age groups will benefit.[10]

If pharmacare were implemented today, some age groups might benefit more than others due to their different needs and associated costs. However, members of all age cohorts will benefit from pharmacare over their lifetimes.

How Much Should the Federal Government Contribute?

Public funding for pharmacare should be shared by the federal, provincial and territorial governments. They already share the costs of other social infrastructure such as doctors and hospitals, social assistance and education. Leadership on pharmacare by the federal government will be critical. The federal government must pay a significant share to induce the provinces to participate and follow national standards. The federal government also has a much greater financial capacity to spend on programs than the provinces do.

When public health care was introduced 50 years ago, the federal government committed to covering half the cost of services provided by doctors and hospitals.[11, 12]

The Canadian Health Coalition (CHC) therefore proposes that the federal government fund at least fifty percent of pharmacare, with the provinces funding the rest.

Magnitude of Spending for Pharmacare

There have been a number of estimates of how much pharmacare would cost and how much the program would save Canadians.

Marc-André Gagnon estimated the total cost of a universal public plan at $18.8 billion for 2012-2013. When factoring in the savings in the administration costs of private plans and tax subsidies, the cost would have totaled $16.3 billion. He estimated total savings on prescription drugs would amount to $11.4 billion.[13]

Using slightly different assumptions, Steve Morgan et al. estimated the cost of pharmacare at $15.1 billion for the same fiscal year. They estimated the reduction of total spending on prescription drugs at $7.3 billion.[14]

These estimates are supported by a study by Express Scripts Canada, which looked at money wasted in private work-based plans in 2011. It was calculated that out of total spending of $10.5 billion, $5.1 billion was wasted, mainly because of the use of higher-cost medications that generate no additional health benefits. In other words, almost half of all spending by private plans was wasted.[15, 16]

It is useful to compare spending on prescription drugs in Canada to the cost of single-payer plans in other countries. For 2015, on a per capita basis, Norway spent about half of the amount spent by Canada, while Sweden and the U.K. spent one third less, and Australia spent about 20 percent less.[17] Canada can therefore reasonably expect a significant decrease in the cost per capita if it adopts a universal public plan.

Last year, the PBO estimated the cost of pharmacare for the 2015-2016 fiscal year at $20.4 billion based on the Quebec public formulary.[18] Cost savings were estimated to total $4.2 billion. However, the PBO made very cautious assumptions. The most critical assumption was that drug prices would decrease by only 25 percent under a national plan. Just a few months after the PBO released its report, the provinces negotiated much larger price decreases for generic drugs for their public plans (about 38 percent),[19] prompting the PBO to note that "…with the purchasing power, if it's there at the national level, certainly you can go way beyond the 25%".[20] Indeed, even after the negotiated price decrease, generics remained much more costly in Canada than in other comparable countries[21].

Substantial future savings are also likely for patented drugs due to the expected revision of the Patented Medicine Prices Review Board (PMPRB) regulations.[22,23] Biologics (complex molecules that are increasing in use) are also an area where Canada could achieve substantial savings. The PMPRB estimated total potential savings at 52 percent of costs, or $1.8 billion, if Canada achieved the uptake and lower prices of biosimilars experienced in many other countries.[24]

Under pharmacare, negotiations with the pharmaceutical 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 introduce competitive bidding for generic drugs and use the inducement of including drugs under pharmacare to their advantage.

Furthermore, the cost of dispensing fees and mark-ups charged by pharmacies would be lower under pharmacare. The PBO assessed this cost would total 36 percent of drug

expenditures under pharmacare, but made no assumptions regarding downward pressure from negotiations under public plans.[25] Yet, in Quebec, dispensing fees under the public plan have been considerably less than those charged under private insurance,[26, 27] and they have recently been negotiated lower.[28] The PBO also noted that additional savings could result from reductions in administrative costs from the elimination of private plans. These costs were estimated at $3.6 billion.[29]

These considerations make it clear that the PBO's estimate of savings from pharmacare was overly cautious. Canada would much more likely attain savings similar to the 33 percent achieved under European single-payer plans. Under that scenario, the total cost for a national plan would have amounted to $16.4 billion in 2015-2016, which is two-thirds of the cost of prescription drugs ($24.6 billion)[30] purchased prior to pharmacare being instituted. This is similar to the estimates calculated by Morgan and Gagnon. It should be noted that these savings will be realized over the several years it takes for pharmacare to be fully implemented.

Table 1 Estimates of Costs and Savings of Universal Public Pharmacare

Study	Cost (billion $)	Savings (billion $)
Morgan et al.	15.1	7.3
Marc-André Gagnon	16.3	11.4
European single-payer	16.4	8.2
PBO	20.4	4.2

Net Additional Spending by the Federal Government

Using this figure of $16.4 billion, the federal government would have spent $8.2 billion in 2015-16 if it covered 50 percent of the cost of pharmacare.

However, the federal government already spent $2.3 billion on drug-related matters that year (including tax credits, direct spending on First Nations peoples, the RCMP, the military, etc.).[31] This means that net new funding would have only been $5.9 billion (i.e. $8.2 billion minus $2.3 billion). These figures for 2015-2016 would probably need to be adjusted somewhat higher for 2019-2020.

An alternative estimate of net new spending by the federal government, one that ignores the substantial price reductions noted above, could be based on the PBO estimated cost of $20.4 billion. In this case, if the federal government covered 50 percent of total drug costs, it would have spent $10.2 billion (50 percent of $20.4 billion). Adjusting that figure for spending already incurred yields an estimate of net new spending of $7.9 billion ($10.2 billion minus $2.3 billion).

Accordingly, the net new spending by the federal government would range between $5.9 and $7.9 billion, with the lower figure being the most likely.

Either way, this would be money very well spent when compared to the estimated yearly savings for employers ($9 billion)[32] and households ($7.1 billion).[33]

The Decision is Political, not Economic

We must be careful with the question: "Where will the money come from?". This is a trope put forward by those who oppose publicly-funded social programs and prefer services to be provided by private, for-profit businesses. They ask this question to put us on the defensive. They don't ask it for the spending they do want. Conservatives said the same thing when doctors were added to public health care fifty years ago. The Canadian Life and Health Insurance Association is using this trope right now to argue against a universal, single-payer drug plan,[34] just as Finance Minister Bill Morneau did last February.[35] They say: "We must be responsible with taxpayers' money". Indeed, we should be responsible. Doing the responsible thing means attending to the health and welfare of Canadians, not finding excuses to put off something we should have done fifty years ago. Why is it that every other high-income country with public health care can offer pharmacare, but Canada cannot?

The economics in favour of pharmacare are overwhelming and the program is long overdue. Public, universal pharmacare could cover everyone and save Canadians between $4.2 billion and $11.4 billion annually. The only thing preventing us from implementing it in the past was a lack of political will to take on the pharmaceutical and insurance industries due to their political power. Public health care has been a terrific investment for Canada. We now need to complete this investment with pharmacare.

Higher Taxes Are Not Necessary

There is no reason to believe that higher taxes will be required to cover pharmacare. Net new spending would amount to between 2 and 2.6 percent of the federal government's overall spending.[36] This modest amount would be overshadowed by other government spending needed to keep the economy on an even keel, especially if there is a recession. If the economy is doing well, the money collected through taxes will increase because more people will be employed. This could bring in more money than the additional spending on pharmacare. What then would be the logic of imposing an additional tax to "pay for" pharmacare?

We don't have a special tax for doctors or hospitals, and there is no reason to have one for pharmacare.

Paying for Pharmacare

The federal money allocated to pharmacare should be budgeted, spent judiciously, and paid for through the federal government's general spending. Spending on pharmacare will have little impact on the fiscal balance, which depends on the state of the overall economy, not on modest spending on a specific program.

Even if funding for pharmacare did result in a slight increase in the federal deficit, this is not cause for concern. It certainly is not an argument against proceeding with this new program. The current fiscal deficit is low, and there is no economic reason that it couldn't be higher. Indeed, it could easily be much larger than the currently budgeted $18 billion[37] without triggering excessive inflation (which is the only real danger of federal government spending being too high).[38]

The argument that new federal spending must be offset by equivalent taxes is a central plank of neoliberalism. Neoliberalism calls for a smaller role for the state achieved through privatization and limits on the ability of governments to run fiscal deficits and accumulate debt. Even conservative economists at the International Monetary Fund have expressed serious doubts about these policies as their benefits in terms of increased economic growth "seem fairly difficult to establish", while their "costs in terms of increased inequality are prominent".[39] Neoliberal arguments are inconsistent with the implementation of pharmacare.

In the 2015 election campaign, the federal Liberals promised deficit spending to invest in our country. They won the election on that basis.[40] Our government should invest in the health of Canadians and the benefits it provides for households and employers by implementing pharmacare, regardless of whether it adds to the fiscal deficit.

Income Taxes

If the economy is booming and inflation is rising unduly, the federal government may wish to raise taxes to slow the economy down. In that case, if the government wishes to offset its spending on pharmacare, it could impose a small increase in personal and corporate income taxes. Personal income tax is the most progressive form of taxation on individuals. Since employers would gain financially by no longer funding drug plans, it makes sense that they would contribute to pharmacare through a small increase in their income taxes. These are the fairest sources of taxation.

Unfair and Counterproductive Taxes Should Be Avoided

An increase in the GST should not be considered. The GST is a regressive tax and is especially unfair to people with very 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.

Co-pays and deductibles should not be considered. Even at very low levels, co-pays and deductibles are known to increase non-adherence to medications due to cost, especially among people with low incomes. Co-pays and deductibles 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.

A payroll tax should not be considered.

1) From the perspective of employers, a payroll tax increases the cost of labour and discourages the hiring of new workers. We want to encourage job creation, not discourage it.

2) A payroll tax is especially bad in sectors where there are foreign competitors. It increases costs for employers in Canada and favours moving jobs out of the country. The cost advantage of pharmacare for Canadian-based employers would be negated by a payroll tax.

3) By increasing the cost of labour, a payroll tax provides an incentive to replace workers with machines.

4) A payroll tax is unfair to low-income workers. It is not progressive and favours people with high incomes (i.e. those whose income is above the maximum level for the tax).

5) Pharmacare will decrease labour costs for employers. In unionized settings, unions would have room to negotiate increases to other benefits or to wages. Applying a payroll tax would negate that benefit.

6) A payroll tax is unfair to small business. Our vastly profitable banks would pay the same amount per worker as the corner grocery store or barber shop that survives on a shoestring budget.

7) A payroll tax is inconsistent with our vision of pharmacare. We want a national public drug plan that is analogous to coverage for hospital and physicians' services. We don't have a payroll tax to cover these services, and we shouldn't have one to cover prescription drugs.

Conclusion

There is no economic reason preventing Canada from joining all the other OECD countries that include prescription drugs in their universal public health care plans. Every study over the last 50 years has recommended that we implement pharmacare. It will be much simpler and more cost effective than the current vast patchwork of private plans with deductibles, co-pays and high administration costs. Pharmacare will consolidate bargaining for drugs country-wide and drive prices down to the more reasonable levels achieved elsewhere. We can't afford to wait any longer. Canada needs pharmacare now.

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[7] Parliamentary Budget Office (PBO), *Federal Cost of a National Pharmacare Program,* September 2017, p.1. www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/2017/Pharmacare/Pharmacare_EN_2017_11_07.pdf This is the cost of drugs paid by private plans that would be covered by pharmacare. The actual savings would be higher as administration costs can also be expected to decline.

[8] Canadian Auto Workers.

[9] PBO, p.19. This figure includes the cost of premiums as well as out-of-pocket expenditures.

[10] PBO, pp.7-8.

[11] The actual level of federal contributions has varied over the years. In the late 1970s, part of the cash transfer was converted to tax points ceded to the provinces. PBO, p.26. Other expenses include long-term care, public health and capital expenditures.

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[31] PBO, p.11. The sum of direct spending was 0.645 billion. Medical tax credits amounted to 1.480 billion and 0.150 billion.
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