

**CMA Submission**

# **National Pharmacare in Canada: Getting There from Here**

**Submission to the House of Commons Standing Committee on  
Health**

**June 1 2016**

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, the CMA's mission is helping physicians care for patients.

On behalf of its more than 83,000 members and the Canadian public, the CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and over 60 national medical organizations.

# Introduction

On behalf of 83,000 physician members, the Canadian Medical Association (CMA) welcomes this opportunity to provide input to the House of Commons Standing Committee on Health study on the Development of a National Pharmacare Program. Recognizing that the term “pharmacare” is used in different contexts, for the purposes of this brief, pharmacare is defined as a program whereby Canadians have comparable access to medically necessary prescription medications, irrespective of their ability to pay, wherever they live in Canada.

## Key Facts

According to the Canadian Institute for Health Information (CIHI), in 2014, of the estimated \$28.8 billion spent in Canada on prescription medications (representing 13.4% of total health spending), governments<sup>i</sup> accounted for 42.0%, and private insurers and out-of-pocket (OOP) payment accounted for 35.8% and 22.2% respectively.<sup>1</sup>

Pharmacare is clearly part of the unfinished business of Medicare. Numerous authors have pointed out that Canada is the only developed country that does not include prescription medications as part of its universal health program. Table 1 below shows how Canada compares with the 22 member countries of the Organization for Economic Cooperation and Development (OECD) on the proportion of public spending for major categories of health expenditure in 2012.

**Table 1. Public spending as % of total spending: Major health spending categories, Canada and 22 OECD country average, 2012**

	% Public Spending		
	Prescription Drugs	Hospitals	Doctors’ Offices
Canada	42	91	99
OECD Average	70	88	72

Source: OECD.Stat, Doctors’ offices figure for Sweden is 2009

In the case of prescription medications, Canada was more than one-third (40%) below the OECD average.

### The Patchwork Quilt of Public-Private Coverage

In 1964 the Hall Commission recommended 50/50 cost-sharing between the federal and provincial governments toward the establishment of a prescription drug program, with a \$1.00 charge for each prescription. At the time, prescription medications represented 6.5% of spending on personal health services.<sup>2</sup> This recommendation was not implemented. It might be further added that the Hall report contained 25 forward-looking recommendations on pharmaceuticals that remain current to this day, including bulk purchasing, generic substitution and a national formulary.<sup>2</sup>

As a result of the lack of inclusion of prescription medications in Medicare, there is wide variation today in public per capita spending on prescription drugs across the provinces. It may be seen in Table 2 that, for 2014, CIHI has estimated that public per capita expenditure ranged from \$219 in British Columbia and \$255 in Prince Edward

<sup>i</sup> Includes federal. Social security fund and provincial/territorial spending

Island (PE) to \$369 in Saskatchewan and \$437 in Quebec.<sup>3</sup> CIHI does not provide estimates of private per capita prescription drug spending (private insurance plus OOP) below the national level.

**Table 2: Spending on prescription drugs: Selected indicators by province and territory, 2014**

Province/ Territory	Public spending <sup>a</sup> (\$ million)	Public per capita spending <sup>a</sup> (\$ )	Private insurance <sup>b</sup> (\$ million)	Average household out-of- pocket <sup>c</sup> \$
NL	156.7	297	177	454
PE	37.3	255	32	516
NS	302.2	321	337	429
NB	210.8	280	284	477
QC	3,588.7	437	2,369	466
ON	4,730.4	346	4,626	324
MB	411.3	321	249	516
SK	415.4	369	192	514
AB	1,383.7	336	1,065	409
BC	1,015.8	219	894	456
YT	14.0	383	-	-
NT	17.5	400	-	-
NU	13.6	372	-	-
<b>Territories</b>	45.1	385	23	-
<b>Canada</b>	12,297.4	334 <sup>d</sup>	10,247	408

<sup>a</sup> CIHI, National Health Expenditure Database 1975-2015, includes all public funding sources

<sup>b</sup> Canadian Life and Health Insurance Association

<sup>c</sup> Statistics Canada, Survey of Household Spending, 2014

<sup>d</sup> Provincial/territorial average

Table 2 also shows the significant role of private insurance in every region of Canada. Data provided by the Canadian Life and Health Insurance Association, shown in Column 3 of Table 2, show that private health insurance companies paid out \$10.2 billion for prescription drug claims in 2014, representing 83% of the \$12.3 billion paid for by governments. In three provinces — Newfoundland and Labrador, Nova Scotia and New Brunswick — the amount paid by private insurance exceeds that paid by governments. Table 2 also shows that there is wide variation in average household OOP spending on prescription drugs, according to Statistics Canada's Survey of Household Spending (SHS). In 2014 this ranged from a low of \$324 in Ontario to a high of \$516 in PE and Manitoba.<sup>4</sup>

Even more striking variation is evident when looking at household out-of-pocket spending on prescription drugs by income quintile (detailed data not shown). According to the 2014 SHS the poorest one-fifth (lowest income quintile) of PE households spent more than twice as much (\$645) OOP on prescription drugs than the poorest one-fifth in Ontario (\$300).<sup>4</sup> Aside from overall differences in public spending there are also differences in which medications are covered, particularly in the case of cancer drugs. The Cancer Advocacy Coalition of Canada reported in 2014 that four provinces have fully funded access to cancer medications taken at home. In Ontario and Atlantic Canada however, cancer drugs that must be taken in a hospital setting and are on the provincial formulary are fully funded by the provincial government; if the drug is taken outside of hospital (oral or injectable), the patient and family may have to pay significant costs out-of-pocket.<sup>5</sup> More generally the Canadian Cancer Society has reported that persons moving from one province to another may find that a medication covered in their former province may not be covered in the new one.<sup>6</sup>

Other sources confirm that prescription medication spending is an issue for many Canadians. On the Commonwealth Fund's 2013 International Health Policy Survey, 8% of the Canadian respondents said that they had either not filled a prescription or skipped doses because of cost issues.<sup>7</sup> Himmelstein et al. reported on a survey of Canadians who experienced bankruptcy between 2008 and 2010. They found that 74.5% of the respondents who had had a medical bill within the last two years reported that prescription drugs was their biggest medical expense.<sup>8</sup>

At least two Canadian studies have documented the impact that out-of-pocket costs, lack of insurance and low income have on non-adherence<sup>ii</sup> to prescription regimens. Law et al. examined cost-related non-adherence in the 2007 Canadian Community Health Survey and found that those without drug insurance were more than four times as likely to report non-adherence than those with insurance. The predicted rate of non-adherence among those with high household incomes and drug insurance was almost 10 times as high as that among those with low incomes and no insurance (35.6% vs. 3.6%).<sup>9</sup> Based on a large-scale study of the incidence of primary non-adherence (defined as not filing a new prescription within nine months) in a group of some 70,000 Quebec patients, Tamblyn et al. reported that there was a 63% reduction in the odds of non-adherence among those with free medication over those with the maximum level of co-payment. They also reported that the odds of non-adherence increased with the cost of the medication prescribed.<sup>10</sup>

## Previous Pharmacare Proposals

In a recent monograph Katherine Boothe has contrasted the development of national prescription medication programs in Australia and the United Kingdom with the failure to do so in Canada.<sup>11</sup>

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<sup>ii</sup> Non-adherence can be defined as doing something to make a medication last longer or failing to fill or renew a prescription.

Among the several Canadian attempts that she describes, the most activity occurred in the decade following the National Forum on Health (NFH), which was struck in 1994 and reported in 1997. A NFH working group paper on pharmaceutical policy recommended first dollar coverage for prescription medications, but acknowledged that it could not occur overnight: “over time we propose to shift private funding on prescribed pharmaceuticals (estimated at \$3.6 billion in 1994) to public funding”.<sup>12</sup> The NFH included this recommendation in its final report, noting that “the absorption of currently operating plans by a public system may involve transfer of funding sources as well as administrative apparatus”.<sup>13</sup>

It is instructive to place the 1994 prescription drug expenditure cited by the NFH in today’s context. According to the Bank of Canada’s inflation calculator, the \$6.5 billion in 1994 would have cost \$9.5 billion in 2014.<sup>14</sup> CIHI estimates that actual spending in 2014 was \$28.7 billion<sup>1</sup> – 203% above the level of 1994 spending, compared to population growth of 23% over the same time period.<sup>15</sup> Annual prescription drug spending increases averaged 7.3% over the period, although they have averaged just over 1% since 2009.<sup>16</sup>

A significant shift from private to public funding is not without precedent. A study prepared for the Hall Commission estimated that 9.6 million Canadians, representing 53% of the total population, had some form of not-for-profit or commercial insurance coverage for medical and/or surgical services in 1961.<sup>17</sup> With the passage of the *Medical Care Act* in 1966 these plans were all displaced as the provinces joined Medicare. The funding shift did not occur overnight, although it did move quickly. In the first year, 1968/69, Ottawa paid out \$33 million to the provinces pursuant to the *Medical Care Act*, which grew quickly to \$181 million in 1969/70, and reaching \$576.5 million in 1971/72.<sup>18,19</sup>

Since the 1997 NFH report the closest that the federal government has come to acting on pharmacare was a commitment in the 1997 Speech from the Throne to “develop a national plan, timetable and a fiscal framework for providing Canadians with better access to medically necessary drugs”, but nothing further was ever made public.<sup>20</sup>

Pharmacare was subsequently examined in two national studies, both of which recommended federal involvement in reimbursing “catastrophic” prescription drug expenditures above a threshold of household income. The Senate study on the State of the Health Care System in Canada, chaired by Michael Kirby, was authorized in March 2001 and the Commission on the Future of Health Care in Canada, headed by Roy Romanow, was approved in April 2001. Both issued their final reports in 2002.

The Kirby plan was designed so as to avoid the necessity of eliminating existing private plans or the provincial/territorial public plans, not unlike the approach taken by Quebec in 1997. In the Kirby plan, in the case of public plans, personal prescription medication expenses for any family would be capped at 3% of total family income. The federal government would then pay 90% of prescription drug expenses in excess of \$5,000. In the case of private plans, sponsors would have to agree to limit out-of-pocket costs to \$1,500 per year, or 3% of family incomes, whichever was less. The federal government would then agree to pay 90% of drug costs in excess of \$5,000 per year. Both public and private plans would be responsible for the difference between out-of-pocket costs and \$5,000, and private plans would be encouraged to pool their risk. Kirby estimated that this plan would cost approximately \$500 million per year.<sup>21</sup>

The Romanow Commission recommended a \$1 billion Catastrophic Drug Transfer through which the federal government would reimburse 50% of the costs of provincial and territorial drug insurance plans above a threshold of \$1,500 per person per year.<sup>22</sup>

The advantage of these proposals is that they are fully scalable. The federal government could adjust either the out-of-pocket household income threshold, the ceiling above which it would assume costs, or the percentage of costs that it would pay above the ceiling.

Following the Kirby and Romanow reports there was a back and forth exchange between the federal and provincial-territorial (PT) governments on a plan for catastrophic coverage. In their February 2003 Accord, First Ministers agreed to ensure that Canadians would have reasonable access to catastrophic drug coverage by March 2006.<sup>23</sup> At their annual summer meeting in 2004 the Premiers later called on the federal government to “assume full financial responsibility for a comprehensive drug program for all Canadians”, with compensation to Quebec for its drug program.<sup>24</sup> In the September 2004 Health Accord, First Ministers directed health ministers to develop a nine-point National Pharmaceuticals Strategy (NPS), including costing options for catastrophic coverage.<sup>25</sup>

A federal-provincial-territorial Ministerial Task Force on the NPS was struck and a progress report was issued in June 2006. The estimates of catastrophic spending were markedly higher than those of the Kirby and Romanow reports. Using a variable percentage of income threshold it estimated that, based on public plan costs, only catastrophic spending represented 42% of total prescription drug spending. If private plan costs were also considered, catastrophic spending would represent 55% of total prescription drug spending. This report proposed four options for catastrophic coverage with estimates for new public funding ranging from \$1.4 to \$4.7 billion.<sup>26</sup> Although no account of the methods was provided it is evident that a significant proportion of existing plan costs were included in the estimates of catastrophic expenditure. At their September 2008 meeting, the PT health ministers called for a national standard for drug coverage not to exceed 5% of net income and for the federal government to share 50/50 in the estimated \$5.03 billion cost.<sup>27</sup>

The uncertainty about the projected cost of a pharmacare plan resulting from widely varying estimates has doubtless contributed to a reluctance of governments to engage on advancing this issue.

## Recent Developments

At the PT level, there has been a concerted effort on price negotiations during the past few years through the pan-Canadian Pharmaceutical Alliance (pCPA) that was established in 2010. As of March 31, 2015, the pCPA reported that price reductions in generic and brand-name prescription medications result in annual savings of an estimated \$490 million.<sup>28</sup> The federal drug plans are now participating in the pCPA and the CMA has recommended that the pCPA should also invite the participation of private health insurance companies.<sup>29</sup>

The prospect of savings through lower prices has been foundational to two recent studies that have made the case that a single public payer pharmacare program with little or no co-payment is affordable.

The first was by Marc-André Gagnon in 2010. The proposal was developed on the basis of a review of cross-provincial and international practices in pharmaceutical policy. The review formed the basis of a set of 11 assumptions that were used to develop four scenarios that resulted in estimates of prescription drug cost savings over the 2008 baseline expenditure of \$25.1 billion that ranged to \$2.7 billion to \$10.7 billion.<sup>30</sup> In a 2014 update Gagnon estimated that a first dollar coverage program would save 10% to 41% of prescription drug costs, representing savings of as much as \$11.4 billion annually on a 2012-13 base of \$27.7 billion.<sup>31</sup>

Steve Morgan and colleagues (2015) have estimated that a universal public plan with small co-payments could reduce prescription drug spending by \$7.3 billion.<sup>32</sup> Subsequently, in **Pharmacare 2020** Morgan et al. set out five recommendations calling for the implementation of a single payer system with a publicly accountable management agency by 2020.<sup>33</sup>

## Taking a First Step Forward

At its 2015 annual meeting, the CMA adopted a policy resolution that *supports the development of an equitable and comprehensive national pharmacare program.*<sup>34</sup> Reflecting on the experience of the past 40 years since the enactment of the *Established Programs Financing Act* in 1977 that eliminated 50:50 cost-sharing, it seems highly unlikely that the federal government would take on a new open-ended program in the health and social arena, cost-shared or not. However, notwithstanding the progress of the pCPA, we are unlikely to address the significant access gaps in prescription medication coverage without the involvement of the federal government. These are fiscally challenging times for both levels of government, with budget deficits expected for several years to come. As noted previously, the Kirby and Romanow proposals for a federal funding role in pharmacare are scalable.

In 2015 the CMA commissioned the Conference Board of Canada to model the cost of covering prescription medication expenditure beyond a household spending threshold of \$1,500 or 3% of gross household income, based on Statistics Canada's 2013 Survey of Household Spending. The projected costs over the 2016 to 2020 are shown in Table 3 below.

**Table 3 - Projected Additional Cost to the Federal Government of Proposed Enhancement of Prescription Medication Coverage by Age Cohort (\$ millions)**

<u>Age cohort</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>Share of total cost</u>
Under 35 years	113.3	116.3	119.4	122.5	125.2	7%
35 to 44 years	177.2	183.5	190.5	197.8	204.3	11%
45 to 54 years	290.2	291.9	298.0	299.2	301.0	18%
55 to 64 years	383.7	400.6	417.6	433.1	444.6	25%
65 to 74 years	309.2	328.5	348.4	369.8	391.6	21%
75 years +	303.0	315.5	329.8	345.2	360.1	20%
<b>All ages</b>	<b>1,566.8</b>	<b>1,617.9</b>	<b>1,670.5</b>	<b>1,724.2</b>	<b>1,773.1</b>	<b>100%</b>

Source: Conference Board of Canada calculations based on Canadian Institute for Health Information data and The Conference Board of Canada's population forecast.

The cost to the federal government of covering the entire amount above the (\$1,500 – 3%) threshold would be \$1.6 billion in 2016.<sup>35</sup>

**Recommendation 1: The Canadian Medical Association recommends that the House of Commons Standing Committee on Health request the Parliamentary Budget Officer to conduct a detailed examination of the financial burden of prescription medication coverage across Canada and to develop costing options for a federal contribution to a national pharmacare program.**

**Recommendation 2: As a positive step toward comprehensive, universal coverage for prescription medications, the Canadian Medical Association recommends that the federal government establish a cost-shared program of coverage for prescription medications.**



### *First dollar coverage?*

The issue of co-payment arises in most discussions of pharmacare. Hall recommended a \$1.00 prescription charge in 1964. In England, which does include prescription medications in the National Health Service (NHS), the current prescription charge is £8.40, although the government has previously noted that 90% of prescription items are provided free of charge.<sup>36</sup> Appleby has noted however that the NHS's in Wales, Northern Ireland and Scotland have eliminated prescription charges.<sup>37</sup> One observational study of dispensing rates in Wales found that the overall impact of removing prescription charges was minimal.<sup>38</sup> Table 4 shows the total volume of prescriptions dispensed in Scotland over the period 2009-2015, which straddles the removal of prescription charges on April 1, 2011. It indicates that percentage increases in the annual dispensing volume diminished after 2012 and the increase observed in 2015 was just 1.4%. It should be added, however, that patient charges accounted for less than 4% of Scotland's dispensing expenditures in 2010.<sup>39</sup> It will be interesting to see the results of further studies in these jurisdictions.

**Table 4 Prescription Dispensing in Scotland, 2009 – 2015**

<b>Year</b>	<b>Number of Prescriptions</b> (million)	<b>% increase from previous year</b>
2009	88.4	3.8
2010	91.0	3.0
2011	93.8	3.1
2012	96.6	3.0
2013	98.4	1.9
2014	100.6	2.2
2015	102.0	1.4

Source: annual tabulations - Remuneration and reimbursement details for all prescribing made in Scotland.<sup>39</sup>

### **Other Elements of a National Pharmaceuticals Strategy**

It was noted previously that the Hall Report contained 25 recommendations on pharmaceuticals, and the 2004 Health Accord called for a 9-point National Pharmaceuticals Strategy. Two of the NPS points that the CMA would emphasize are the need to influence prescribing behaviour and the need to advance electronic prescribing (e-prescribing).

The CMA refers to the first of these points as “optimal prescribing” and defines it as the prescription of a medication that is: the most clinically appropriate for the patient’s condition; safe and effective; part of a comprehensive treatment plan; and the most cost-effective available to best meet the patient’s needs. Toward this end the CMA has identified principles and recommendations to promote optimal prescribing, including the need for current information on cost and cost-effectiveness.<sup>40</sup>

The CMA believes that e-prescribing has the potential to improve patient safety, to support clinical decision-making and medication management, and to increase awareness of cost and cost-effectiveness considerations. In 2012 the CMA and the Canadian Pharmacists Association adopted a joint vision statement calling for e-prescribing to be the means by which prescriptions are generated for Canadians by 2015.<sup>41</sup> Clearly that date has come and gone and we are not there yet. The current state primarily consists of demonstration projects and “workarounds”. The CMA was pleased to see an amount of \$50 million allocated to Canada Health Infoway in the 2016 federal budget to support the advancement of e-prescribing and telehomecare.<sup>42</sup>

Finally the CMA remains very concerned about ongoing shortages of prescription drugs. We would caution that whatever measures governments might take to implement a pharmacare program these must not exacerbate drug shortages.

**Recommendation 3: The Canadian Medical Association recommends that the Federal/Provincial/Territorial health Ministers direct their officials to convene a working group on a comprehensive National Pharmaceuticals Strategy that will consult widely with stakeholders representing patients, prescribers, and the health insurance and pharmaceutical industries to report with recommendations by spring 2017.**

## Conclusion

In conclusion, few would argue that prescription medications are less vital to the health and health care of Canadians than hospital and medical services. We would not have had the Medicare program that Canadians cherish today without the leadership and financial contribution of the federal government, and similarly without it now we will not have any form of a national pharmacare program.

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