RNAO QPOR QUEEN's PARK ON THE ROAD 2018

Universal pharmacare

RNAO urges the province to support a national pharmacare program covering all medically necessary drugs without means testing, user fees or co-payments for Ontarians of all ages. Do you agree with RNAO?

Drug coverage in Ontario and Canada

Every developed country with a universal health-care system provides universal coverage of prescription drugs except for Canada.[1] Most Canadians do not have access to public drug coverage, and the lack of common purchasing of pharmacare means that we face some of the highest drug prices in the developed world. Canadians pay about 35 per cent more than the median for countries in the Organization for Economic Co-operation and Development (OECD),[2] and Canada has the highest per capita drug expenditure in the OECD after the U.S.[3] It is thus not surprising that public drug spending in Ontario had risen to 9.4 per cent of the 2017 health budget – up from 1.2 per cent in 1975.[4] [5]

In the absence of a national pharmacare program, many Ontarians rely on a patchwork of existing public drug plans,[6] and the rest have to pay personally or obtain private insurance. Currently, the Ontario Drug Benefit Program covers seniors, people receiving social assistance, and participants in the Ontario Disability Support Program, while the Trillium Drug Program subsidizes those whose drug costs are high relative to their income.[7] [8] [9] Ontario also offers a number of smaller programs that address specific drug needs.[10] In 2017, 40.8 per cent of Ontario prescription expenditures were covered by the provincial government, 1.2 per cent by the federal government, and 0.4 per cent by the Workplace Safety and Insurance Board. The other 57.6 per cent was paid by private insurers and out-of-pocket by the public.[11]

The lack of universal pharmacare today forces those who are living with low or modest incomes without access to adequate drug coverage to either go without medication, pay out-of-pocket instead of purchasing other life necessities such as food, or go into debt.[12] [13] Law et al., writing in the Canadian Medical Association Journal (CMAJ), found that one in 10 Canadians receiving prescriptions reported they did not adhere to them because of the cost.[14] A 2015 Angus Reid survey found that in the past year, 23 per cent of respondents reported they, or another member of their household, did not take drugs as prescribed due to cost.[15] Numerous international studies have also confirmed the health consequences of people not filling prescriptions due to cost.[16] [17] [18] [19] [20] [21]

Health effects of not having access to medications

The inability to pay for medications can cause significant health problems, and in some cases, can be fatal. For example, in Ontario, insufficient drug coverage has been a factor in thousands

of avoidable deaths among those with diabetes under the age of 65. Mortality rates drop when people with lower incomes living with diabetes reach 65 because their medication is then covered under the Ontario Drug Benefit program (ODB).[22] [23] While pharmacare would benefit all Ontarians, research shows it is particularly important for people with lower incomes, no matter what their health conditions.[24] [25] [26] [27] [28] [29] [30] A 2018 survey of 28,091 Canadians concluded that out-of-pocket charges made drugs unaffordable for 8.2 percent of Canadians who had prescriptions. It also concluded that people facing out-of-pocket expenses were foregoing other necessities, and as a result, were using additional insured health services.[31]

Cost advantages of universal pharmacare

Potential savings for Canadians from pharmacare are significant. Gagnon and Hébert estimate $10.7 billion in annual savings (or 42.8 per cent of total Canadian spending on prescription pharmaceuticals) from an aggressive national pharmacare program.[32] A 2015 CMAJ article estimated the expected savings at $7.3 billion in a baseline scenario.[33]

Savings to individuals, families, businesses, and the health-care system from pharmacare would come from:

- Reduced administrative, marketing and regulatory costs due to a single-payer system.
- Avoiding diversion of money into profits.
- More effective, evidence-informed prescribing.
- Use of purchasing power to reduce excessive drug prices.
- More efficient use of health system resources (uninsured services tend to be underused because of affordability concerns, which leads to an increased risk of costly health complications).

With respect to diversion into profits, that happens both in the pharmaceutical market and the health insurance market. The private health insurance market in Canada is dominated by for-profit firms – 80 per cent by a 2008 estimate.[34] It is not a very good deal for Canadians, who are paying more for less: Canadians pay a great deal in drug premiums and the share they get back in the form of benefits has been dropping sharply. In the case of Canadian group plans, that benefit share dropped from 92 per cent to 74 per cent between 1991 and 2011. For people on individual plans, the share dropped from 46 per cent to 38 per cent over the same period.[35] The rising spread between insurance company revenue and benefits paid out (8 per cent for individual plans to 26 per cent for group plans) reflects insurance administration costs plus diversion to profits. A national pharmacare program would direct this money into more comprehensive drug coverage.

A national pharmacare program would also provide the government with more bargaining power to counter the monopoly power enjoyed by drug manufacturers due to strong patent protections. Without that bargaining power, we face high drug prices (For example, in January 2018, net margins of US biotechnology drug companies were estimated at 12.57 per cent and those of pharmaceutical drug companies were estimated at 14.05 per cent. That contrasts with a net margin of 7.90 per cent for all sectors.[36]). These high drug prices affect everyone: consumers, who pay out of pocket; employers and others who pay group or individual drug insurance premiums; and government, which provides public drug insurance.

Pharmacare would address other dimensions of affordability for government. Our current multi-payer system shifts costs from the private sector to the public sector. For example, the government ends up insuring the highest risk people who are not working due to age or illness, with the lower risk people being picked up by private insurers through employment. In the case of Quebec, 30 per cent of those enrolled in private plans are public sector employees, which is an indirect public subsidy to private insurers. On top of that, federal tax subsidies amount to 13 percent of private drug plan expenditures.[37] Quebec has compulsory drug insurance, requiring its residents to enrol in private or public plans; this promotes a multi-payer system. Small wonder that in Quebec "the system remains inequitable, inefficient and unsustainable, according to a recent official report by the [Quebec] Commissaire à la santé et au bien-être."[38 39]

There is also an important competitive advantage to having universal pharmacare, as it would lower health insurance costs for Ontarian or Canadian employers and put them in a better position relative to international competitors. A recent estimate put the potential cost savings to Canadian employers of pharmacare at $1 per hour per worker, in addition to the $4 cost advantage they already enjoy due to Canadian Medicare.[40]

Evidence-based prescribing

A public single-payer pharmacare program is a necessary condition for Canadians to get access to the right drugs, but it is not sufficient. It is also critical that a national pharmacare program have an evidence-based formulary and guidance be provided on optimal prescribing.[41 42] This would pool information on safety, effectiveness and cost, and would be important when dealing with the growing pool of drugs targeted at rare diseases. In these cases, the evidence is based on very small samples and manufacturers supply the studies while exerting strong lobbying pressure for coverage of very expensive drugs.[43] More generally, all health system practice should be guided by evidence. As *Choosing Widely Canada* notes, citing the Canadian Institute for Health Information, "up to 30% of tests, treatments, and procedures in Canada are potentially unnecessary."[44]

Two competing funding models

While the single-payer model is superior in terms of efficiency, cost and access, the mixed public and private funding model de facto prevails across the country and it still has proponents who see the government as providing the role of insurer of last resort. This is the model by design in Quebec, and it is the direction that the current government in Ontario is taking.[45]

On the face of it, it might seem to be cheaper for governments to let employers do the heavy lifting and fill in coverage gaps for those who don't have private drug insurance. To the contrary however, research published in the CMAJ on the Quebec model is sobering.[46 47] As noted above, Quebec has a compulsory drug insurance system with multiple payers – private and public. Compulsory drug insurance did increase the compliance rate on prescribing by reducing out-of-pocket costs, but Quebec compliance is worse than in countries that had lower out-of-pocket costs. That is because large deductibles, copayments and drug insurance premiums add significant costs to Quebecers with government drug insurance.[48 49]

While resulting improvements in access to pharmaceuticals in Quebec were disappointing, the story on per capita costs was unambiguously bad. As the BC Chamber of Commerce noted in its

explanation of the economic benefits of universal pharmacare for businesses, private employers and households in Quebec now spend $200 more per capita than their counterparts in the rest of the country.[50] Not only is Quebec foregoing the benefits of negotiating for more reasonable drug prices, it is also foregoing all the savings on administration costs: while administrative costs represent 1.7 per cent of public insurance costs, they represent 18 percent of private insurance costs.[51]

Support for pharmacare

RNAO has long advocated for a national pharmacare program,[52] [53] [54] [55] [56] [57] and continues this advocacy in the media[58] [59] and in action alerts responded to by our members.[60] [61] [62] RNAO also advocated for a provincial pharmacare program as the first step towards a national pharmacare program.[63]

An impressive list of other organizations is calling for a national pharmacare program, including: the Canadian Federation of Nurses Unions,[64] [65] Ontario Nurses Association,[66] Canadian Nurses Association,[67] Canadian Doctors for Medicare,[68] [69] Canadian Medical Association,[70] Standing Senate Committee on Social Affairs, Science and Technology,[71] Canadian Health Coalition,[72] [73] [74] the Council of Canadians,[75] and Canadian Association of Retired Persons.[76] [77] Members of the public have also expressed remarkably strong support for a universal pharmacare program, as public polling on the topic of pharmacare indicates.[78] [79] [80] [81]

The federal and provincial terrain

After the October 2015 election, the federal political context changed and pharmacare advocates looked to Ottawa for leadership on this issue. In January 2016, federal and provincial/territorial health ministers met in Vancouver to lay the groundwork for a new Health Accord, and they promised to work together on drug policy.[82] In 2016-17, the federal House of Commons Standing Committee on Health held hearings on the development of a national pharmacare program,[83] and concluded that it was time to implement a pharmacare program that would provide universal access to essential medications, without means testing, user fees or co-payments.

In the spring of 2017, two Ontario parties – Liberals and NDP – offered competing provincial pharmacare strategies. The Liberals' pharmacare plan ("OHIP+"),[84] which was announced as part of their 2017 budget, [85] and paid the full costs of all 4,400[86] prescription drugs covered under the ODB program for children and youth under age 25, with no co-payments or deductibles.[87] While this was an excellent start towards universal pharmacare, it resulted in a three-tiered program with free medication for those under 25; coverage with deductibles and co-payments for those on the Ontario Disability Support Program (ODSP), and on Ontario Works (OW) and for seniors;[88] and no coverage (other than private insurance) for the remainder of Ontarians from 25 and 64. The Liberals announced they would invest $465 million in pharmacare, with the program starting Jan. 1, 2018.[89]

The proposed NDP pharmacare plan committed to cover the "most common and essential 125 drugs" for all Ontarians,[90] [91] but this is only a fraction of the 4,400 medications covered under the Ontario Drug Benefit (ODB) program. The NDP plan would cap co-payments at the level currently available under the ODB program.[92] The NDP said independent experts would develop

the list of covered drugs, and that it would expand over time. They also indicated the program will cost $475 million, and could be fully implemented by 2020.[93]

RNAO welcomed both commitments as steps forward, and called for a plan that incorporates the best features of each: pharmacare for the entire population with full coverage and no co-payments or deductibles of all prescription drugs currently listed under ODB.[94] Should Ontario adopt such a program, there would be a strong potential for ripple effects across the country.[95] Canada needs leadership to move toward the national plan that everyone wants,[96] and taking this step in Ontario could be the necessary push.

The June 7, 2018 election of the Progressive Conservative Party in Ontario ushered in a very different pharmacare regime. On June 30, the Minister of Health announced that OHIP+ would be substantially scaled back. [97] Going forward, OHIP+ will only cover children and youth who lack private drug insurance. OHIP+ will also cover eligible expenses that are not covered by the drug insurers for children and youth who have other coverage. This means that Ontario is shifting back more to a multi-payer system. That system, as noted above, has proven to be very costly in Quebec without fully solving access and equity problems.

A renewed push from the federal government for a national pharmacare program
In April 2018, the Standing Committee on Health completed its thorough review of the evidence, and provided a series of comprehensive recommendations to the federal government, including:[98]

- Expand the *Canada Health Act* to include drugs dispensed outside hospitals.
- Develop a common, voluntary national prescription drug formulary.
- Improve drug pricing and reimbursement processes.
- Improve drug data and information systems.

"The [Standing] Committee believes that the best way to move forward in establishing a universal single payer public prescription drug coverage program is by expanding the Canada Health Act to include prescription drugs dispensed outside of hospitals as an insured service under the Act...The Committee has concluded that merely addressing coverage gaps will not lead to better health outcomes or better cost control."[99]

In the spring of 2018, Dr. Eric Hoskins was appointed Chair of the federal Advisory Council on the Implementation of National Pharmacare. The Council is leading a national dialogue on how to implement national pharmacare for Canadians. RNAO is pleased to participate in this consultation.[100]

RNAO's PHARMACARE ASK

- Support a national pharmacare program that covers all medically necessary drugs at no cost to Canadians, guided by the principles of the Canada Health Act (public administration, comprehensiveness, universality, portability and accessibility).

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[71] "Recommendation 28: That the federal government work with the provinces and territories to develop a national pharmacare program based on the principles of universal and equitable access for all Canadians; improved safety and appropriate use; cost controls to ensure value for money and sustainability; including a national catastrophic drug-coverage program and a national formulary." Source: Standing Senate Committee on Social Affairs, Science and Technology. (2012). *Time for transformative change: A review of the 2004 Health Accord*, p xviii. Retrieved from http://www.parl.gc.ca/content/sen/committee/411/soci/rep/rep07mar12-e.pdf.

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