CANADIAN FEDERATION OF NURSES UNIONS
LA FÉDÉRATION CANADIENNE DES SYNDICATS D'INFIRMIÈRES ET INFIRMIERS

Submission by

the Canadian Federation of Nurses Unions (CFNU)

to

the Advisory Council on the Implementation of National Pharmacare

September 28, 2018

nursesunions.ca | 2841 Riverside Drive, Ottawa ON K1V 8X7 | 1-800-321-9821 | info@nursesunions.ca

Introduction

The Advisory Council on the Implementation of Pharmacare has been tasked with conducting an economic and social assessment of domestic and international models of pharmacare, working with provincial/territorial and indigenous leaders, and consulting with Canadians, experts and stakeholders from relevant fields. As part of this latter effort, it has issued a discussion paper with a series of questions intended to help frame the work of the Council and guide its engagement with Canadians.

The Canadian Federation of Nurses Unions (CFNU), representing almost 200,000 frontline nurses across Canada, has been advocating for the implementation of national pharmacare for more than two decades. It has presented its support for national pharmacare at several Council of the Federation meetings, spoken directly with federal and provincial health ministers, and included pharmacare as a key plank in its 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, as well as on the best available evidence. As a key stakeholder representing nurses across Canada, we are pleased to contribute to the work of the Advisory Council on the Implementation of Pharmacare.

The Advisory Council has stated that "patients must be at the centre of any conversation about health care reform." As the voice of Canada's frontline nurses working on the front line of our health care system, we agree. Our members report witnessing patients every day, whose conditions are made worse due to lack of access to affordable prescription drugs. As the Council has noted, patients and their families struggle to make ends meet in order to afford their medications, limiting everyday essentials such as food and heating. It is because of our commitment to our patients that nurses support a national universal pharmacare plan.

Canada's nurses support the implementation of an effective national pharmacare program based on the following principles:

Public Administration

National pharmacare must seamlessly incorporate prescription drug coverage into the greater public health care system. The system must be governed by a public authority on a non-profit basis to ensure accountability exclusively to the public interest and democratic institutions.

Universality

To prevent people from falling through the cracks, everyone in Canada should be covered by the same plan on equal terms and without financial barriers. This will ensure universal coverage based on need and not ability to pay. Furthermore, it will nearly eliminate cost-related non-adherence to prescriptions, which contributes to the deaths of over 600 Canadians per year who suffer from one disease alone.[1]

Single-Payer

Only a single-payer system can effectively leverage bulk buying to bargain down prices for covered prescription medications and save between $4 and $11 billion per year. These savings could be reinvested in needed health care services such as seniors care, home care, mental health and Indigenous health. A single-payer system will also achieve billions in administrative efficiencies, much like the single-payer public health care system. Put simply, it makes economic sense because "the bigger the buyer, the bigger the bargaining power."

National Formulary

A common, comprehensive national formulary must be established based on the evidence and administered by an arm's-length, depoliticized public agency. The agency's primary objective will be to maximize health benefits per dollars spent, using value-for-money and clinical assessments.

What Canada Needs: Comprehensive Coverage, Publicly Administered and Delivered

A national, single-payer, universal pharmacare program should cover all those living in Canada who have obtained a prescription to treat an illness or condition. National pharmacare should be publicly administered with a common, comprehensive national formulary to ensure equitable access across Canada. 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 Canada's 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 address the full range of economic, health and societal impacts.

The evidence: Access issues result in poorer health outcomes and increased mortality.

Out-of-pocket expenditures for prescription drugs increased by 33% on average (in constant dollars) between 1997 and 2009, but the cost increases were much more significant for low-income households: a 21% increase for the richest 20%, compared to a 64% increase for the poorest 20%.[2] The proportion of out-of-pocket expenditures for prescription drug spending outside of hospitals rose to 22% in 2017, representing more than $7 billion in out-of-pocket spending by individuals across Canada.[3]

Cost-related issues result in a lack of adherence to drug treatment regimens. The Angus Reid Institute found that more than one in five Canadians surveyed 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.[4] Research shows that more than 1.6 million Canadians — 8.2% of those ordered to take medications in 2016 — didn't fill their prescriptions, skipped doses or otherwise neglected to take medications because of cost. The highest percentage of cost-related non-adherence was in British Columbia, likely due to the high cost of living, combined with high deductibles for medications.[5]

Between 10 and 20% – or 3.5 to 7 million Canadians – have no health insurance at all,[6] and many more lack adequate coverage for their families. This may be particularly true for women who are more likely to hold part-time positions than men, struggling to balance family obligations with paid work. Even those with full-time permanent positions that have health insurance benefits may end up paying significant sums out-of-pocket for their prescribed medicines, with co-payments averaging between 18 to 20%, and rising.[7] Deductibles and annual or lifetime maximums are also a way for employers to contain costs leading to potentially significant out-of-pocket payments.

Even small co-payments have been shown to impact adherence to drug treatment plans, resulting in impacts on health care outcomes, even for those with existing health insurance plans.[8] [9]

Not taking medications means many people unnecessarily end up in emergency rooms. In 2016, 93,000 individuals ended up in the emergency room and 300,000 consulted a doctor because they did not take their medications as prescribed, resulting in increases to health care costs.[10] Ultimately, cost-related non-adherence leads to increased mortality, a "body count" which the CFNU estimated in its latest report:

- Using population-level data on the number of deaths that are preventable with effective and timely health care, we estimate that shortfalls in Canadian prescription drug coverage are responsible for, in the range of, 370 to 640 premature deaths of Canadians with ischemic heart disease every year.
- Using an Ontario study of diabetes-related mortality, we estimate that cost-related non-adherence to prescribed drug regimens in Canada contributes to, in the range of, 270 to 420 premature deaths of working-age Canadians with diabetes every year.
- Using US data on the effects of expanded drug coverage, we estimate that shortfalls in drug coverage in Canada lead to, in the range of, 550 to 670 premature deaths from all causes among older working-age (55-64) Canadians every year.

These numbers are conservative and likely underestimate the impact of even these two health conditions. Further, since only two health conditions were considered in this analysis, the real "body count" is undoubtedly much higher.[11]

Overall, the evidence demonstrates that access is a widespread issue affecting millions of Canadians in a variety of ways.

The evidence: Our current patchwork system results in cost-shifting, price inflation, high administrative fees and inappropriate prescribing.

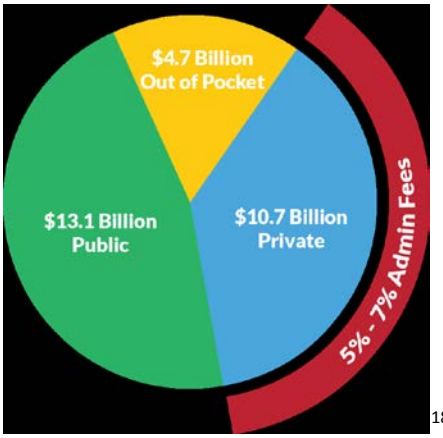
Our current patchwork system with multiple public and private drug plans results in cost-shifting, artificially inflated prices, high administrative fees, and the prescribing of expensive drugs based on marketing rather than evidence of a drug's therapeutic value. As a result, we are currently wasting $7.3 billion annually or $14,000 every minute of every day – a figure that could be reinvested into our health care system.[12]

Only a national, publicly administered and delivered, single-payer, universal pharmacare program will lead to reduced costs and better prescribing. Negotiating on behalf of all Canadians and all provinces will allow for bulk buying, thereby increasing purchasing power to achieve the lowest possible pharmaceutical prices. The underlying economic principle is that "the bigger the buyer, the bigger the bargaining power," and the greater the savings for Canada.

Currently, Canada has the third highest per capita pharmaceutical prices in the world.[13] Canada's current system is fragmented and inequitable, and lacks transparency, meaning that provincial governments pay different prices when purchasing the same pharmaceuticals. Similarly, a persons' access to prescription medicine is determined not by their medical needs but by where they live in Canada.[14]

We are currently spending $28.5 billion (2015-2016) on prescription drugs, and over half of this figure is private spending: either out-of-pocket payments or private health insurance plans. Notably, in comparison with the rest of the countries in the Organization for Economic Co-operation and

Development (OECD), we do poorly in terms of public spending on prescription drugs, ranking amongst the countries with the lowest proportion of public spending at 36% (2015).[15] Based on the Parliamentary Budget Officer's costing of a national, universal, single-payer pharmacare program with a common formulary, reduced administrative costs, and no financial barriers presented by co-payments, national pharmacare has the potential to save $4.2 billion ($3.4 billion from the private stream alone).[16] In contrast, the private sector, which currently makes up $10.7 billion in expenditures, has multiple formularies, more than 100,000 different private insurance plans,[17] no capacity for negotiation and bulk purchasing, high administrative fees (5-7%), and high co-payments (18-20% on average). With high prices for existing drugs and new speciality drugs (such as biologics) being introduced every day, pushing up the costs of health benefit plans (of which drugs represent the biggest line item), employers may be forced to scale back coverage (or eliminate it entirely). Alternatively, they may increase co-payments to help maintain their profit margins.



[18]

These thousands of private plans have no way of assessing the cost-effectiveness and efficacy of prescription drugs. Whatever drug is prescribed by the doctor most often is covered by the plan. And drug companies spend significant sums on marketing campaigns, encouraging doctors to prescribe their leading drugs more often. It is estimated that drug companies spend $60,000 per doctor per year on drug promotion, advertising, providing free samples and paying doctors to attend conferences.[19] Nothing about this process is objective, and doctors are generally sold the benefits of a particular drug, with little mention of its side effects. The most egregious example of this is Purdue, whose promotion of Oxycontin as a non-addictive painkiller has contributed to Canada's, and North America's, current opioid crisis.

A national prescription drug program would help to ensure that drugs are prescribed based on the evidence, not based on the marketing efforts of pharmaceutical companies. This means not only comparing new drugs to placebos in randomized control trials but also considering whether new drugs are a real improvement over existing drugs which are off-patent and, therefore, less expensive for our health system. Drugs that have been used for some time may often also be safer because they have been used for longer in the population, and any adverse drug reactions would be better known. Indeed, inappropriate prescribing for seniors outside of hospitals cost six public plans an estimated $419 million in 2013.[20]

Unfortunately, it is easier to get new and expensive products reimbursed by private health insurance in the North American market, even when they do not provide additional therapeutic value. In fact, in the latest annual report of the Patented Medicines Price Review Board, 91% of the new patented drugs that entered the Canadian market were shown to *not represent a significant therapeutic improvement* as compared with existing products.[21] Under the current system, many drugs are replacing older drugs – or being added to health benefits – based on marketing efforts, even if they provide little or no value added to users.

A national, single-payer program would include a national formulary, based on the clinical evidence, providing a valuable source of information and clarity to physicians, nurse practitioners and pharmacists, who currently depend on pharmaceutical companies' marketing efforts for information. Employers and their advocates, such as British Columbia Chamber of Commerce[22], and unionized workers with existing private plans, including the 3.3 million members of the Canadian Labour Congress,[23] recognize that the current system of prescription drug coverage is irrational, costly, unsustainable and unsafe.

The evidence: Income-based coverage and hybrid models (private-public) do not improve equity, address access issues, promote appropriate prescribing practices, nor lead to cost-containment.

In Canada, we are fortunate in being able to examine and evaluate the impact of long-term income-based coverage and hybrid models in British Columbia (income-based for 15 years) and Quebec (hybrid model for 21 years). The evidence below shows us that neither the Quebec nor British Columbia 'pharmacare' model leads to cost-containment or cost-reductions. Instead, costs are merely shifted onto the employers and individuals. Further, neither model is progressive, as inevitably cost issues result in non-adherence to drug treatment plans, and the associated decline in health outcomes, leading to preventable emergency room visits, hospitalizations and deaths.

British Columbia's *Fair PharmaCare*

In 2003, British Columbia moved from an age-based public plan to an income-based model where public subsidies are available after prescription drugs costs surpass 3% of household income. Under this model, individuals pay an annual deductible based on their family income, after which they pay 30% of the cost of prescription drugs up to a maximum amount. After the maximum amount is reached, *Fair PharmaCare* covers the entire cost of prescription medications for the rest of the year.[24]

This income-based model has high deductibles and co-payments, which have led to individuals not taking their drugs. According to research published in 2018, British Columbia had the highest percentage of individuals not able to afford one or more prescriptions at 8.1% (compared to 5.5% for Canada) likely due to the high cost of living, combined with high deductibles for medications. As previous studies have noted, the highest rate of cost-related non-adherence was among those with lower incomes. In 2016, 23% of British Columbia respondents with incomes under $40,000 said they couldn't afford one or more prescriptions.[25]

This finding reaffirms the results of a 2015 Angus Reid poll, which found that "consistent with prior studies, British Columbia has the highest rate of access barriers: 29% of households including someone who failed to take medicines as prescribed, if at all."[26]

Income-based drug benefit plans also have been shown to reduce seniors' access to necessary medicines, with the deductibles acting as a financial disincentive for patients to fill needed prescriptions, reducing adherence to the prescribed therapy. For seniors, who are more likely to be high-needs users of prescription drugs, deductibles impose a significant burden.[27] Pharmaceuticals are the largest

out-of-pocket health care expense for seniors in British Columbia, representing an average cost of $615 annually for BC seniors – more than twice the average $277 paid by seniors in Ontario.[28]

Further, costs, while reduced for government, migrate in income-based programs to employers, unions and patients who are unable to contain costs and leverage the purchasing power of government as the single-payer in the pharmaceutical marketplace.[29]

This is why the government of British Columbia and the B.C. Chamber of Commerce both welcome the idea of trading in British Columbia's current income-based model for a comprehensive, national, universal pharmacare program.

Quebec's hybrid model (private-public)

In 1997, Quebec created a drug coverage system making it mandatory for workers to enroll in private plans when they are available. Employers that provide any health benefits are required to provide private drug coverage for their employees. Those for whom no private plan is available – seniors, those on social assistance, and anyone without private coverage through their employers – end up on the mandatory public drug plan. The result is that all Quebeckers are covered by some form of drug insurance. This is the good news.

However, there are many problems that have emerged in the Quebec model over the years. These problems should give us pause when considering the option of following Quebec's lead in pursuing a hybrid private-public model for pharmacare.

First, there is the prohibitive cost – Quebec spends $200 more per person than the rest of Canada to provide prescription drug coverage to everyone in the province. Compared to countries with universal pharmacare, the difference is even greater: private and public spending for medications is 75% more per person in Quebec. Premiums can also be very expensive in Quebec, with a larger proportion paid by lower-income households than higher-income households. For part-time workers, in private plans, premiums could amount to as much as 10% of their income.[30] In addition, patients still have to pay out-of-pocket a maximum co-payment of 32.5% when purchasing prescriptions, which can add up to more than $1,000 a year.[31] As a result, according to a recent survey, out-of-pocket costs in Quebec are the highest in the country, with 32% spending $500 plus out-of-pocket.[32]

Administrative costs are also high in Quebec, reaching an extraordinary 18% for private insurers compared to 1.7% for public plan. In the rest of Canada, inequity persists in the system, because drug prices vary between the public and private plans, with public plans shifting costs onto private plans. The result: the burden on employers and employees increases as premiums rise and labour costs rise in turn. Meanwhile, out-of-pocket payments continue to impinge on access, affordability and adherence to drug treatment regimens.[33]

In light of this evidence, it's clear that the application of a hybrid model across Canada would fail to effectively contain costs and ensure equity of access and should therefore not be the model for Canada.

What Drugs Should be Covered Under National Pharmacare?

As stated in the CFNU principles, Canada's nurses support a national pharmacare program that provides a common, comprehensive national formulary established on the best scientific evidence and administered by an arm's-length, depoliticized public agency.

Selecting the list of drugs eligible for coverage can be a particularly sensitive and fraught undertaking. There are many complicated considerations, including scientific testing, a changing marketplace of drugs, public accountability and powerful lobbies. It is for these reasons, and others, that the architecture of any pharmacare system must be built to withstand external pressure and to preserve the twin goals of providing for the health needs of the population and maximizing the value of dollars spent.

The CFNU acknowledges our status as an advocacy group with a political agenda – we are among many with divergent opinions in the health care sector. Knowing this, we do not believe it is our place to opine on the qualitative selection of drugs for coverage under pharmacare. Indeed, we believe that drug assessments and selection should be conducted free from the interference or political pressure of *all* advocacy groups. Under a national pharmacare program, a national agency, staffed by appropriately insulated and expert public servants, must be empowered to evaluate the clinical efficacy, safety and cost-effectiveness of a medicine before selecting it for coverage.

Nevertheless, establishing a formulary (or list of drugs covered) that is national in scope is critically important. Indeed the national formulary is key to achieving the efficiencies promised in virtually all expert studies. A new national pharmacare agency would be empowered to negotiate prices and contracts with manufacturers on behalf of the entire population, thereby maximizing the purchasing power of Canada and bringing down prices. A national formulary is also the key to equalizing and preserving the quality of coverage across Canada. As Canadians move from one province or territory to another their coverage would remain the same. Furthermore, no region of Canada would enjoy better coverage than another because of medically irrelevant factors such as economic performance and government revenue.

Despite intentionally removing ourselves from commentary on the qualitative nature of the formulary, Canada's nurses do have a position on the quantitative question. In recent years, many models of coverage have been discussed in Canada. From largest to smallest, these formulary options include an open, comprehensive, implicit national formulary, commonly prescribed, to essential and finally CLEAN medicines. Even within these categories, examples of vastly different formularies exist. For example, the Ontario comprehensive formulary for eligible populations comprises approximately 4,400 prescriptions, whereas the Quebec comprehensive formulary covers over 8,000 prescriptions.

As stated previously, the exact number and selection of the national formulary must be left to the experts who serve exclusively the public interest. Nevertheless, Canada's nurses support the principle that the national formulary must be comprehensive. It is our position that a comprehensive formulary is one that provides coverage for as many medications as are judged safe and effective, and that provides the best value for money. By definition, comprehensiveness therefore includes common medications as well as specialty medications, which is crucial to ensuring the equity and inclusivity of the plan.

Unlike most private insurance plans, we do not support the concept of an open formulary, because it seriously undermines the integrity of the system, permitting "doctors and other providers to prescribe more expensive medicines when less expensive ones are just as good or better."[34] Moreover, open formularies fail to provide evidence-based guidelines to prescribers, encouraging off-label prescribing and contributing to the ongoing troubles with overprescribing.[35]

As described above, a significant gap exists between the number of drugs covered between the Quebec and Ontario plans. In assessing the efficacy of both comprehensive formularies – and determining which path to pursue for all of Canada – it is essential to bear in mind the overwhelming evidence that Quebeckers pay more per capita for prescription medications than any other jurisdiction. Canadian experts repeatedly point to the Quebec system as defined by its ineffectiveness at containing costs. The Quebec system fails to incentivize the selection of more cost-effective medications that have the same proven therapeutic outcome. This should serve as a cautionary tale for policymakers when deciding on the parameters for the size of the national comprehensive formulary.

Some advocates have proposed incremental growth in the formulary size, starting with a small basket of either CLEAN medications or the WHO (World Health Organization) Model List of Essential Medicines. According to this proposal, universal, single-payer pharmacare would begin with a smaller list of high-impact covered medicines and gradually grow in coverage. Coverage growth would be aligned with adjustments to government finances to permit incrementally greater expenditure on pharmacare. The trouble with this proposal is that it fails to account for the realities of Canadians politics. Rarely, if ever, are commitments to incrementally grow health and social spending adhered to. For this reason, Canada's nurses advocate the immediate implementation of a comprehensive formulary to ensure a completed system is built from the outset. This will ensure maximum public health benefit in the shortest period of time.

How Should a National Pharmacare Program be Financed?

As with any new public program, the question of financing is a key consideration. Ensuring that a pharmacare program is established to meet its mandate to provide prescription drug coverage, while putting in place measures to maintain the long-term fiscal sustainability is the challenge before us. However, national pharmacare is in the enviable position of offering a policy program that promises major system-wide efficiencies and cost reductions, with a relatively modest additional public investment. This investment would amount to no more than 1.5% of total current federal spending for 2018-2019. In short, achieving universal, single-payer pharmacare for Canada is more a question of political choice than of fiscal challenges.

While some vested interests continue to defend it, there is little doubt that the status quo cannot be permitted to continue. With billions of dollars in waste and thousands of lives lost and compromised each year under the current patchwork system, there is a better way forward for Canada.

Before discussing specific expenditure and revenue estimates for pharmacare, let us bear in mind some macro-level fiscal and economic data for Canada. Total federal government expenditure in the 2018 Federal Budget is projected to be just short of $340 billion.[36] Of this, the federal government will transfer nearly $40 billion health care dollars to the provinces and territories, as part of the Canadian Health Transfer.[37] In light of the significant long-term fiscal challenges facing many of the provinces[38] and the stronger fiscal capacity and stability of the federal government, Canada's nurses believe the federal government must assume the fiscal and political leadership necessary to achieve national pharmacare. The federal government is therefore responsible for paying the start-up costs for the system and ought to offer substantial cost coverage to entice provinces and territories to opt in. Unlike Medicare, where the federal share of spending has declined over the recent decades, Canada's nurses believe there should be strict statutory obligations for federal fiscal contributions within the legislative framework for pharmacare. While substantial federal contributions are a prerequisite, Canada's nurses

also know that cost sharing negotiations between federal, provincial and territorial governments are complex. Therefore, we will not recommend specific contribution percentages.

Combined, Canada's federal, provincial and territorial governments spent nearly $15 billion on public prescription plans in 2017. This spending grew by 5.8% from 2016 – a rate of growth faster than physician services and more than double the rate of growth in hospital spending. The rate of growth in public spending also increased by 4.5% between 2015 and 2016 and by 9.3% the year before.[39] With the emerging use of expensive biologics, public expenditures are expected to continue to rise rapidly over the coming years.

In addition to public spending, the people of Canada pay more than $7 billion per year out of pocket for prescriptions required to stay healthy and survive.[40] Clearly, the public is already spending significant sums on pharmaceuticals through taxes, employee health benefit plan premiums and out-of-pocket expenses. Despite this substantial expenditure, not everyone is covered in Canada, and many of those living here lack access to needed prescription drug treatment. Without substantial reform to the current prescription drug system in Canada, these sums will continue to grow at a rate higher than they would under national pharmacare, exacerbating the current inequities in Canada's health system.[41]

Therefore, the question confronting Canadians and policymakers is not how much a comprehensive, single-payer pharmacare program would cost Canada overall, but rather what marginal increase in public spending is required to transform the current patchwork of public coverage into comprehensive universal coverage for Canada. With the overwhelming evidence pointing to between $4 and $11 billion in savings in health care dollars per year, resulting from the implementation of a national pharmacare program, there is a substantial incentive for governments to act now.[42,43,44,45]

Canada's Parliamentary Budget Officer (PBO) found that a single-payer system of coverage for a comprehensive national formulary (based on the Quebec formulary) would have a gross federal cost of between $22.3 billion (2018-2019), rising to $23.7 billion per year by 2020-2021.[46] This figure fails to account for savings of about $1.1 billion which would result from the elimination of direct federal spending on prescription drug coverage for certain specific populations (e.g., First Nations and Inuit persons, Veterans, members of the military, members of the Royal Canadian Mounted Police, refugees, and inmates in federal penitentiaries).[47] Thus, the net cost for 2018-2019 would be approximately $21.2 billion. In addition, the Quebec formulary, as previously noted, is vast (containing 8,000 medications), costly and wasteful, so the PBO numbers likely overestimate the true cost of comprehensive pharmacare employing a more judicious formulary size.[48] Anticipating a smaller formulary than Quebec's, and erring on the side of caution, it is reasonable to estimate that gross public expenditure on a single-payer, comprehensive and universal pharmacare system would be in the region of $20 billion per year. With yearly public expenditure already at, or near, $15 billion[49], overall public spending would only need to increase by roughly $5 billion annually to achieve our goal of providing national universal pharmacare.

This estimate is reinforced by data from the Parliamentary Budget Office and recent peer-reviewed publications in the *Canadian Medical Association Journal*. According to the former, a $7.3 billion incremental increase in public expenditure would universally cover the Quebec formulary of 8,000 medications for all of Canada.[50] According to the latter, $1.2 billion in additional public funding would cover the Essential Medicines list of 117 medications for all of Canada.[51] As we are aiming for a comprehensive formulary, modelled off of the Ontario list of 4,400 and applied nationally, a $5-billion-dollar additional public price tag is a reasonable estimate.

The establishment of such a pharmacare system would also require expenses to administer the program. As previously noted, Canada's nurses support the formation of a national pharmacare agency, at arm's length from the government and appropriately insulated from political and marketing pressures. Policymakers could look to Canadian Blood Services (CBS) for a model of such a national agency.[52] Similar to CBS, provinces and territories would delegate their authority to the agency, under the terms of a Memorandum of Understanding. The good news is that the new agency would not have to be built from the ground up. Public monies already fund the Patented Medicines Prices Review Board, Canadian Agency for Drugs and Technologies in Health, and the pan-Canadian Pharmaceutical Alliance to the tune of approximately $15 million,[53] $25 million[54] and $1.5 million[55] respectively every year. These agencies employ hundreds of highly and relevantly qualified personnel. This existing publicly funded capacity could be reimagined and re-deployed to form the national pharmacare agency.

The financial benefits of a universal, single-payer and comprehensive pharmacare system are myriad.

With the additional $5 billion in public spending, most of the more than $7 billion in out-of-pocket drug spending by Canadians would vanish. Moreover, the need for the approximately $10 billion dollars[56] spent by private health insurers on prescription drug coverage per year would greatly diminish.

As previously discussed, such a system would also improve the capacity to control drug prices, by employing stronger purchasing power, and result in reduced average prices in Canada. We need only consider that Canada has the third highest prices for prescription drugs in the world, in part because of our ineffectual multi-payer system. There are numerous stark examples illustrating the high price Canadians pay for prescription drugs, compared to similar countries with similar health care systems. Notably, Olanzapine, a common drug used to treat depression, bipolar disorder and schizophrenia, costs $70.88 per 100 tablets in Canada compared to $5.35 per 100 tablets in New Zealand (both values in Canadian dollars).[57]

Perhaps most importantly, patients in Canada would have access to the prescription medications they need regardless of income, employment status, age or location of residence. Savings to the health care system would accrue as universal pharmacare would reduce the number of overnight hospital stays by tens of thousands per year.[58] Finally, billions of dollars could be saved in health premiums, which could then be redistributed to create more good jobs.

With Canada's GDP nearing $2 trillion in 2017 and federal expenditure at $340 billion per year, the $5 billion required in additional public expenditure represents less than 1.5% of total federal spending. These figures further underscore the relatively small fiscal hurdle required to fully implement the program. Contrasting pharmacare with the federal government's recent rapid decision to purchase the Trans Mountain Pipeline for an estimated $9 billion, with additional costs of building the pipeline,[59] reveals that a $5-billion-dollar decision can be simply a matter of political priorities.

Nevertheless, the blueprint for national pharmacare in Canada still requires a plan to raise the modest sum of $5 billion to top up existing public spending on prescription drug coverage. Governments have numerous fiscal tools at their disposal to raise revenue to pay for programming for Canadians. While it is not the role of Canada's nurses to recommend which specific fiscal tool (or blend of tools) the government should to use, we will provide an example of options developed by Canadian economists for the consideration of the Advisory Council on the Implementation of National Pharmacare and the Government of Canada. These options also underscore the minimal degree of change needed to revenue streams to pay for pharmacare. The options also exist within the context of a fiscal framework that doesn't require more public borrowing.

The primary categories of revenue generation for the federal government are personal income taxes, business taxes and consumption taxes. Drawing on data generated by the PBO and the Institute for Fiscal Studies and Democracy[60] for the year 2020, we find that a 1% increase in each of these revenue streams is estimated to generate the following for the federal government:

Corporate Income Tax: (1% increase):	$1.8 billion
Personal Income Taxes, Marginal tax rate: (1% increase)	
Lowest:	$3.9 billion
Second:	$2.4 billion
Third:	$0.7 billion
Fourth:	$0.3 billion
Highest:	$0.4 billion
Goods and Sales Tax: (1% increase)	$8.5 billion

With the additional $5 billion in approximate public spending required to build universal, comprehensive, national pharmacare, only minor fiscal adjustments would be required to get there. Based on the above numbers, for example, national pharmacare would be easily achievable with a blended approach, such as a 0.5% increase in corporate income tax, a 0.5% increase in marginal personal income tax rate for the third, fourth and highest tax brackets, and a 0.5% increase in GST. In this example, total yearly federal revenue would surpass the $5 billion required to pay for the program. While others will determine the distributional impact of such a change, and whether it is the most progressive and efficient, this example simply serves to illustrate the minor and achievable changes required to fully fund national pharmacare.

Government could also offset the cost of pharmacare by targeting and reducing the roughly $1.6 billion in annual tax subsidies[61] to private health plans. Furthermore, other savings could be accrued, including from price reductions for drugs via single-payer bulk purchasing and reduced ER visits and hospitalizations as more patients properly adhere to their prescription drug treatment plans.

As nurses, we know that Canada's public health care system would benefit from a system of prescription drug coverage that would reduce instances of cost-related non-adherence to prescriptions. When our patients can't afford their medications, they fall ill, return to hospital and, often, their chronic conditions worsen. The evidence is clear that with proper coverage these daily tragedies can be prevented. It is for this reason that we unequivocally oppose the use of fees, such as co-payments or deductibles, within a national pharmacare program to generate revenue for the government. As evidenced in the greater health care system, user fees simply create financial barriers that prevent lower-income patients from accessing the care they need.

Part of the selling factor for the implementation of a national pharmacare program are the savings to workplaces that would be accrued as a result of the removal of most prescriptions from private health insurance plans. This potential boon is one of the reasons why businesses groups, such as the British Columbia Chamber of Commerce, have endorsed single-payer, national pharmacare.[62] Similarly, workers know that savings to premiums in the workplace can be bargained into better remuneration or more well-paid jobs. Workers also know that they will have more money in their pockets, with the elimination of significant out-of-pocket drug costs.

Conclusion

In summary, the implementation of national pharmacare is ultimately more of a political question than a fiscal one. With substantial savings ($4 to $11 billion) and efficiencies achievable under pharmacare across the entire health care system, the financial case is obvious. With hundreds to thousands of lives and tens of thousands of avertable instances of health deterioration at stake per year, the moral case for pharmacare is profound. Paying for the full roll-out of universal, single-payer and comprehensive pharmacare in Canada would require modest adjustments to existing revenue streams to raise an estimated $5 billion across the entire economy. A strong federal legislative framework would place responsibility squarely on the shoulders of the federal government to entice provincial and territorial ones to join the national program. Once undertaken, national pharmacare will generate enormous economic, health system and public health improvements, surpassing the small additional cost of running the program.

In closing, let us remember that the provision of universal, prescription drug coverage in Canada was always envisioned as a key plank of our public Medicare program. Our public health care system has come to occupy a profound place in our national identity and its extension to prescription drug coverage is both natural and imperative. As Canadians, we work together to ensure everyone receives the health care they need. Therefore, Canada's nurses urge the Advisory Council and the government of Canada to create a national pharmacare program as an emblem of the best of what our country can achieve.

Endnotes

[1] Lopert, R., Docteur, E., Morgan, S. (2018). *Body Count.* CFNU. Retrieved from https://nursesunions.ca/wp-content/uploads/2018/05/2018.04-Body-Count-Final-web.pdf

[2] Sanmartin, C., D. Hennessy, Y. Lu and M. R. Law *et al. (2014).* Trends in out-of-pocket health care expenditures in Canada, by household income, 1997 to 2009. Ottawa: Statistics Canada. April 2014.

[3] Parliamentary Budget Officer (PBO). (2017). *Federal Cost of a National Pharmacare Program*. Retrieved from http://www.pbo-dpb.gc.ca/en/blog/news/Pharmacare

[4] Angus Reid Institute. (2015). *Prescription Drug Access and Affordability an Issue for Nearly a Quarter of All Canadian Households*. Vancouver: Angus Reid Institute.

[5] Law, M. et al. (2018). The consequences of patient charges for prescription drugs in Canada: a cross-sectional survey. *CMAJ Open*. Retrieved from http://cmajopen.ca/content/6/1/E63.full

[6] House of Commons Standing Committee on Health. (2018). *Pharmacare Now: Prescription Medicine Coverage for all Canadians*. Retrieved from http://publications.gc.ca/site/eng/9.855506/publication.html

[7] Ibid.

[8] Goldman, D.P., Joyce, G.F., Zheng, Y. (2007). Prescription drug cost sharing: Associations with medication and medical utilization and spending and health. *Journal of the American Medical Association*. 2007 Jul 4;298(1):61-9.

[9] Barron, J. et al. (2008). Effect of Prescription Copayments on Adherence and Treatment Failure with Oral Antidiabetic Medications. P& T. 2008 Sep; 33(9): 532-536, 539-540, 553.

[10]Law, M. et al. (2018). The consequences of patient charges for prescription drugs in Canada: a cross-sectional survey. *CMAJ Open*. Retrieved from http://cmajopen.ca/content/6/1/E63.full

[11] Lopert, R., Docteur, E., Morgan, S. (2018). *Body Count.* CFNU. Lopert, R., Docteur, E., Morgan, S. (2018). *Body Count.* CFNU. Retrieved from https://nursesunions.ca/research/body-count/

[12] McKenzie, H. (2016). *Down the Drain: How Canada has wasted $62 billion health care dollars without pharmacare.* Retrieved from https://nursesunions.ca/wp-content/uploads/2017/05/Down_The_Drain_Pharmacare_Report_December_2017.pdf

[13] CIHI. (2017). *Information Sheet: Drug Spending at a Glance,* 2017 Retrieved from https://www.cihi.ca/sites/default/files/document/nhex2017-drug-infosheet-1-en.pdf

[14] Gagnon, M.-A. (2014). *A Roadmap to a Rational Pharmacare Policy in Canada.* CFNU. Retrieved from https://nursesunions.ca/wp-content/uploads/2017/05/Pharmacare_FINAL.pdf

[15] Organization for Economic Co-operation and Development. OECD Health Statistics 2017. Based on data assembled by the Canadian Institute for Health Information (CIHI).

[16] Parliamentary Budget Officer (PBO). (2017). *Federal Cost of a National Pharmacare Program*. Retrieved from http://www.pbo-dpb.gc.ca/en/blog/news/Pharmacare

[17] Advisory Council on Pharmacare. (2018). A Discussion Paper. Retrieved from https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/implementation-national-pharmacare/discussion-paper.html

[18] Ibid.

[19] Canadian Health Coalition. (2016). Brief to HESA for the Study of the Development of a National Pharmacare Program. Retrieved from http://www.ourcommons.ca/Content/Committee/421/HESA/Brief/BR8290924/br-external/CanadianHealthCoalition-2016-05-16-e.pdf

[20] Morgan, S. et al. (2016) Frequency and cost of potentially inappropriate prescribing for older adults: a cross-sectional study. *CMAJ Open* 4(2): E46-51.

[21] Gagnon, M.-A. (2018). Pharmacare: improving access to expensive drugs. Impact Ethics. August 3, 2018, in *Law & Policy*, *Pharmaceuticals*, *Public Health*, *Science and Technology*. Retrieved from https://impactethics.ca/2018/08/03/pharmacare-improving-access-to-expensive-drugs/

[22] BC Chamber of Commerce. (2016). Economic Benefits of Universal Pharmacare for Businesses. Retrieved from: http://www.bcchamber.org/policies/economic-benefits-universal-pharmacare-businesses

[23] http://www.aplanforeveryone.ca/

[24] Ivanova, I. (2017). *Poverty and Inequality among British Columbia Seniors*. Canadian Centre for Policy Alternatives. Retrieved from https://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2017/04/ccpa-bc_seniors-inequality.pdf

[25] Law, M. et al. (2018). The consequences of patient charges for prescription drugs in Canada: a cross-sectional survey. *CMAJ Open*. Retrieved from http://cmajopen.ca/content/6/1/E63.full

[26] Angus Reid Institute. (2015). *Prescription Drug Access and Affordability an Issue for Nearly a Quarter of All Canadian Households*. Vancouver: Angus Reid Institute.

[27] Morgan, S., Daw, J, Law, M. (2014). *Are income-based public drug-benefit programs fit for an aging population?* Retrieved from http://www.bccare.ca/wp-content/uploads/IRPP-Report-Dec-2014.pdf

[28] Ivanova, I. (2017). *Poverty and Inequality among British Columbia Seniors*. Canadian Centre for Policy Alternatives. Retrieved from https://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2017/04/ccpa-bc_seniors-inequality.pdf

[29] Morgan, S., Daw, J, Law, M. (2014). *Are income-based public drug-benefit programs fit for an aging population?* Retrieved from http://www.bccare.ca/wp-content/uploads/IRPP-Report-Dec-2014.pdf

[30] UBC. (2017). A lesson for Canada: Quebec pharmacare system creates winners and losers. Retrieved from https://news.ubc.ca/2017/10/10/a-lesson-for-canada-quebec-pharmacare-system-creates-winners-and-losers/

[31] Gagnon, M.-A. (2015). Quebec should not be the model for national health pharmacare. *Globe and Mail*. June 26, 2015. Retrieved from https://www.theglobeandmail.com/opinion/quebec-should-not-be-the-model-for-national-pharmacare/article25135678/

[32] Angus Reid Institute. (2015). *Prescription Drug Access and Affordability an Issue for Nearly a Quarter of All Canadian Households*. Vancouver: Angus Reid Institute.

[33] Gagnon, M-A. (2015). Quebec should not be the model for national health pharmacare. Globe and Mail. June 26, 2015. Retrieved from https://www.theglobeandmail.com/opinion/quebec-should-not-be-the-model-for-national-pharmacare/article25135678/

[34] Testimony by Dr. Danielle Martin, Vice-President, Medical Affairs & Health System Solutions, Women's College Hospital at the Standing Committee on Health. (2016, April 18). Retrieved from http://www.ourcommons.ca/DocumentViewer/en/42-1/HESA/meeting-7/evidence

[35] Ibid.

[36] The federal budget as tabled in the House of Commons. (2018, February 27). *Equality + Growth: a strong middle* class. Retrieved from https://www.budget.gc.ca/2018/docs/plan/budget-2018-en.pdf

[37] Department of Finance. *Federal Support to Provinces and Territories.* Retrieved from https://www.fin.gc.ca/fedprov/mtp-eng.asp

[38] Institute of Fiscal Studies and Democracy. (2018). *National Pharmacare in Canada: Choosing a Path Forward.* Ottawa: University of Ottawa.

[39] Canadian Institute for Health Information (CIHI). (2017). *Prescribed Drug Spending in Canada, 2017 A Focus on Public Drug Programs*. Ottawa: Author.

[40] Parliamentary Budget Officer (PBO). (2017). *Federal Cost of a National Pharmacare Program*. Ottawa: Author. Retrieved from http://www.pbo-dpb.gc.ca/en/blog/news/Pharmacare

[41] Morgan, S.G., D. Martin, MA Gagnon, B Mintzes, J.R. Daw, and J. Lexchin. (2015) Pharmacare 2020: The future of drug coverage in Canada. Vancouver, Pharmaceutical Policy Research Collaboration, University of British Columbia.

[42] Ibid.

[43] Gagnon, M-A. (2014). *A Roadmap to a Rational Pharmacare Policy in Canada.* CFNU. Retrieved from https://nursesunions.ca/wp-content/uploads/2017/05/Pharmacare_FINAL.pdf

[44] Parliamentary Budget Officer (PBO). (2017). *Federal Cost of a National Pharmacare Program*. Ottawa: Author. Retrieved from http://www.pbo-dpb.gc.ca/en/blog/news/Pharmacare

[45] Morgan, S.G., M. Law, J. R. Daw, L. Abraham and D. Martin. (2015). Estimated Cost of Universal Public Coverage of Prescription Drugs in Canada. *Canadian Medical Association Journal* (CMAJ), 187(7): 491–97. doi:10.1503/cmaj.141564.

[46] Parliamentary Budget Officer (PBO). (2017). *Federal Cost of a National Pharmacare Program*. Ottawa: Author. Retrieved from http://www.pbo-dpb.gc.ca/en/blog/news/Pharmacare

[47] Parliamentary Budget Officer (PBO). (2017). *Federal Cost of a National Pharmacare Program*. Ottawa: Author. Retrieved from http://www.pbo-dpb.gc.ca/en/blog/news/Pharmacare

[48] House of Commons Standing Committee on Health. (2018). Pharmacare Now: Prescription Medicine Coverage for all Canadians. Retrieved from http://publications.gc.ca/site/eng/9.855506/publication.html

[49] Canadian Institute for Health Information (CIHI). (2017). *Prescribed Drug Spending in Canada, 2017 A Focus on Public Drug Programs*. Ottawa: Author.

[50] House of Commons Standing Committee on Health. (2018). Pharmacare Now: Prescription Medicine Coverage for all Canadians. Retrieved from http://publications.gc.ca/site/eng/9.855506/publication.html

[51] Morgan, S.G., M. et al. (2017). Estimated effects of adding universal public coverage of an essential medicines list to existing public drug plans in Canada. CMAJ February 27, 2017 189 (8) E295-E302; DOI: https://doi.org/10.1503/cmaj.161082

[52] Flood, C. et al. (2018). Universal Pharmacare and Federalism: Policy Options for Canada. Ottawa: IRPP. Retrieved from

http://irpp.org/research-studies/universal-pharmacare-and-federalism-policy-options-for-canada/

[53] Patented Medicines Price Review Board. http://www.pmprb-cepmb.gc.ca/view.asp?ccid=1380

[54] Canadian Agency for Drugs and Technologies in Health (CADTH). (2018). Financial Statements. https://www.cadth.ca/sites/default/files/corporate/planning_documents/CADTH-FS-FY17-18-e.pdf

[55] Pan-Canadian Pharmacetuical Alliance. (2016). Memorgandum of Understandng. Retrieved from https://francophonie.sqrc.gouv.qc.ca/VoirDocEntentes/AfficherDoc.asp?cleDoc=11814205612124017204322222815502124821507202119 3

[56] CIHI. (2017). *Information Sheet: Drug Spending at a Glance,* 2017 Retrieved from https://www.cihi.ca/sites/default/files/document/nhex2017-drug-infosheet-1-en.pdf

[57] Ahopia, Vik. (2018, February 3). The real story behind the sudden drop in Canada's drug prices. CBC: Second Opinion. Retrieved from https://www.cbc.ca/news/health/second-opinion-february-3-2018-1.4517468

[58] Lopert, R., Docteur, E., Morgan, S. (2018). *Body Count.* CFNU. Retrieved from https://nursesunions.ca/wp-content/uploads/2018/05/2018.04-Body-Count-Final-web.pdf

[59] Global News. (2018, April 7). Cost to twin Trans Mountain pipeline now $1.9B higher, Kinder Morgan says. Retrieved from https://globalnews.ca/news/4374822/trans-mountain-cost-higher/

[60] Institute for Fiscal Studies and Democracy. 2018. Internal document.

[61] Flood, C. et al. (2018). Universal Pharmacare and Federalism: Policy Options for Canada. Ottawa: IRPP. Retrieved from http://irpp.org/research-studies/universal-pharmacare-and-federalism-policy-options-for-canada/

[62] BC Chamber of Commerce. (2016). Economic Benefits of Universal Pharmacare for Businesses. Retrieved from http://www.bcchamber.org/policies/economic-benefits-universal-pharmacare-businesses