RNAO submission re Bill C-64 to the Standing Senate Committee on Social Affairs, Science and Technology

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The Registered Nurses' Association of Ontario (RNAO) is the professional association representing registered nurses (RN), nurse practitioners (NP) and nursing students in all roles and sectors across Ontario. Since 1925, RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contributions to shaping the health system, and influenced decisions that affect nurses and the public we serve.

RNAO welcomes the opportunity to express our support for Bill C-64, An Act Respecting Pharmacare, to the Senate Standing Committee on Social Affairs Science and Technology and thanks committee members for their attention to our views on the matter. RNAO asks the committee to send Bill C-64 back to the Senate floor unamended and with your full endorsement. Furthermore, we ask that you urge the Senate to pass the bill and move it forward with haste for royal assent.

Introduction

RNAO has long advocated for pharmacare, recognized for decades as a missing piece in Canadian medicare.[1]

Sixty years ago, the Royal Commission on Health Services, also known as the "Hall Commission", recognized the high cost of life-saving, life-sustaining and disease-preventing drugs and called for prescription drugs to be part of Canadian medicare.[2] Yet, according to the Advisory Council on the Implementation of National Pharmacare (the Advisory Council), every major study of the Canadian health system from 1964 through to their report in 2019 commented on the continued lack of pharmacare[3], with gaps continuing today. As nurses, we see daily the detrimental effects of these gaps on the health of those we care for.

As the Advisory Council noted: "Prescription drugs are a vital part of health care, helping patients to manage and cure disease. But unlike other foundational pillars of medicare – doctors and hospitals – prescription drugs used outside of hospitals are not part of basic health insurance. In this respect, Canada is unique among all other industrialized countries with universal systems of public health care coverage."[4]

The recent advent of Bill C-64 – although limited to coverage of specific prescription drugs and related products intended for contraception or the treatment of diabetes – does show meaningful progress in addressing this shortfall. And, the bill creates some of the institutions needed for a meaningful expansion of pharmacare across Canada. For example, it sets out powers and obligations of the Minister of Health with respect to the development of a national formulary and a national bulk purchasing strategy thereby laying the groundwork for the number of reimbursed drugs to be expanded and for costs to go down.

Altogether, Bill C-64 represents a very real and meaningful step toward a full pharmacare program and an expansion of medicare that will see Canada – at long last – catch up with our counterparts in other industrialized countries. So, it's time to affirm Canada's commitment to pharmacare and to continue to build upon the foundation of a universal system of publicly-funded health care laid so long ago in our country. We urge you to send Bill C-64 back to the Senate floor unamended and with your full endorsement.

Bill C-64 and the progressive realization of the right to health care

RNAO believes that health is a resource for everyday living and that health care is a universal human right. We respect human dignity and are committed to diversity, inclusivity, equity, social justice, and democracy. In these beliefs, we follow the World Health Organization [5] and multiple international conventions, including the Universal Declaration of Human Rights [6] and the International Covenant on Economic, Social, and Cultural Rights [7]. Bill C-64 is a significant step forward in the progressive realization of the right to the opportunity, equal with other individuals, to make for oneself the life that they are able and wish to have. That opportunity depends on the provision of health care, including, as Justice Hall put it in 1964, life-saving, life-sustaining and disease-preventing drugs. Bill C-64 begins a process of increasing access to prescription drugs in Canada.

Current structure of drug coverage and access to prescription drugs

As outlined by Carleton University's Marc–André Gagnon in his submission to this committee,[8] the current structure of drug coverage in Canada is highly fragmented. Canada's 100 public drug plans and 100,000-plus private plans form a confusing patchwork of coverage with yawning gaps through which many Canadians fall. Thirty-nine percent of prescription drug expenditures in Canada are covered through public provincial and territorial plans. All such plans cover seniors and social assistance recipients, though in different ways and to a different extent. The federal government also has a drug plan that includes First Nations people and Inuit as well as the military, the RCMP and refugees. Federal expenditures account for just three per cent of total drug expenditures in Canada.

In total, Canada's public expenditures on prescription drugs are the fourth-lowest amongst member countries in the Organization for Economic Co-operation and Development (OECD) – just ahead of Poland, Bulgaria and Chile – leaving lots of room for private insurers to fill the gap. Private drug plans, mainly provided by employers, account for an additional 37 per cent of total drug expenditures in Canada. Of course, drug expenditures covered by private insurance plans most often have to be supplemented to some extent by co-payments and deductibles. These types of payments form part of the 20 per cent of total drug expenditures that come out of the pockets of Canadians. Out of pocket expenditures also include prescription drug expenditures that are not covered by public or private insurance formularies and the prescription drug expenditures of Canadians who have no coverage at all. One in five Canadians (21 per cent) fall into the latter category, reporting zero prescription drug coverage. As Gagnon notes, "Consequently, access to medicines is still conceived of in terms of privileges offered by employers to employees."[9]

Current cost of drugs and access to prescription drugs

Access to prescription drugs in Canada is further limited by their very high cost in this country. As Gagnon states, "Canada is characterized by both high costs per capita for prescription drugs and a significant proportion of the population who cannot access the drugs they need."[10] Canada ranks third among the 38 member countries belonging to the OECD in per capita expenditures on pharmaceutical goods. That high per capita cost burden is due to the fact that the price of patented drugs in Canada is second highest in the world, with prices 28 per cent more expensive than the OECD median. Moreover, the price of generics is 45 per cent more expensive than the OECD median.

Many Canadians do not fill the prescriptions they need, or skip or lower doses, due to the high costs of medication:

- A 2024 national poll reported that nearly one in four Canadians – 22 per cent – split pills, skipped doses, or did not fill or renew a prescription due to cost.[11]
- A 2022 study canvassing pharmaceutical access and use during the pandemic reported that more than 10 per cent of Canadians were not filling prescription doses or were skipping doses.[12]

Cost-related non-compliance with prescriptions creates an enormous health burden and an enormous burden on the health system. As Justice Hall said after releasing his seminal report, "The only thing more expensive than good health care is no health care."[13] The facts 60 years later: 10 per cent of Canadians with chronic conditions end up in the emergency room due to worsening health because they were unable to afford prescription medications[14], and more than 600 people die every year in Canada from ischemic heart disease because they cannot afford their medications. As noted by the Advisory Council in 2018 – proving Justice Hall right – extinguishing out-of-pocket expenses for just three health problems (diabetes, cardiovascular disease and chronic respiratory conditions) would result in a potential savings of $1.2 billion realized from at least 220,000 fewer visits to emergency rooms and 90,000 fewer hospitalizations.[15]

The evidence is clear: failing to invest in universal prescription drug coverage results in preventable deaths and makes people's health worse. Cost-related non-compliance with prescriptions contributes to the premature deaths of up to 640 Canadians with ischemic heart disease and up to 420 premature deaths among working-age Canadians with diabetes every year.[16] And, tens of thousands of Canadians aged 55 years or older suffer cost-related or non-compliance-related health deterioration each year.[17]

Access to diabetes medications and devices

Bill C-64 will increase access to necessary medications and devices for the 3.7 million people in Canada – 9.4 per cent of the population – living with diagnosed diabetes. As reported by the Library of Parliament, this number has doubled over the past decade and is expected to continue to rise.[18] In addition to the increased number of people diagnosed with diabetes, the number of diabetics using medication to control diabetes has also been increasing over the years.[19] As of 2019, nearly three-quarters of adults diagnosed with diabetes used medication to control the disease. In 2015, one in four Canadians with diabetes reported that drug costs affected their adherence to their treatment plan.[20]

In Ontario, insufficient drug coverage has been a factor in thousands of avoidable deaths of diabetics under the age of 65. RNAO's best practice guideline, *Assessment and Management of Foot Ulcers for People with Diabetes*, outlines the implications of not minimizing complications related to diabetes, including enormous societal costs and burdens on the health system and social services.[21] A study has shown that mortality rates drop when people with lower incomes living with diabetes qualify of medication under the Ontario Drug Benefit plan at age 65.[22] It has been estimated that first-dollar coverage for diabetes products could save over 700 lives annually in Ontario alone.[23]

Access to contraceptive medications and devices

According to Health Canada, "cost has been identified by Canadian contraceptive care providers as the single most important barrier to access to these medications."[24] It is estimated that there are more than 9 million people in Canada of reproductive age – nearly 25 per cent of the total population. At present, only a fraction of this population is covered for contraceptives through a public drug plan.

The high cost of contraceptive drugs in Canada – estimated at $300 per year for oral contraceptives and up to $500 for an intrauterine device – inhibits use, compromises reproductive rights and increases the risk of unintended pregnancies. One U.S. study found that providing free contraceptives could reduce unplanned pregnancies by 32 per cent.[25] Conversely, Health Canada points to studies that have demonstrated that publicly funded no-cost universal contraception can result in public cost savings.[26] One example: No-cost contraception could save the British Columbia health-care system approximately $27 million per year.[27]

The cost-saving potential of universal, single-payer pharmacare

Many studies point to the net cost savings of universal, publicly-funded, single-payer pharmacare, as recommended in the Advisory Council's 2019 report.[28]

The Advisory Council anticipated an initial cost of $3.5 billion to launch a national program with universal coverage for essential medicines only.[29] Over time, that cost to government, with the implementation of a comprehensive formulary, was anticipated to grow to $15.3 billion.[30]

In this case, however, big investments will lead to big rewards – and net savings – for Canadians. The Advisory Council estimated net savings in system-wide spending on pharmaceutical drugs of $5 billion per year.[31] The Parliamentary Budget Office arrived at a similar conclusion.[32] Even with anticipated public sector costs of $13.4 billion by 2027–2028, pharmacare would provide a net benefit of $2.2 billion to Canadians.[33]

Much of the net savings from pharmacare come from increased bargaining power under a single-payer system.[34] One estimate shows that confidential rebates secured by public drug plans are equivalent to 20 – 29 per cent of the official price of patented drugs.[35] This represents $3.9 billion annual savings on only 42 per cent of total drug expenditures in Canada. Annual savings would be much greater with a single payer that also purchased for the one in five Canadians who currently have no coverage at all.

We note that the power and interests of private drug plans are vastly different. Rebates, when secured, are only a fraction of those obtained by public drug plans; they generally translate into profit for shareholders, not lower costs for the insured.[36] Indeed, co-payments and deductibles continue to be based on "official" – not rebated – drug prices.[37]

Equitable access to health and health care

Coverage for prescription drugs and related products intended for contraception or the treatment of diabetes will increase equitable access to health and health care and demonstrate more broadly the potential of pharmacare to realizing the right to health and health care. Health Canada tells us that contraceptives were included in Bill C-64 "specifically because improved access to contraception improves equality… Some populations are disproportionally affected by the lack of coverage. Women, people with low incomes and young people, all of whom are all more likely to work in part-time or contract positions, often lack access to private coverage. One study found that women and girls from lower-income households are more likely to use less-effective contraceptive methods or no contraceptive method."[38]

Similarly, coverage of drugs and products related to the treatment of diabetes will advance the right to health and health care. Broadly speaking, we know that the cost of prescription drugs land unequally on people in Canada; immigrants and racialized persons are less likely to have insurance to cover costs of medications. Specifically:

- more immigrants (29 per cent) than non-immigrants (17 per cent) reported a lack of coverage for medication, and
- more racialized persons (29 per cent) than non-racialized, non-Indigenous persons reported a lack of coverage for medication.[39]

Similarly, health outcomes or disease incidence tends to land unequally on the population: a key example is diabetes. Health Canada advises that diabetes disproportionately affects certain populations within Canada. Evidence shows that First Nations and Métis people, and people of African, East Asian and South Asian ethnic backgrounds have higher rates of Type 2 diabetes compared to the general population.[40]

Conclusion

Sixty years have passed since the Royal Commission on Health Services outlined the need to include the cost of pharmaceutical drugs under medicare in Volume 1 of its extensive report. Although called the "Hall Commission" (after its chair, Justice Emmett Hall), one of the six other eminent commissioners was Dr. Alice Girard, a registered nurse. And, Justice Hall and Dr. Girard worked together again on the 1979 Health Services review [41] which cemented medicare into Canada's social safety net.

As nurses do, Dr. Girard went about her important business quietly and to great effect. One can easily see the nursing perspective in these two seminal reports from the 20th century. The work of nurses across Canada is a daily reminder of the value of universally accessible and publicly-funded health services. Yet, our 21st century nurses continue to see daily the harms that result when the people they give care to cannot afford or access the medications and medical supplies they need to get and stay well.

As outlined above, the commitment to cover diabetes and contraception medications and supplies is a promising start – but much more is needed to ensure all Canadians can access the medications they need when they need them. Continued failure to invest adequately and broadly in pharmacare will cost lives. The government has an important role to play in making the upfront investments needed that will ensure the longer-term prices and savings sorely needed in a country in which people pay the third-highest amount on prescription drugs per capita.

Our nurses know that health inequities will persist as long as health care – including universal, single-payer pharmacare – is not fully and universally available and accessible in this country. Women, young people, seniors and equity-seeking groups who have less access to jobs that would provide them private drug coverage will all pay a steeper price down the road.

Bill C-64 is an opportunity to take a significant step forward in the progressive realization of the right to health care. We urge you to move the Bill back to the Senate floor, unamended, with haste.

References

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[2] Government of Canada. (2018). *Towards Implementation of National Pharmacare: Discussion Paper*. P.31 https://www.canada.ca/content/dam/hc-sc/documents/corporate/publications/council_on_pharmacare_EN.PDF,

[3] See above note 2.

[4] See above note 2.

[5] See for example: WHO. (2017). Access to essential medicines as a part of the right to health. Retrieved from: http://www.who.int/medicines/areas/human_rights/en/; WHO. (2014). Access to essential medicine. Geneva: World Health Assembly. WHA67.22. Retrieved from: http://apps.who.int/medicinedocs/documents/s21453en/s21453en.pdf

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[7] United Nations Human Rights Office of the High Commissioner. (2017). International Covenant on Economic, Social and Cultural Rights. Retrieved from: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx

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[9] See above note 8 at page 2.

[10] See above note 8 at page 10.

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[15] See above note 3 at page 16.

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[18] Library of Parliament. (2024) *Legislative Summary: Bill C:64: An Act Respecting Pharmacare* – Preliminary Version (Unedited). (April 15.) Retrieved from: https://lop.parl.ca/staticfiles/PublicWebsite/Home/ResearchPublications/LegislativeSummaries/PDF/44-1/PV_44-1-C64-E.pdf

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[21] RNAO. (2013.) *Assessment and Management of Foot Ulcers for People with Diabetes* (2nd ed.). Pages 15-16. Available at: https://rnao.ca/bpg/guidelines/assessment-and-management-foot-ulcers-people-diabetes-second-edition

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[28] See for example: Royal Commission on Health Services (Hall Commission). (1964). Volume 1 – 1964. Print only with online reference here: https://www.canada.ca/en/health-canada/services/health-care-system/commissions-inquiries/federal-commissions-health-care/royal-commission-health-services.html; National Forum on Health. (1997.) *Canada Health Action: Building on the Legacy – Volume I – The Final Report.* Retrieved from: https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-renewal/canada-health-action-building-legacy-volume1.html; Commission on the Future of Health Care in Canada (Romanow Commission). (2002.) *Building on Values: The Future of Health Care in Canada*. Print only per web reference: https://www.canada.ca/en/health-canada/services/health-care-system/commissions-inquiries/federal-commissions-health-care/commission-future-health-care-canada-romanow-commission.html; Standing Committee on Health. (2018.) *Pharmacare Now: Prescription Medicine Coverage For All Canadians*. Retrieved from: https://www.ourcommons.ca/DocumentViewer/en/42-1/HESA/report-14

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[30] See above note 2 at page 14.
[31] See above note 2 at page 92.
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