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The Development of a National Pharmacare Program

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Canada's Nurses
STANDING UP
FOR PHARMACARE

Introduction

The Canadian Federation of Nurses Unions (CFNU) represents almost 200,000 frontline nurses across Canada. For almost two decades we have advocated for the implementation of a national pharmacare plan, including at several Council of the Federation meetings, speaking directly with federal and provincial health ministers, and during election campaigns. In advocating for pharmacare, we are drawing on the recommendations of the 1965 Hall Commission, the 1997 National Forum on Health, and the 2002 Romanow Report on our health care system.

Canada's nurses work on the front line of our health care system. Our members treat patients everyday whose conditions are made worse due to lack of access to affordable prescription drugs. When patients suffer because they cannot afford to take their prescribed medications, it is costly to our health care system. It is also devastating for their families struggling to make ends meet. This is the fundamental reason why nurses support a national universal pharmacare plan.

As an organization, we rely on the best available evidence to support our policy recommendations. Pharmacare experts, drawing on international evidence, now agree that a pan-Canadian national pharmacare program with a single-payer system, utilizing a national formulary and integrated within our medicare system would provide tangible benefits in terms of Canada's purchasing power and health system sustainability. Further, such a program would address the issues of access, appropriateness, and prescription drug safety, which are priority issues for nurses' unions, given their impact on our patients. While many different models of pharmacare are being proposed, it is essential that any program be based on the best available evidence to-date and that it addresses the full range of economic, health and societal impacts.

Value

In 2014, the CFNU published *A Roadmap to a Rational Pharmacare Policy in Canada*.[1] This foundational work made the economic case for pharmacare, estimating savings of between 9-11 billion should pharmacare be fully implemented. In 2015, *CMAJ* published *Estimated Cost of Universal Public Coverage of Prescription Drugs in Canada*.[2] According to the article, universal public drug coverage would reduce total spending on prescription drugs in Canada by $7.3 billion, with substantial savings for the private sector, at a net cost to the federal government of approximately $1 billion. While some have argued the transition costs would be prohibitive, the current system's inherent weaknesses are costing Canada billions per year, while failing to ensure that access is available to necessary treatments, and that appropriate prescription drugs, of benefit to patients, are being prescribed.

Almost 300 professors and other university-affiliated leaders in health policy, health economics, health services research, medicine, pharmacy, nursing, and psychology have reviewed and

endorsed the recommendations of Pharmacare 2020,[3] including 12 members of the Order of Canada. Pharmacare 2020 envisions a public drug program based on the following elements:

1) Universal coverage of selected medicines at little or no direct cost to patients through Pharmacare; 2) Selecting and financing medically necessary prescription drugs at a population level without needs-based charges (deductibles, coinsurance, or risk-rated premiums); 3) A publicly accountable body to manage pharmacare, one that integrates the best available data and evidence into decisions concerning drug coverage, drug prescribing, and patient follow-up; 4) Establishing pharmacare as a single-payer system with a publicly accountable management agency to secure the best health outcomes for Canadians from a transparent drug budget.[4]

The experts agree that our current fragmented system, as it is structured, is inefficient, inequitable, wasteful and unsustainable.[5] The Canadian pharmaceutical insurance system could be considered an anomaly.

If Canada paid the same official price for drugs as the OECD median, Canadians would save about 25% on patented drugs. Canada has a universal public health insurance system, but it is the only country in the world to have excluded prescription drugs from that system, as if drugs were not an essential element of health care. Universal public drug insurance is not the exception but the rule among OECD nations.[6] Savings to our government health care programs could be reinvested in our health care system to benefit seniors, indigenous peoples, and the one in five Canadians suffering from mental health issues.

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Canada has the second lowest percentage of the population covered by a public drug insurance plan in all OECD countries, after the U.S. However, it has the second highest expenditure per capita (2012) on pharmaceuticals, after the U.S. From 2000-2012, Canada experienced stronger annual growth in prescription drug costs per capita than any other similarly developed nation, surpassing even the U.S. Further, Quebec's hybrid system is not a model for Canada as Quebec had the highest rate of annual growth in prescription drug costs per capita (2000-2012), greater than even that for Canada as a whole.[7] In fact, Quebec has the highest costs per capita among the Canadian provinces, with employers and employees paying steep premiums, reducing Quebec's competitiveness.[8]

Despite measures taken by the provinces in terms of coordinated bulk buying, Canada has been unable to contain the rising costs of pharmaceuticals. Limited savings have been achieved by the provinces to-date through the pan-Canadian Pharmaceutical Alliance. Since 2010, the provinces, minus Quebec, have been negotiating drug pricing collectively, and recently Quebec and the federal government have joined these negotiations. However, these negotiations apply only to public drug plan purchases which cover less than 50% of prescription drug expenditures

in every province.[9] Canada needs a comprehensive system which covers all prescription drugs and effectively lowers costs as well as ensuring appropriate prescribing and access.

Evidence shows, and international comparisons prove, purchasing power would be maximized through a pan-Canadian single-payer system based on a national formulary of medications selected for universal coverage. Integrating this program within our medicare system would improve the collection and analysis of related health datasets, thus improving the capacity of all provinces and territories to employ evidence-based risk-sharing policies.[10]

A study in 2014 put the medical loss ratio (the percentage of premium income paid out as benefits) of private insurers at 82% (2012). The Canadian Life and Health Insurance Association (CLHIA) confirms that this figure is correct for 2012, with an average medical loss ratio of 85% between 1997 and 2012. The remaining 15%-18% is paid out in profits and dividends, and admin costs (which include staff, claims processing, advertising, etc.).[11] This is still substantially lower than the medical loss ratios of public plans.[12] Whatever the precise figure for administrative costs for private health insurers, it is evident that public plans are more efficient than private plans, if emphasis is placed on providing real value for Canadians in terms of the provision of pharmaceutical benefits.

The Business Case for National Pharmacare

Business, labour and municipal governments are coalescing around the need for a national pharmacare plan as the economic evidence continues to point to the positive influence of a public single-payer system on the Canadian economy.

Canada's foremost labour economist, Jim Stanford, notes that public health care is a major asset in attracting investments to Canada. He adds that including universal pharmacare within our current medicare system would boost Canada's competitiveness internationally:

> *In my judgment as an economist with over two decades of experience in the automotive sector and other strategic manufacturing sectors, the implementation of public prescription drug insurance coverage (in addition to its obvious efficiency and social benefits) would be a significant advantage in the ongoing effort to attract and retain private business investment in globally mobile, high-value industries (such as automotive manufacturing).*
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> *One interesting factor supporting Canada's attractiveness as a site for mobile investment is the impact of our public health care system on international production cost comparisons. In the U.S. (our largest trading partner and closest competitor), employer-funded health care costs are a significant component of total labour expense. High-quality private health insurance premiums can easily add $20,000 (U.S.), or $10 per standard work hour, to the cost of hiring a skilled worker or*

professional in the U.S. In Canada, in contrast, core health services are provided through the public health system – and funded primarily through taxes paid by Canadians. This approach has many benefits: it produces a system that is more efficient (generating better health outcomes at lower cost), and more accessible and inclusive (ensuring near full coverage). But another benefit of socialized health care is the fact that the cost of health care is transferred from being the direct responsibility of employers, and instead is funded collectively through the overall tax base of society. This dramatically reduces the extent to which health costs can become a disincentive for private employment and investment.

However, the value of that "health advantage" has been reduced in recent years by the growing relative importance of prescription drug expenses in total health care costs. The efficiency and equity benefits of public health care in Canada are undermined, when a growing share (30 percent or more) of total health costs are now associated with prescription drug expenses which are still provided privately (and hence add a significant and growing amount to the cost of hiring workers in Canada).

Consider the impact of health insurance costs in the auto assembly industry. This is a sector where Canada faces a very challenging competition with other jurisdictions (including the U.S.), each of which is determined to enhance its share of output and employment in this vital high-value sector… The industry faces a critical juncture in coming years, to win commitments from global automakers for renewed capital investment and product allocation in Canadian facilities. At current exchange rates, all-in labour costs in Canada (all labour-related expenses, including wages, premiums, non-wage benefits, cost of paid time off, and statutory payments to government) are attractive relative to the U.S., but much higher than Mexico. And the automakers worry that if the Canadian dollar rises in value again, then Canadian locations will be more expensive. Other countries (like Mexico) base their appeal on low-cost labour, while the U.S. relies heavily on huge government investment subsidies to win new projects. Canadian stakeholders are working hard to make the case for new investments in Canadian locations. Based on internal company data, the cost per hour worked of health care (including supplementary benefits, such as drug coverage) in auto assembly facilities is about $5 per hour worked lower in Canada than in the U.S. (where automakers incur much bigger costs for private health insurance for their employees).

Canada operates in a fiercely competitive international economy. For the future success of our international trade, our productivity, and our incomes, it is essential that Canada maintain and grow the domestic footprint of strategic, high-value, export-oriented industries... In this battle for investment, Canada must assemble an

investment package that is comprehensive, attractive – yet sustainable and consistent with our social values and priorities. There is little point joining a "race to the bottom" with other jurisdictions regarding which country can suppress labour costs the most: we could never win that race, and as a society we would lose even if we "won." It is much preferable to present a Canadian "value proposition" to investors that is rooted in quality, productivity, innovation, and inclusion.

By ensuring that all necessary health costs (including prescriptions) will in the future be covered under the same principles of universal public insurance, a public pharmacare plan would solidify the ongoing economic advantage of public health care in the battle to attract investment in crucial global industries.[13]

The Federation of Canadian Municipalities (FCM), which represents 90% of Canada's municipal population, passed a motion in June 2016, calling for "the federal government to work with the provinces and territories to develop and implement a National Pharmacare program," citing the health and economic benefits.[14]

Similarly, the B.C. Chamber of Commerce passed a motion in late May 2016, urging the federal government to create a universal pharmacare program that does not share the limitations of the Quebec system in offloading costs onto business.[15]

"Our fragmented system of drug coverage programs across the provinces reduces access to medicines, diminishes drug purchasing power, duplicates administrative costs, and isolates pharmaceutical management from the management of medical and hospital care," said Anita Huberman, CEO of the Surrey Board of Trade and author of the motion. "Furthermore, it is needlessly costing Canadian businesses billions of dollars every year," she added.[16]

Safety and Appropriateness

Recently, the Canadian Medical Association has been highlighting the Choosing Wisely[17] campaign. This is an admirable program to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures. There is no better place to start than with prescription drugs where marketing and lobbying, rather than safety and appropriateness, often determine usage rates. As Kevin McNamara, former Deputy Minister of Health and Wellness in Nova Scotia, pointed out at the CFNU's recent parliamentarian breakfast, there is no use providing prescription drugs that are of absolutely no benefit, or even cause harm to the patient. There has to be an increased focus on the efficacy of the drugs being prescribed.[18]

The situation with respect to inappropriate, unsafe prescribing is particularly acute for seniors who often have chronic conditions with many prescriptions. For example, in 2014 the Canadian Institute for Health Information (CIHI) reported that among seniors on public drug programs, 63.8% of seniors living in long-term care facilities across the country claimed a prescription for a drug on the Beers list – an index of medications deemed potentially unsuitable for seniors

because of an increased risk of side effects and lack of efficacy. Among the most commonly used drugs on the list were antipsychotics, despite their link to deaths among those suffering from dementia. Over 30% of the long-term care residents were using multiple Beers drugs. Over 20% of all senior claimants in the community reported chronic use of drugs on the Beers list.[19] A recent report puts the cost of inappropriate prescribing for seniors outside of hospital settings at an estimated $75 per older Canadian, or $419 million in total, in 2013, with more than one in three older people filling at least one prescription meeting the Beers Criteria. When including indirect health care costs, such as the increased risk of falls, fractures and hospital admissions, the study estimated a cost to the health care system of $1.4 billion in 2013.[20]

Given these findings, greater scientific rigor and transparency is needed as part of a national strategy for pharmaceutical policy in Canada so that data is routinely collected, assessed and published about drug safety and effectiveness throughout the product's life cycle. This federal commitment would provide vital information to health care providers, patients and regulators through a national, readily accessible, centralized data network which would ensure that the selection of medicines on a national formulary is guided by the best available evidence and overarching public health goals.[21] Our current system is letting down both patients and health care providers by not providing this needed guidance and evidence.

Equity and Access

From a labour perspective, moving to pharmacare would place limits on the open formulary currently used by insurance companies. But insurers would adapt and offer products which allow access to a wider range of drugs, just as they offer other health insurance benefits not covered by medicare to our members. Private insurance would continue to be part of our health care system in some form, but no longer would 60% of drug coverage be managed by private interests at high costs and without universal coverage. Governments exist to ensure that our health care system safeguards the health of all citizens, in particular our most vulnerable who include seniors, indigenous peoples and those living in poverty.

In 2013 almost a quarter (23.9%) of prescription drug spending was financed through out-of-pocket payments by households and individuals.[22] Out-of-pocket expenditures in prescription drugs increased by 33% on average (in constant dollars) between 1997 and 2009, but the cost increases have been much more significant for low-income households: 21% for the richest 20%, compared to 64% for the poorest 20%.[23] According to a 2015 Angus Reid survey, these costs were highest in Quebec, with 32% spending $500 plus out of pocket.[24]

The Angus Reid survey found that more than one in five Canadians reported that in the past year they, or members of their household, did not take medicines as prescribed, if at all, because of the cost. This proportion is highest in B.C. (29%), possibly because of access barriers related to B.C.'s "catastrophic" drug coverage. The same poll found that 91% support a national pharmacare program in Canada, and 87% support adding prescription drugs to the universal health coverage of medicare.[25]

Research from 1996 puts the rate of hospital admissions resulting from non-adherence to medications[26] at 6.5%. The total cost of non-adherence in Canada was estimated at $7 billion to $9 billion per year with 125,000 deaths.[27] Given the growth in the seniors' population, it is likely the situation has worsened in the ensuing years. Barriers to adherence can include not only the actual cost of drugs but also dispensing fees, co-payments, and deductibles.

Given these inherent barriers to access, a catastrophic drug program is not the answer. Numerous studies have shown that deductibles under catastrophic drug plans act as barriers to filling prescriptions. For example, seniors in British Columbia – a province that adopted catastrophic coverage for the elderly and non-elderly alike in 2003 – are more likely to skip prescriptions because of the cost and face the potential for hospital admission. By design, deductibles under catastrophic drug benefit programs are very high, essentially acting as a tax on those with the most significant medical needs – including most seniors. Catastrophic drug plans impose proportionately greater direct financial burdens on those with lower incomes and increase costs for employers (as evidenced by the B.C. experience). They also perpetuate high administrative costs because they involve multiple players, most of which are for-profit companies. Multi-payer systems cost roughly 10% more than single-payer systems solely due to additional administrative costs. Further, catastrophic drug programs do not address appropriateness and safety because the government formulary affects only a minority of patients, and only after high deductibles. Most patients won't be covered under the plan, limiting both the government's purchasing power and safe, appropriate, evidence-based prescribing.[28,29]

We can do better – we must do better because patients are literally dying as a result of our lack of action. As health professionals on the front line, we hear their stories every day. Canada's nurses are asking for immediate federal leadership on a national pharmacare program. The evidence, collected over two decades, leads us to only one conclusion – now is the time for action!

The Canadian Federation of Nurses Unions (CFNU) is Canada's largest nurses' organization representing nearly 200,000 nurses and student nurses. The CFNU has been advocating for national discussions on key health priorities, such as a national prescription drug plan, a comprehensive approach to long-term and continuing care, greater attention to health human resources, and federal government engagement on the future of public health care.

Our Patients' Experiences

A patient of mine couldn't control his diabetes because he worked as a security guard for the city. He was making too much for discounted meds but couldn't afford what he was prescribed on his salary.

My father stopped taking his Lipitor (without my knowledge) because it was too expensive. He didn't have a pension and was living with my mother. They only had CPP and OAS as income. He died of a heart attack at age 69.

My patient, an elderly woman, isn't eating well. She can't afford her meds and enough food, so every day she is faced with this dilemma – whether she can afford to continue treatment…

A patient needed anxiety meds. Her husband worked but had his wages garnisheed for a previous debt. On paper, they had a good income, but she couldn't get the meds she needed because, in fact, they had no money.

My patient – 28 years old – lost his job in the oil patch and lost his drug coverage for his stomach ulcer meds too. Ended in emergency with severe pain which had been going on for weeks. The ulcer had eaten through his stomach. Needed multiple tests, 4 hours of surgery and 5-7 days in hospital…all because he couldn't afford his meds.

One in 10 Canadians can't afford to fill their prescriptions…

So, imagine how many millions of Canadians have similar stories to share…

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