Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

# RNAO Submission to the Advisory Council on the Implementation of National Pharmacare

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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 settings and roles across Ontario. It is the strong, credible voice leading the nursing profession to influence and promote healthy public policy.

RNAO is pleased to participate in this national consultation[1] on how to implement affordable national pharmacare. RNAO also welcomes the appointment of Dr. Eric Hoskins as the Chair of the Advisory Council on the Implementation of National Pharmacare (the Council). Dr. Hoskins has an excellent understanding of the importance of pharmacare. We urge the federal government to move quickly on this long overdue expansion of the Canada Health Act.

## The Standing Committee on Health Pharmacare Report

RNAO welcomes the initiative to move forward with a national pharmacare program. The federal Standing Committee on Health has already reviewed the evidence thoroughly, and its recommendations are clear:[2]

- 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 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."[3]

## Pharmacare – a Missing Piece of Canadian Medicare

As the Council's discussion document correctly points out: "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 discussion paper notes that every major study of the Canadian health system over the past 50 years has remarked upon this important gap in Canada's public health insurance system. The result is a mixed drug insurance system that differs across the country, is partially public and partially private, with drug prices that are very high by international standards, and millions of people who fall through the gaps in coverage. Many Canadians either cannot afford to fully comply with prescriptions or must cut other essential expenditures in order to comply. Either way, it is bad for their health and ultimately comes back to haunt the health system.

## A Matter of Rights

RNAO believes that access to conditions that permit health, including access to health care, is a universal human right, as is well established by multiple international conventions.[5] Foundational human rights documents that enshrine the right to health include the constitution of the World Health Organization (WHO) (1946),[6] the Universal Declaration of Human Rights (1948),[7] and the International Covenant on Economic, Social, and Cultural Rights (1966).[8] The WHO has long recognized access to essential medications as a part of the right to health.[9] [10]

## Evidence-Based Prescribing

It is critical that a pharmacare program have an evidence-based formulary and guidance be provided on optimal prescribing.[11] [12] This would pool information on safety, effectiveness, and cost. This is particularly important when dealing with the growing number of drugs targeted at rare diseases, as in these cases, the evidence is based on very small samples and often manufacturers supply the studies while at the same time exerting strong lobbying pressure for coverage of these typically very expensive drugs.[13] More generally, all health system practice should be guided by evidence.

## RNAO's Long-Standing Pharmacare Recommendations

RNAO has long called for a national pharmacare program – a call it reiterated in its 2016 submission to the federal Standing Committee on Health.[14] That submission outlines RNAO's on-going recommendations:

1. Universal coverage of all medically necessary drugs at no cost to Canadians via a single-payer system, guided by the principles of the Canada Health Act (public administration, comprehensiveness, universality, portability and accessibility). No user fees. No means testing. No co-payments.
2. Immediate transition to full coverage, as opposed to phasing in.
3. The government must win fair prices for prescription drugs by national price negotiations and resisting excessive patent protection for pharmaceuticals.
4. The development and delivery of all necessary information and guidance to support appropriate prescribing practices.

## The Consultation Questions

### 1. Who should be covered under pharmacare?

RNAO's position is that coverage should be universal – all Canadians should be covered under similar terms and conditions, regardless of location or ability to pay. The system should have no deductibles, means testing, or co-payments; otherwise, access is reduced. A review of the literature on out-of-pocket payments for pharmaceuticals concluded: "Increased cost sharing is associated with lower rates of drug treatment, worse adherence among existing users, and more frequent discontinuation of therapy."[15] And of course, use-based payments disproportionately bear on those with significant health needs.[16]

It is administratively simpler and cheaper to cover everyone, and it gives everyone a stake in ensuring that pharmacare meets a high standard. Furthermore, without universal coverage, it is impossible to have a single-payer system. A single payer is essential to drive down the excessive price of drugs through single-payer buying power. If only lower income people are covered, then the rest of the population would be covered by other payers, thus removing that crucial buying power. Those benefits will be discussed in the answer to the second question below.

Some may worry about the fairness of covering the cost of pharmaceuticals for people with higher incomes, but it must be recalled that those people are also paying more in tax. The net effect of universality is to make income distribution fairer, because the benefit to lower income people is larger relative to their incomes.

### 2. How should national pharmacare be delivered?

National pharmacare should be delivered entirely through public insurance, just in the way that hospital and physician services are currently covered. Otherwise, we would forego all the cost-saving of a single-payer system. As noted above, implicit in universal coverage is that it be done by a single payer. The example of Quebec is a cautionary tale. It has a compulsory drug insurance system with multiple payers – private and public. Access to pharmaceuticals did increase as a result of the imposition of compulsory drug insurance, but so did per capita costs. 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.[17] Large deductibles, copayments and premia add significant costs to Quebecers with government drug insurance.[18] [19] 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.[20]

The multi-payer system also shifts costs from the private sector to the public sector. For example, the government ends up insuring the highest risk people who are too old or ill to work, with the lower risk people being skimmed by private insurers through employment. In the case of Quebec, 30 per cent of those enrolled in private plans are public 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.[21] 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."[22] [23]

Additionally, the private health insurance market in Canada is dominated by for-profit firms -- 80 per cent by a 2008 estimate.[24] The share of premiums paid out as benefits has been dropping sharply. It is not a very good deal for insurance consumers. In the case of Canadian group plans, the share dropped from 92 per cent to 74 per cent between 1991 and 2011. It was even worse for individual plans: the share dropped from 46 per cent to 38 per cent over the same period.[25] The rising spread (8 per cent to 26 per cent for group plans) reflects additional costs plus diversion to profits.

With a single-payer universal system, everyone wins:

- All Canadians, because drug prices and drug expenditures will drop.
- The public, who will now have guaranteed access without cost to essential medications
- Employers, who will now be spared paying most or all of the drug portion of their health premiums. 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 Medicare.[26]
- Workers, who will gain jobs created by the resulting lower employment costs.
- Governments, whose existing obligations would become less onerous due to cheaper drug prices and due to better prescribing, and who could cover their new obligations by taxing back some of the drug premium savings of employers. As explained below, the government would also avoid indirect subsidies for private drug insurance as well.

The exception would be the drug companies, drug insurance companies, and health benefit management companies, who benefit from the existing costly system. Those players will advocate against a single-payer system, but Canada must choose a system that benefits the overall population. The few jobs lost to those employers due to an effective national pharmacare program would be swamped by the many jobs created through the lowering of employment costs. Canada needs to transition away from unproductive employment in such activities as private administration of drug benefit plans. That said, many of these jobs are not even located in Canada; they are in the home offices of multinational enterprises like major pharmaceutical companies.

Estimates of savings from aligning drug spending with global benchmarks are substantial. Lowering per capita drug spending in Canada to the OECD average would save $9.6 billion per year.[27] Lowering it to the level in the UK or New Zealand – two countries that are very successful at driving down drug prices -- would save Canada $14 billion.[28] [29]

Savings from pharmacare extend beyond reduced prices. Non-adherence to medications causes illness and results in 6.5 percent of all Canadian hospitals admissions. The cost of that non-adherence has been estimated at $7 billion to $9 billion annually in Canada,[30] and it could largely be avoided through universal pharmacare.

Given that pharmacare, by another estimate, would save the private sector $8.2 billion and would only directly increase public expenditures by $1 billion, it is likely that the indirect health system savings to government from greater drug compliance would end up more than covering government costs.[31] Moreover, as noted above, the savings to employers are so large that a tax on a portion of those savings would readily pay for any shortfall.

**3. Which drugs should be covered as part of a national pharmacare plan?**

In principle, all medically necessary drugs should be covered. This does not mean that all drugs ought to be covered – only those that provide therapeutic benefit, and only those that provide increased therapeutic benefit over existing, lower-cost drugs. It is estimated that 56 per cent of private drug plan expenditure is wasted on drugs that do not deliver additional therapeutic benefits over existing formulations.[32]

As new and at times very expensive drugs are developed that offer therapeutic benefit, a process to ascertain its cost-effectiveness must be developed. In our view such a process needs to be arm's-length from government and enable the capacity to bring together evidence, finances and public opinion – thus allowing for democratic input into choices among therapeutically sound options. This might be operationalized through the expansion of an existing agency's mandate or a specially appointed arm's-length expert panel. The first task would be constructing a national formulary with options at the margin to weigh the benefits and costs of high cost, low usage items (assuming that those prices have already been negotiated downwards).

**4. How much variability across different drug plans or jurisdictions should there be in the list of drugs covered by national pharmacare?**

Ideally, there would be no variability between jurisdictions, but if it is decided to that decisions on costly low-use drugs must respond to local stakeholders, then the price of that consultation and flexibility may be some variability in the list of drugs covered.

**5. Should patients pay a portion of the cost of prescription drugs at the pharmacy (e.g., co-payments or deductibles)?**

As discussed above, even small co-payments deter some people -- usually those living in poverty -- from complying fully or partially with their prescriptions. That in turn adversely affects their health and in the long-run, ends up costing the health system more money. And it robs people and society of the lost productivity. Furthermore, copayments and deductibles add to administrative complexity and cost.

Ordinarily, the rationale of a copayment in insurance is to encourage the ensured person to avoid unnecessary risks ("moral hazard,"[33] in the insurance language). For example, people might not

take normal precautions property against theft if they know they will get replacement value if the insured object is stolen. But health is different. Medical or drug insurance doesn't work that way because people are not going to be more reckless with their health if they know they are fully insured. Prescription drugs and physician visits are not consumption items; people would much rather not have to use that kind of insurance, but they are very glad to have it when they do fall ill. If they face co-payments, then they may not be able to afford to comply with their prescriptions.

**6. Should employers, which currently play a significant role in funding drug coverage for their employees, continue to do so (either through contributions to a private plan or through a public plan)?**

A proper universal pharmacare program would take away the need for private insurance of drugs that are medically necessary. There may be a small role for employers to provide insurance for drugs that are not medically necessary or are otherwise not covered under the national formulary. This might include patent versions of drugs that are only listed as generics or drugs deemed too expensive to list or drugs which have other purposes (e.g., cosmetic).

**RNAO's National Pharmacare Recommendations to the Federal Government**

1. Establish 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).
2. Make that pharmacare program universally accessible, with first-dollar coverage so that there are no deductibles, copayments or other user fees.
3. Transition immediately to full coverage of all Canadians and of all medically necessary drugs, with no phase-in.
4. Use the single-payer bargaining power to negotiate fairer prices for prescription drugs and use any available power such as compulsory licensing[34] to resist excessive patent protection for pharmaceuticals.
5. Develop and deliver all necessary information and guidance to support appropriate and effective prescribing practices.

**Support for Pharmacare**

The evidence points to a universal pharmacare system, and Canadians are strongly supportive of pharmacare as well.

| Pharmacare polling | | | |
|---|---|---|---|
| **Date** | **Company** | **Issue** | **Support** |
| May 2013 | EKOS[35] | Support universal public drug plan for all necessary prescription drugs | 78% |
| July 2015 | Angus Reid[36 37] | Support pharmacare in Canada | 91% |
| | | Support adding prescription drugs to medicare coverage | 87% |
| May 2017 | Environics[38] | Strongly or somewhat strongly support implementing a national pharmacare program providing universal access to prescription drugs for all Canadians. | 91.4% |

An impressive list of organizations is calling for a national pharmacare program, including: RNAO,[39 40] Ontario Nurses Association,[41] the Canadian Federation of Nurses Unions,[42 43] Canadian Nurses Association,[44] Canadian Doctors for Medicare,[45 46] Canadian Medical Association,[47] Standing Senate Committee on Social Affairs, Science and Technology,[48] Canadian Health Coalition,[49 50 51] and Canadian Association of Retired Persons[52 53]

When evidence and public opinion align, we urge the government to proceed with the courage of its convictions in this consultation process.

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