CMA submission:

IMPLEMENTATION OF NATIONAL PHARMACARE

Submission to the Advisory Council

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ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, the CMA's mission is to empower and care for patients and its vision is to support a vibrant profession and a healthy population.

On behalf of its more than 85,000 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.

The Canadian Medical Association (CMA) welcomes this opportunity to provide input to the Advisory Council on the Implementation of National Pharmacare (Advisory Council) on the issues set out in its discussion paper.[1] The striking of the Advisory Council by the federal government is long overdue. We will focus on the questions set out in the discussion paper and draw attention to more specific issues that the Advisory Council should consider as it develops its final report.

At the outset, Canada's physicians are very concerned about their patients' access to prescription medicines. A June 2018 survey of the CMA member e-panel found the following:

- 71% reported that they always/often ask their patients if they have prescription drug coverage before writing a prescription;
- 60% reported that greater than 20% of their patients are either uncovered or inadequately covered for prescription drugs; and
- 79% reported that copayments pose affordability challenges among their patients with drug coverage and that they resort to a variety of strategies to help them.

Indeed, when asked to pick one of three options for a national prescription program, the results were as follows:

- 57% - a single, national, public pharmacare plan operated by the federal government and funded by taxes collected by the federal government;
- 34% - a mix of private prescription drug plans operated by private insurance companies and public drug plans run by the provinces and territories, supplemented by a prescription drug plan provided by the federal government for persons with high out-of-pocket drug costs; and
- 9% - separate regional, public pharmacare plans in each province and territory, funded by taxes collected by both the federal government and the provincial governments.

Who should be covered under national pharmacare? / How should national pharmacare be delivered?

The CMA's position is that all Canadians should have access to medically necessary drugs regardless of their ability to pay. The challenge is how to resolve the issue of the most expedient and affordable means of achieving this in a manner that is acceptable to the provincial/territorial governments.

At the present time there are two main options that are being discussed. The first is the approach recommended by the Standing Committee on Health (HESA) that calls for the development of a common national prescription drug formulary and the amendment of the Canada Health Act to include out-of-hospital prescription drugs in the definition of insured health services; essentially a universal, single public payer program.[2] The second is the "closing the gap" or "catastrophic coverage" approach recommended previously by the Kirby and Romanow commissions, and which was one of the unfulfilled commitments that First Ministers made in the 2003 Health Accord.

There is a large difference in the cost of these two approaches. Regarding the first, the federal Parliamentary Budget Office (PBO) has estimated the net cost to the federal government of assuming the cost of a pharmacare program modelled on the Quebec drug formulary at $19.3 billion in 2015-16, increasing to $22.6 billion in 2020-21.[3] Regarding the second approach, in 2002 the Kirby commission suggested that a catastrophic drug program with a cap of 3% of family income would cost $500 million per year.[4] A 2015 study by the Conference Board estimated that a program with a cap of 3% of household income or $1,500 would cost the federal government $1.6 billion in 2016, increasing to $1.8 billion in 2020.[5]

There are parallels between the present situation with insurance coverage for prescription drugs and the insurance coverage for medical services that existed at the time of the Hall Commission (1961-1964).

In 1961 there were 9.6 million Canadians with some form of medical insurance or prepayment coverage, representing 53% of the population.[6] Almost one-half of this number (4.5 million) were covered by the physician-sponsored not-for-profit Trans-Canada Medical Plans.[7] In its 1962 brief to the Hall Commission the CMA projected that this percentage would increase to 67% by 1970 and it recommended a "closing the gap" approach for the uninsured and under-insured:

> *That, for the 1,520,000 persons, or approximately 8% of Canada's population who may adjudged to be medically indigent, tax funds be used to provide comprehensive medical insurance on services…for persons in economic circumstances just superior to the identifiable indigent we recommend the application of tax funds on proof of need to permit the partial assistance which they require.*[8]

After Hall reported in 1964 with the recommendation of first dollar public Medicare, as they say, the rest is history. More than 50 years after the initial passage of the Medical Care Act in 1966, virtually nobody would suggest that Canada got it wrong.

In the case of pharmacare today, the circumstances are somewhat different. First the prevalence of prescription drug insurance is much higher today than medical insurance was back in the early 1960s. A 2017 report from the Conference Board estimates that just 5.2% of Canadians are uninsured for prescription drugs.[9] Other survey estimates indicate that roughly one in 10 Canadians report financial difficulty in filling prescriptions[10], although some surveys have yielded higher results, such as a September, 2018 Abacus Data poll that found that 23% of Canadians reported that the medicines they need are unaffordable.[11] Second, the role of the provincial/territorial (PT) governments paying for prescription drugs today is much greater than their role in paying for medical services prior to Medicare. In 1961 it was estimated that all public sources accounted for 12.4% of medical care expenditures.[12] In 2017, PT governments accounted for an estimated 37% of prescription drug spending.[13]

It is also instructive to consider how Medicare ramped up from its initial spending under the Hospital Insurance and Diagnostic Services Act in 1958-59 through to the first payments under the Medical Care Act a decade later, shown in Table 1. The table shows clearly that Medicare payments increased gradually over the two stages. Medicare as a share of total federal program spending increased from 1% in 1958-59 to a high of 11% in 1971-72. Interestingly, federal spending on Medicare never reached the 50/50 cost-sharing that was offered, reaching 36% in 1976-77, the year prior to the Established Programs Financing Act coming into effect. As an aside, according to the 2017 Fall Economic statement the Canada Health Transfer, valued at $37.1 billion in 2017-18 represents 12.2% of program spending.[14] This history highlights the need to consider how the federal government might phase in the program recommended by HESA given the cost estimated by the PBO at $19.3 billion. This appears a daunting challenge in light of the recent increases in federal health funding, which amount to annual increases in the Canada Health Transfer of just over $1 billion plus the $11 billion allocated in the 2017 federal budget over a 10-year period for home care and mental health.[15]

There is no disagreement that at the present time the fiscal prospects are better for the federal than the PT governments. In its 2018 Fiscal Sustainability Report, the PBO reported that over the 2018-92 projection period the federal government could either increase annual spending or reduce taxes by 1.4% of Gross Domestic Product ($29 billion) and maintain its net debt at the current (2017) level.[16] However, the government has many other spending priorities. Conversely, sub-national governments would be required to either increase taxes or reduce spending by 0.8% of GDP or ($18 billion) to maintain net debt at the current level.

The CMA has previously recommended that the federal government pursue a "close the gap" approach in partnership with the PT governments and the private insurance industry. This approach could be scaled up toward a full national public pharmacare by either or both of lowering the household income threshold or raising the level of federal contribution.[17] However this has never developed any serious momentum. While the first Ministers committed in their 2003 Accord to *take measures, by the end of 2005/06 to ensure that Canadians, wherever they live, have reasonable access to catastrophic coverage,*[18] this ran aground with the first and only progress report of the National Pharmaceuticals Strategy in 2006.[19] It was

evident in the report that much of the current public funding had been shifted into the catastrophic category, ranging from $6.6 billion to $10.3 billion across the four scenarios presented. The only further public PT government pronouncement on a catastrophic drug plan was a three-point proposal set out in a backgrounder for the PT health Ministers meeting in 2008 calling for a funding formula that would: protect the autonomy of the PTs in program design; set a ceiling of 5% of income; and recognize the federal government's role as an equal partner with 50/50 cost sharing of a total estimate cost of $5.03 billion (2006).[20] The amount of $5.03 billion would have represented 62% of PT spending on prescription drugs in 2006.

More recently, an "essential medicines" approach to universal pharmacare has been put forward by Morgan and colleagues, modelled on 2015 data. Essential medicines are defined by the World Health Organization (WHO) as *those that satisfy the priority health care needs of the population*.[21] WHO maintains a model list of essential medicines, and the 2017 version contains some 430 medications.[22] Using a multi-step review process, Taglione and colleagues adapted the 2013 version of the WHO list to produce a shorter list of 125 medications that they assessed against the prescription audits of two Toronto-based family health teams comprising 4,777 and 35,554 patients in 2014. They reported 90.8% and 92.6% coverage with the preliminary list of 125 medications in the two sites respectively.[23] The list is now called the CLEAN Meds list (http://cleanmeds.ca/).

Morgan and colleagues used 117 items from the CLEAN Meds list to model the impact of adding universal public coverage of an essential medicines list to the existing public drug plans in Canada, based on 2015 data. They reported the following base case results:

- Total public expenditure would increase by $1.229 billion to $11.99 billion;
- Total private expenditure would decrease by $4.272 billion to $11.172 billion; and
- Public expenditure on essential medicines would be $6.14 billion, representing 51% of the total $12 billion in total public expenditure.[24]

In further research conducted for the Patented Medicine Prices Review Board (PMPRB), Morgan examined the listing of the CLEAN Meds list across the public formularies in Canada for 2015 and found that the public plans listed 93% on average of the 125 medicines, and that this increased to 98% when weighted by drug plan costs.[25] The Institute of Fiscal Studies and Democracy at the University of Ottawa has done a similar analysis of 128 medications on the CLEAN Meds list and coverage ranged across provinces from Manitoba at the bottom (with 88 covered completely and 8 requiring special authorization) to Quebec at the top with coverage of 121 items.[26]

This would suggest that one approach would be for the federal government to offer to cover universal coverage for essential medicines, which would cost at least $6 billion. There would be coordination issues with both public and private plans, as was the case when Ontario introduced OHIP + in early 2018 to extend coverage to persons under 25.[27] This could be subsequently scaled up by adding coverage for additional medications.

In terms of how pharmacare should be delivered, that will depend on how far the federal government wants to go. Could the federal government administer a national pharmacare program? It already controls levers including drug approval by Health Canada and price-setting through the PMPRB, and it provides the majority (70%) of funding to the Canadian Agency for Drugs and Technologies and Health which oversees the Common Drug Review.[28] In May, 2015 Canadian Blood Services (CBS) CEO Dr. Graham Sher proposed that CBS could be considered as a model for national pharmacare, given its history of running a national (except Quebec) formulary of plasma protein drugs at no cost to patients.[29] In his subsequent testimony to the HESA pharmacare study Sher described CBS' success in negotiating price reductions through public tendering and bulk purchasing' although he did also note that their formulary includes 45 brands and classes of plasma protein products, far fewer than the thousands of items in PT formularies.[30] More recently Flood et al. have suggested that one option for pharmacare could involve the PT governments delegating authority to an arm's-length agency similar to CBS that would purchase drugs and administer drug benefits.[31]

However, in the comuniqué following their June 2018 meeting the PT health Ministers emphasized that *provinces and territories must retain responsibility for the design and delivery of public drug coverage…Quebec will maintain its own program and will receive comparable compensation if the federal government puts a pan-Canadian program in place.*[32] This was repeated by the Premiers in their communiqué three weeks later, which would suggest that a national agency approach is a non-starter. Moreover, none of the PT drug plans testified to the HESA pharmacare study.

One issue that has received scant attention in all of the discussions about pharmacare since 2015 is the future role of private supplementary health insurance. When Medicare came in in the late 1960s, while the expenditures increased steadily, enrolment in non-profit medical insurance plans disappeared virtually overnight, dropping from 8.3 million enrollees in 1968 to 1.1 million in 1970 and none thereafter.[33] This appears unlikely to happen to private insurance in the foreseeable future. For example, in the essential medicines modeling done by Morgan et al. the essential medicines would represent just 27% of total prescription drug expenditures and all public drug expenditures would account for 52% of the total.[24]

If the federal and PT governments were able to collectively "wave a magic wand" and come up with the PBO's $19.3 billion and a purchasing and distribution strategy it seems likely that this would raise questions about the continued viability of the health insurance benefits industry. In their testimony to HESA, the Canadian Life and Health Insurance Association did allude to an impact on the industry should prescription drugs become a public program but was not specific.[34] We have been unable to locate any international comparative literature on the structure of the health benefits industry. In 2017 CLHIA's members paid out $11.3 billion in drug benefits, representing 44% of the $25.5 billion total. Dental benefits accounted for $8.1 billion, or 32% of the total.[35] Dental benefits paid by CLHIA members accounted for two-thirds (65%) of the estimated total expenditures on dental benefits in Canada in 2017; just 6% were publicly funded.[13] Socio-economic inequalities in access to dental care are well-documented[36], but this issue is nowhere on the public policy agenda.

In addition, any transition from private to public coverage will require some administrative coordination. As noted above, Morgan et al. estimated that an essential medicines approach would reduce private spending by $4.2 billion, a large proportion of which would be currently paid for by private insurance.[24]

Which drugs should be covered/how much variability across jurisdictions should there be?

In terms of which drugs should be covered, the CMA believes that optimal prescribing is the prescription of a drug 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 drug available to meet the patient's needs.[37]

There is no dispute that private insurance companies offer wider formularies than the public drug programs. In their 2017 study the Conference Board compiled information on the number of drugs dispensed in 2015 through: both public and private plans, public plans only; and private plans only. This was presented for nine provinces, excluding PEI. Across the nine provinces, the following averages were observed:

- 4,878 drugs were dispensed from both public and private plans;
- 336 drugs were dispensed from public plans only;
- 1,938 drugs were dispensed from private plans only.[9]

On the 2018 CMA member e-panel survey, physicians were much more likely to report formulary coverage issues with their patients who with public coverage than they were for their patients with Private coverage. More than five in 10 (54%) physicians reported that they always/often have formulary coverage

issues with their publicly insured patients versus just over one in 10 (13%) for their privately insured patients.

If the federal government plans to pursue national pharmacare Canadians should be well-informed about the range of prescription drugs that will be available to them.

In terms of the variability of coverage, if pharmacare or some portion of it becomes a publicly insured service it should be offered to all Canadians under uniform terms and conditions, as specified in the CHA.

In practical terms, Morgan and colleagues have previously demonstrated that there is a high degree of commonality in the formularies across the public drug programs. Based on a review of 2006 formulary listings of 796 drugs across all provincial formularies except PEI, they found that coverage ranged from 55% to 73%, but when weighted by national retail sales the measure of formulary coverage exceeded 86% in all 9 provinces.[38] More recently, in the 2017 PMPRB study of formulary coverage Morgan studied 729 drugs across all provinces and the Non-Insured Health Benefits Plan for 2015. The public plans listed an average of 79% of the 729 drugs, and this increased to 95% when drug costs were factored in.[25] These findings would lend further support to the case for an essential medicines approach to national pharmacare.

Should patients pay a portion of the cost of drugs/should employers continue to play a role?

If the federal government intends to define out-of-hospital prescription drugs as an insured service under the CHA it will be necessary to address the feasibility of first dollar coverage in light of the accessibility criterion that prohibits user charges. The CMA addressed this issue in our 2016 brief to the HESA pharmacare study with reference to Scotland, which eliminated prescription charges in April, 2011.[39] There are now more recent data. In the four years leading up to the elimination of prescription charges the volume of prescriptions dispensed increased by 3.6% annually. In the seven years since the charges were eliminated, the annual increase has been 1.8%; indeed between 2016/17 and 2017/18 there was a decrease of 0.06%.[40] It should be added however that dispensing charges only accounted for 3% of prescription costs in 2008/09. Wales and Northern Ireland have also eliminated prescription charges for their citizens. The experiences of these countries should be examined more closely.

There has been very little research on how employers would react to the implementation of a full or partial public pharmacare plan. Ipsos conducted research among the employer community in 2012. Just under one in two (47) of respondents indicated that they would support *a public program for supplementary benefits introduced by the federal government that was funded by increased taxes,* but nearly nine in ten agreed that *even if the government implemented a program I would recommend that our company/organization still offer a supplementary health benefits program (over and above the government offer) because it would give us an advantage in recruiting/retaining employees.*[41]

If some form of a public pharmacare program is implemented, this will reduce the amount of drug benefits that private insurance companies are required to pay out, which should result in lower premiums for those employers who provide supplementary benefits. The implications of this in terms of how a pharmacare program might be funded have not received much scrutiny to date. However, regardless of the notionally ear-marked health taxes or premiums that are levied against businesses or individuals, Medicare has been paid for out of general tax revenues.

Conclusion

In conclusion, the initial modeling study published by Morgan et al. in 2015[42] has resulted in welcome attention to the longstanding issue of access to prescription drugs for Canadians who are either uninsured or under-insured. However the discussions have been light on how we could transition to a situation where Canadians can access prescription drugs on the same basis as they access medical and hospital services. This would require concerted discussion between the federal and PT governments and

the health insurance benefits industry and this has not yet occurred. The discussions since 2015 have mainly ignored the issue of highly expensive drugs for rare diseases and very expensive drugs for more common diseases, such as biologic drugs for rheumatoid arthritis. The CMA is pleased to see that HESA is launching a study on the barriers to access to treatment and drugs for Canadians with rare diseases and disorders.[43]

Recommendations

The Canadian Medical Association recommends that the Advisory Committee on the Implementation of National Pharmacare:

1. ***Engage with the federal and provincial/territorial governments and the health insurance industry on the feasibility of a universal federally funded "essential medicines" prescription drug plan as a scalable approach to the implementation of a national pharmacare plan.***

2. ***Engage the business community and the health insurance industry on the question of the continued viability of the provision of supplementary health benefits (e.g. dental care) should a national pharmacare plan be implemented.***

3. ***Study the international experience of Scotland and other countries with respect to the provision of first dollar coverage of prescription drugs.***

Table 1. The Evolution of Medicare ($ million)

Year	HIDS	Medical Care Act	Total program spend	Medicare as a % of total program	Total hospital spend	Total physician spend	Medicare as a % of total H&P
1958-59	54.7	0	4716	1%	640.608	301.337	6%
1959-60	150.6	0	4919.4	3%	735.626	325.689	14%
1960-61	189.4	0	5160.5	4%	834.932	355.014	16%
1961-62	283.9	0	5681.6	5%	930.568	388.305	22%
1962-63	336.7	0	5652.5	6%	1031.749	406.075	23%
1963-64	392.2	0	5878.7	7%	1150.306	453.395	24%
1964-65	433.9	0	6167	7%	1273.38	495.657	25%
1965-66	319.6	0	6623.9	5%	1434.274	545.056	16%
1966-67	397.4	0	7589.2	5%	1637.647	605.2	18%
1967-68	468.6	0	8497	6%	1880.699	686.189	18%
1968-69	561.9	33	9258	6%	2179.906	788.089	20%
1969-70	635.9	181	10204	8%	2456.687	901.435	24%
1970-71	734.3	400.5	11262	10%	2775.391	1031.555	30%
1971-72	844.6	576.5	12831	11%	3095.367	1239.775	33%
1972-73	960.5	630.8	16324	10%	3384.801	1375.127	33%
1973-74	1065.7	677.9	20247	9%	3803.61	1471.971	33%
1974-75	1307.6	762.7	26037	8%	4579.041	1647.025	33%
1975-76	1709.2	795.8	30023	8%	5533.707	1900.483	34%
1976-77	2030.5	1003.6	34209	9%	6357.3	2071	36%

Sources:
Hospital Insurance and Diagnostic Services (HIDs) and Medical Care Act – Public Accounts of Canada Issues 1958-59 – 1976-77. Spending by National Health and Welfare.
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