Delegate Backgrounder

Canadian Federation of Medical Students
Lobby Day February 22, 2016 - Ottawa, ON

Pharmacare in Canada

An Advocacy Initiative by Canadian Medical Students to Improve Access to Medicines

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With appreciation,

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I. Executive Summary

Canada is the only developed nation in the world with universal healthcare but no corresponding pharmaceutical coverage. We are left with a system where outpatient pharmaceutical costs are covered by public, private, and out-of-pocket sources. This fragmented system has caused significant financial problems. Canada's annual rise in prescription drug expenditures are rising faster than other countries in the Organisation for Economic Co-operation and Development (OECD) at greater than 6.9%. Furthermore, Canada's medication prices are amongst the highest in the world - approximately 30% above the OECD average. Due to the relatively low proportion of public funding for pharmaceutical expenses, these costs come from the pockets of our patients.

These financial burdens have become health burdens. Approximately 10% of Canadians cannot afford their prescribed medications. This inability to pay for medications is highest amongst those without private insurance, which constitutes about 23% of Canadians.

A wealth of research has suggested a national pharmacare plan can address our financial inefficiencies and health inequities. When accounting for competitive pricing from bulk purchasing, reduced tax deductions, and other improvements, the estimated savings increase to about $11 billion. This large figure does not include the health and social benefits that would result when Canadians are able to obtain medically necessary treatments for their health conditions.

The CFMS recommends that the Government of Canada:

A) Establish a concrete plan and corresponding timeline for the exploration of how to create a national formulary, as a first step towards a national pharmacare program;

B) Demonstrate continued collaboration with provinces and various stakeholder groups and consideration of evidence-based reports when evaluating how to improve access to pharmaceutical care for all Canadians;

C) Work with pertinent stakeholder groups to ensure that this national formulary also has the capacity to develop and disseminate guidance about safe and appropriate prescribing practices.

Elements of an economically and socially effective pharmacare system may include the following:

1) Ensures universal coverage for medically necessary medications with limited patient charge
2) Integrates financing for medications with financing for other medically necessary services covered under the Canada Health Act
3) Adequately consolidates purchasing power to ensure the lowest possible drug prices
4) Works from a National Drug Formulary developed based on sound scientific evidence to ensure the best value-for-money for prescriptions

II. Current State of Pharmaceutical Coverage in Canada

This section will provide a brief summary of the complex pharmaceutical system currently implemented in Canada. *For more information*, please refer to the following backgrounder from the Canadian Institute for Health Information, at the following URL: https://secure.cihi.ca/free_products/Prescribed%20Drug%20Spending%20in%20Canada_2014_EN.pdf

In accordance with the mandate given her by the Prime Minister, and the Liberal Party 2015 platform, Health Minister Jane Philpott is expected to sign the Federal Government into the pan-Canadian Pharmaceutical Alliance, a bulk purchasing group made up of provincial and territorial governments which has saved its members roughly 490 million dollars annually (Graeme). The federal government, which provides healthcare to inmates, veterans, the RCMP, aboriginal peoples, and the military, is a large purchaser of durgs (roughly 630 million $ in 2014) (Graeme) and the provinces feel that its large purchase volume will add significant bargaining power to the Alliance. Private insurers are not part of the Alliance, and need to be formally invited to take part; there have been calls by private insurers to include them in the Alliance (Paterson).

It is important to realize that the drugs paid for by provinces after negotiation through the Alliance include those used in hospitals and those given out through provincial programs (such as those for those living on welfare), but have no effect on the costs paid by the 'average' Canadian for outpatient prescriptions, which are covered out-of-pocket or through private insurance ("Bulk-buying" editorial) . In addition, adding private insurers to the Alliance would likely have the effect of cementing their role in prescription drug coverage, making universal pharmacare less likely.

In summary, while joining the Alliance means the Federal Government will likely save a great deal on drugs, making money available for other projects, it will not eliminate the difficulties many Canadians face when they are faced with copays or out-of-pocket expenses for drugs. In other words, bulk purchasing is *not* pharmacare, though it is a necessary part of any successful pharmacare strategy. Thus, the advent of government bulk purchasing does not obviate the need for a national pharmacare strategy ("Bulk-buying" editorial).

At this point the Trudeau government's stance on institution universal pharmacare is not clear.

Current Federal Coverage

The Canada Health Act of 1984 stipulates that Canadian health care must be accessible, portable, universal, comprehensive, and publicly administered (University of Ottawa, 2014). The original intent of the Canada Health Act was to implement incremental change leading to a truly universal healthcare system, with the plan to introduce i) hospital care, the ii) medical services, followed by iii) prescription drugs and iv) home care (Morgan, Daw, and Law, 2013). While hospital care and medical services are provided to Canadians, there have been

financial, political, and logistical barriers to funding prescription medicines. As a result, the Canadian health care system has the dubious distinction of being the only system in the world with universal health care, and yet no universal drug coverage (Morgan, Daw, and Law, 2013). Federal drug coverage is outlined as follows:

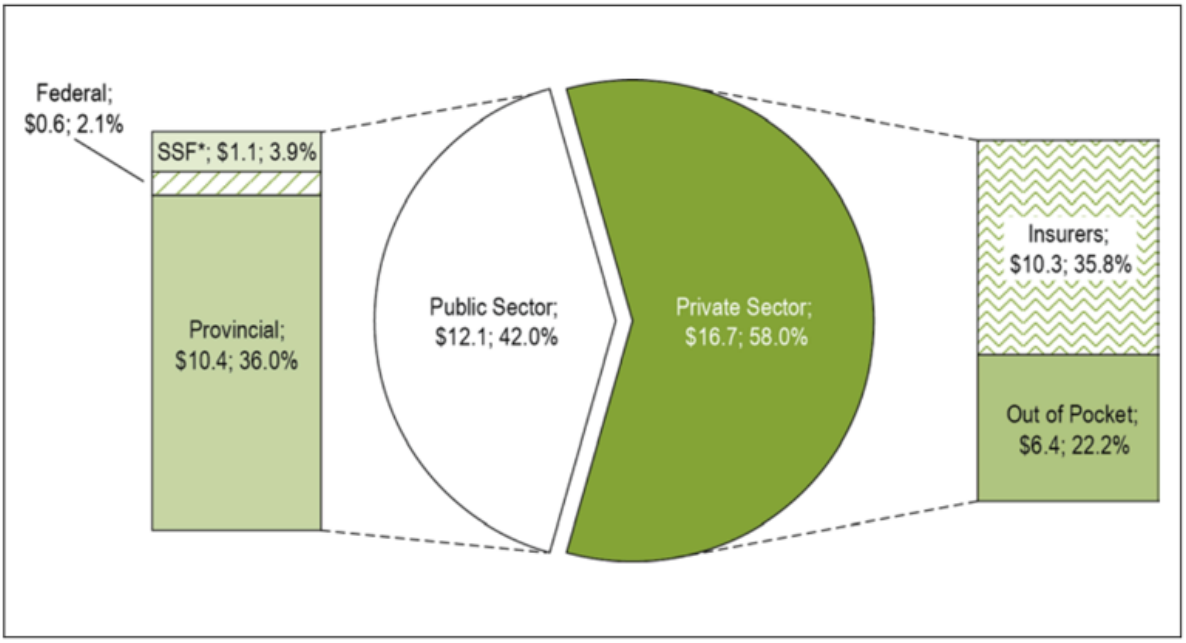
Hospitals
The Canada Health Act certifies that all drug therapies provided in a Canadian hospital are insured and publicly funded. When not in hospital, the coverage of pharmaceuticals is under provincial and territorial government administration. (Health Canada, 2004)

Federal Public Drug Benefit Programs
The Government of Canada provides pharmaceutical coverage for approximately one million Canadians that belong to specific groups including: First Nations and Inuit, military, Veterans, certain groups of refugees covered under IFHP, RCMP, and inmates of federal penitentiaries. (Health Canada, 2004)

Outpatients
Drug coverage for outpatients varies and may be covered by the public sector (Provincial/Territorial, Federal, and Social Security Funds), private insurers, or out-of-pocket. These cost are further explained following Figure 1.

The Common Drug Review for Drug Coverage
In addition to federal coverage, Canada has a widely variable provincial/territorial coverage (outlined in a further section of this backgrounder). A division within the Canadian Agency for drugs and Technologies in Health (CADTH), the Common Drug Review (CDR), is responsible for taking a formalized approach to unifying drug reimbursement decisions in Canada. The objective of the CDR is to conduct systematic reviews of the clinical effectiveness and cost-effectiveness of pharmaceuticals in Canada, as well as reviews of patient input for drugs and providing formulary listing recommendations to Canada's publicly funded drug plans (with the exclusion of Quebec). Once CDR has made their formulary funding decision, this is passed to the individual provinces and territories, who ultimately decide whether or not the product will be covered. Provincial/territorial coverage can only choose to cover pharmaceuticals that are approved by the CDR.

Figure 1: Prescribed Drug Expenditure in Canada, 2014



Notes

* Social Security Funds (SSFs) include health care spending by workers' compensation boards and the premium component of the Quebec Drug Insurance Fund.

f: Forecast.

$ billions; percentage share of total prescribed drug expenditure.

Source

National Health Expenditure Database, 2014, Canadian Institute for Health Information.

In 2014, prescribed medications cost Canadians $28.8 billion, of which $12.1 billion (42.0%) was financed by the public sector (CIHI, 2015). This leaves $10.3 billion (35.8%) that was supplied by private insurers and $6.4 billion (22.2%) that was paid out-of-pocket by Canadian households (CIHI, 2015). These costs are illustrated in Figure 1. Ten drug classes made up 32.9% of the public drug program spending including pharmaceuticals used to treat conditions such as high blood pressure, heartburn, Rheumatoid Arthritis, Crohn's Disease, macular degeneration, high cholesterol, asthma, and depression (CIHI, 2015). In addition to large amounts of spending on the above medications as a result of the sheer volume prescribed, there are also extremely high costs for specific classes of medicines like biologics, which results in the majority of public drug spending supporting a small number of high-cost individuals (CIHI, 2015).

National Pharmaceutical Strategy (NPS)

The Health Canada web page states that "First Ministers agreed that no Canadian should suffer undue financial hardship in accessing needed drug therapies, and that affordable access to drugs is fundamental to equitable health outcomes for all our citizens" (Health Canada, 2004). This was in reference to the formation of the NPS as part of the 10-Year Plan to Strengthen Health Care of 2004 (Health Canada, 2004). We have now passed the ten-year mark without meeting the specific goals outlined under the NPS.

III. Challenges with Current Pharmaceutical Coverage in Canada

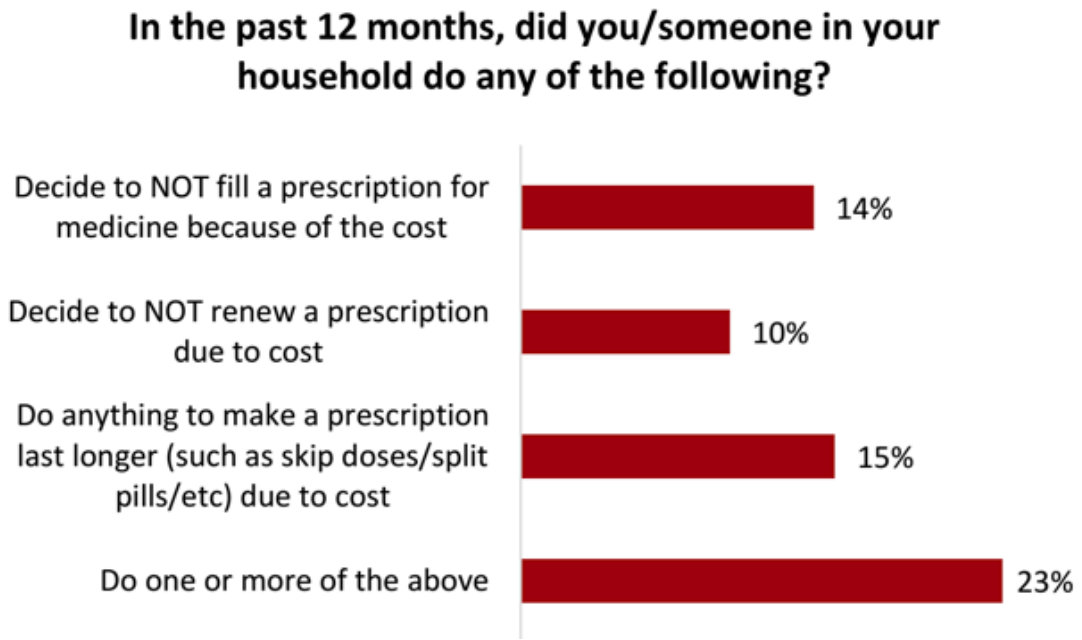
The current fragmented system of pharmaceutical coverage has created problems in a number of areas in Canada's healthcare system. These problems can be broadly classified under the following 3 categories: 1) access to pharmaceuticals, 2) health equity and 3) pharmaceutical costs.

Access to pharmaceuticals

Universal access to necessary medical care has long been a guiding principle of Canada's healthcare system. The Canada Health Act mandates universal, accessible and comprehensive healthcare for all Canadians, yet a significant portion of Canadians still report difficulty in accessing necessary prescription medications.

In a 2007 survey of over 5,700 Canadians who had received a prescription within the past year, nearly **1 in 10 respondents reported cost-related prescription non-adherence** (Law et al., 2012). This translates into nearly **1 in 4 Canadian households currently being affected by prescription medication non-adherence** (Angus Reid Institute, 2015). Cost-related prescription non-adherence is strongly associated with not having prescription medication insurance and with low household income level (Law et al., 2012). Of those households who reported cost-related prescription non-adherence, 14% did not fill a prescription at all, 10% did not renew a prescription and 15% skipped doses, split pills or did other things to make a prescription last longer (Angus Reid Institute, 2015).

Figure 2: Obstacles in Access to Pharmaceuticals for Canadians



Source: Angus Reid Institute, Prescription drug access and affordability report, 2015.

This lack of universal pharmaceutical access is at odds with the values outlined in the Canada Health Act. In a 2015 survey of the attitudes of Canadians towards access to pharmaceuticals,

almost **9 in 10 expressed support for the right of every Canadian to access necessary prescription medications**, regardless of income (Angus Reid Institute, 2015). The same proportion of Canadians support the concept of a national pharmacare program in Canada that would ensure universal access to prescription medications (Angus Reid Institute, 2015)
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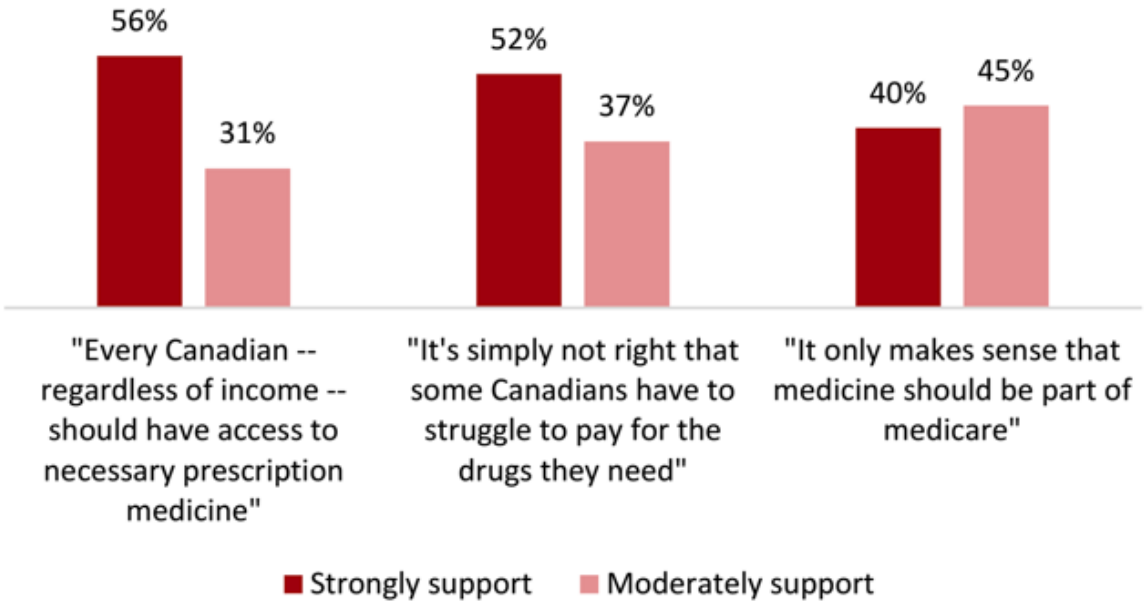
Figure 3: Canadian Public Perception on Access to Pharmaceuticals



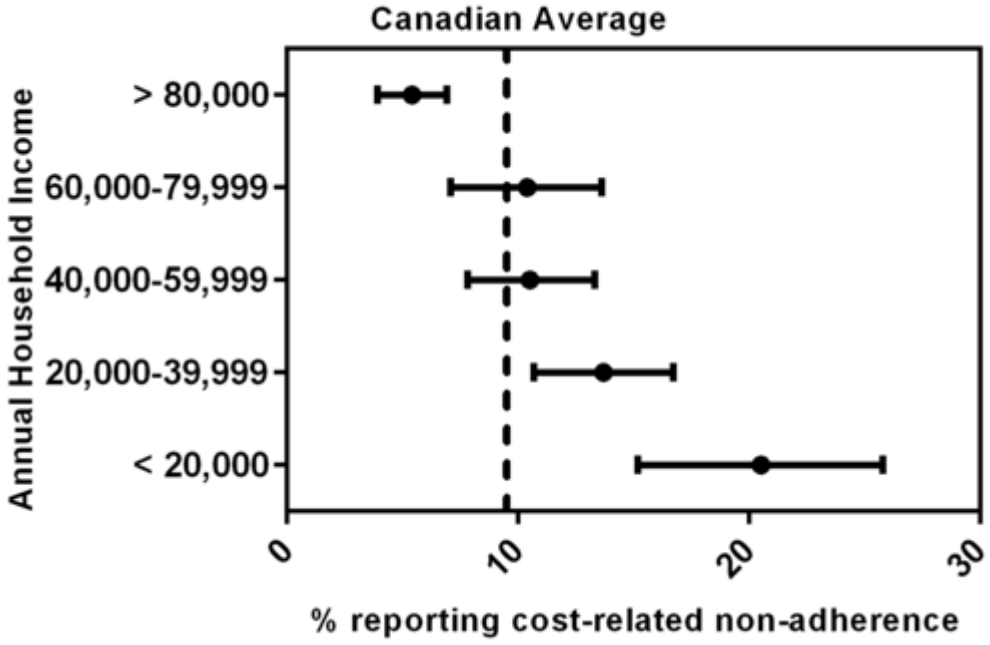
Source: Angus Reid Institute, Prescription drug access and affordability report, 2015.

Health equity

Health equity is a principle of healthcare delivery that emphasizes reducing remediable differences in health outcomes between populations. Equity is a principle that is deeply entrenched in the Canadian healthcare system. As a result, Canadians believe in the provision of good healthcare to all, regardless of factors such as income and geographical region.

However, there are several aspects of the current pharmaceutical coverage system in Canada that has created sharp disparities in health outcomes. There is a clear association between household income and likelihood of cost-related prescription non-adherence. Approximately 1 in 5 Canadians with an annual household income of less than $20,000 report some form of prescription non-adherence, compared to just 1 in 20 Canadians with an annual household income of greater than $80,000 (Law et al., 2012).

Figure 4: Cost-Related Non-Adherence to Prescriptions



Source: Law et al. CMAJ. 2012;184(3):397-302

In addition to disparity based on income, provincial administration of pharmaceutical coverage has resulted in disparity based on geographical region. For example, residents of British Columbia are more than 50% more likely than residents of Ontario to report cost-related prescription non-adherence (Law et al., 2012). Several factors are thought to be contributing to this disparity. British Columbia does not have pharmaceutical coverage for seniors (who have the highest medication costs), whereas Ontario provides public coverage for seniors over the age of 65. British Columbia also has the highest levels of household debt in Canada, which would make it more difficult to afford to fill or renew prescriptions (Morgan et al., 2013).

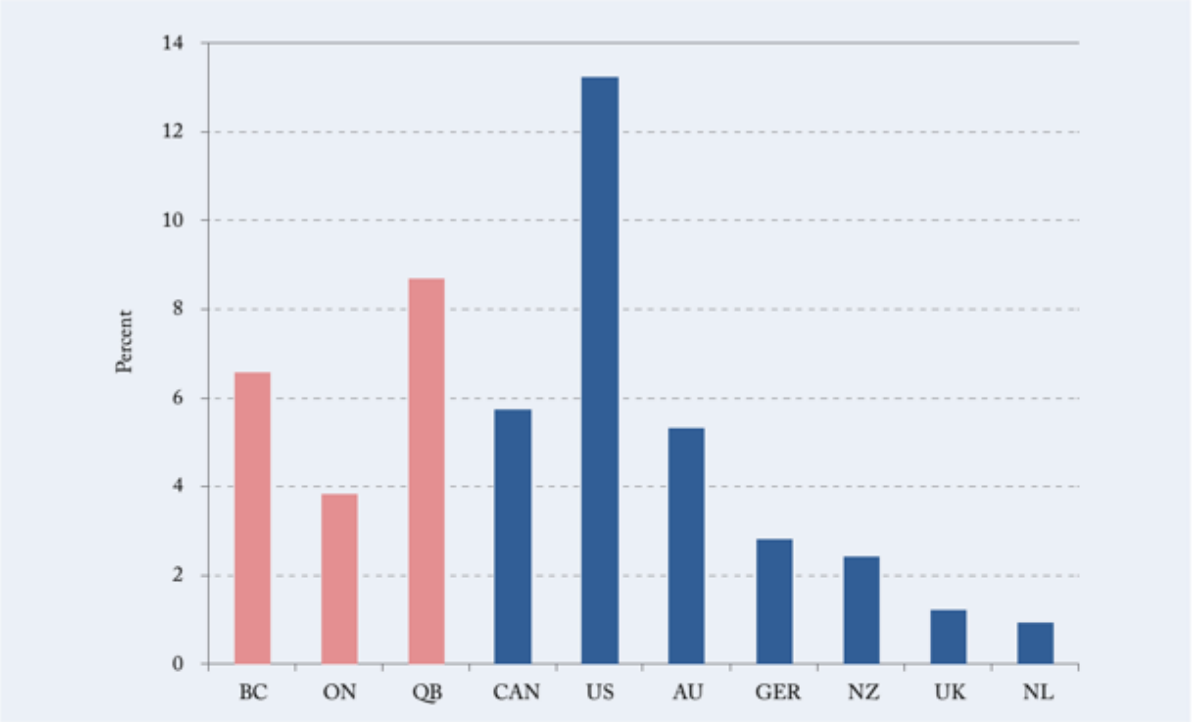
Other demographic factors associated with increased cost-related prescription non-adherence include: age less than 65 years, poor health status and having 2 or more chronic health conditions (Law et al., 2012). Patients who cannot or do not adhere to medications have poorer health outcomes (Osterberg and Blaschke, 2005). Medication costs create a disparity in which Canadians do not have the equal opportunity to receive medical treatment and enjoy good health – an outcome that is out of keeping with the principles of universal healthcare.

Pharmaceutical costs

The current system of pharmaceutical coverage in Canada has led to exorbitant costs for both the public and private sectors. High prescription medication costs combined with a lack of public pharmaceutical coverage has led to significant household out-of-pocket expenses on prescriptions. The fragmented system of coverage has led to prescription drug expenditures that is rising at an unstainable rate.

Approximately 6% of Canadian households report out-of-pocket prescription medication costs exceeding $1,000 annually. This is significantly higher than almost any other OECD jurisdiction other than the United States (Morgan et al., 2013).

Figure 5: Percentage of Households Reporting Out-of-Pocket Expenses for Prescription Medicines Exceeding US $1,000, by Jurisdiction



Source: Morgan et al. CD Howe Institute Commentary, 2013

Approximately 16% of total healthcare expenditure in Canada is devoted to pharmaceuticals. Pharmaceuticals now represent the second-largest share of healthcare expenditure from all sources, second only to spending on hospitals and greater even than spending on physicians (CIHI, 2014).

Canada's current pharmaceutical system compares unfavourably on the international stage. Not only are costs and prices already high compared to most other OECD countries, expenditures are also rising more rapidly (see Appendix 1). This places Canada at a significant competitive disadvantage with other OECD countries and has the potential to become an economic crisis if pharmaceutical costs cannot be contained (Gagnon, 2014).

There are multiple reasons for Canada's financially inefficient pharmaceutical system:

1) A fragmented pharmaceutical coverage system decreases bargaining power

When countries like the UK or Australia negotiate drug prices, they are able to do so on behalf of tens of millions of people. This increases their bargaining power and leads to lower drug prices (Morgan et al., 2013). Simply stated, "buying in bulk" allows for lower pricing. In Canada, our fragmented system decreases our purchasing power as multiple payers (i.e. the

provincial governments) must negotiate with the pharmaceutical companies separately. This is illustrated in Canada by drug costs that are much higher in smaller jurisdictions such as Prince Edward Island when compared to Ontario.

2) Reliance on private insurance leads to higher premiums and administrative costs

Insurance companies managing private drug plans are compensated by the premiums paid on those plans. There is therefore no financial incentive on the part of private insurers to decrease costs. This has led to a sharp increase in premiums – 15% annually from 2003 and 2005 (Canadian Health Coalition, 2007), while pharmaceutical prices rose by just 8% annually within the same timeframe (CIHI, 2014).

Studies have shown that private health plans have more administrative costs than public plans. In Canada's public Medicare system, just 1.3% of total spending is devoted to administrative costs compared to 13% in private plans (Woolhandler et al., 2003).

Administrative costs in private insurance plans tend to be much higher due to the additional costs of marketing, risk-adjustment based on health of insured persons, and supply negotiations in multi-payer contexts (Gagnon, 2014)

3) Public investment in pharmaceutical R&D in Canada does not result in good return-on-investment

Canadian intellectual property law currently provides for 20 years of patent protection for pharmaceutical products that come to market in Canada. This has contributed to a dramatic increase in the costs of pharmaceutical products and represents a significant investment in pharmaceutical research and development (R&D) that has not paid the expected dividends (Canadian Health Coalition, 2007).

Pharmaceutical R&D investments as a percentage of sales in Canada have remained low (10.1%) compared to other OECD countries such as Belgium (28.6%) Denmark (79.0%). Furthermore, the majority of pharmaceutical R&D expenditures has gone towards the creation of drugs that do not offer any additional significant therapeutic benefit over existing products. Of the 455 newly patented drugs introduced in Canada over a period of 5 years from 1996-2000, only 25 were found to have major improvements in therapeutic value (Lexchin, 2003).

IV. Benefits of National Pharmacare

Health and Social Benefits

1) Promoting Access to Necessary Medicines

A 2013 CD Howe report (Morgan, Daw, and Law, 2013) examined medication compliance in jurisdictions with different out-of-pocket costs, and showed that lower costs lead to greater adherence to necessary medication. In the graph from the report [Figure 5], by far the greatest compliance is in the UK and the Netherlands, where coverage is universal and co-pays are very low.

2) Ensuring Financial Protection and Equity

The same CD Howe report (Morgan, Daw, and Law, 2013) examined the percentage of households paying more than $1000 in out-of-pocket expenses for medications. Again, there is a strong correlation between minimizing out-of-pocket costs and having a lower percentage of the population experiencing exorbitant medication costs. A growing proportion of drug costs are taken up by so-called "niche-busting" drugs, used for a very small proportion of the population with very serious health issues (Chustecka, 2012). These drugs can cost upwards of hundreds of thousands of dollars per patient per year (Nelson, 2014), but are in some cases the most effective therapies available for a given population subgroup (familiar examples are imatinib and trastuzumab ("Targeted Cancer Therapies", 2014), though they are older and their prices have come down with time and the introduction of generics; newer examples include Dinutuximab, which has been FDA approved for treatment of neuroblastoma (Sebastian, 2015)). While currently most Canadian provinces provide a form of "catastrophic" coverage, meaning that either there is a fixed ceiling on out-of-pocket drug costs, or a deductible fixed to a percentage of income, under current conditions many people still pay thousands of dollars annually for medically necessary drugs (Phillips, 2009) [See Figure 2]. People do not have control over whether they become seriously ill, and an equitable universal pharmacare system will protect patients from exorbitant drug costs if and when they do.

Financial Benefits

1) Eliminating the Inefficiencies of the Private Insurance Market

Administrative costs of private health insurance in Canada amounted to 15.1% of total costs, compared to 3.2% for publicly administered health care (Morgan, Daw, and Law, 2013). Moving to a single-payer system in Canada would save $1.35 billion annually simply from administrative efficiency and abolishing the need for advertising that exists in the private insurance market (Gagnon, 2014). As well, Federal tax subsidies to private insurance companies amount to an estimated $1.2 billion annually, a cost that would be eliminated with a universal public pharmacare program (Gagnon, 2014). Thus simply eliminating the private market would lead to cost savings of $2.5 billion per year for the government, money that could then be invested into pharmacare start-up costs, health, education, and other priorities. Another analysis showed that the government could expect, in the best case, up to 2.9 billion

dollars in saving, in the worst case 5.4 billion dollars in cost increases, and in the most likely case a 1 billion dollar cost increase (Morgan et al., 2015), which the authors did not view as a prohibitive cost justifying not embracing a pharmacare model. Employers and other providers of private medication coverage would save the most, up to 8.2 billion dollars according to a the same recent analysis (Morgan et al., 2015). The same analysis showed that, overall, spending on prescription medications would decrease by 7.3 billion dollars.

2) Increasing Purchasing Power

Buying in bulk is a common way to secure low prices for medications, and pharmacare would centralise purchasing, increasing purchasing power (Morgan et al., 2015). Currently the Provinces have taken the lead on this, creating the Pan-Canadian Purchasing Alliance (PCPA) in 2010 (Kaur et al., 2014), where provincial public drug plans have pooled resources for joint pricing negotiations. As of October 2013 more than 20 joint negotiations had been completed and 13 more were in the works. The PCPA estimates that these joint negotiations have saved a combined $260 million in drug costs annually (Kaur et al., 2014; Pan-Canadian Pharmaceutical Alliance). However, public drug plans only cover 45% of drug costs nationally, and coordination between provinces is a complicated process, and so the PCPA has significant natural and logistical limitations (Gagnon, 2014). With the consolidation of a fragmented system of coverage into a single drug purchaser for the country, purchasing power will greatly improve and drug costs will decrease .

3) Rational Health System Decision Making

While we don't have a specific estimate, it is clear that our fragmented and inequitable system of pharmaceutical coverage leads to adverse health outcomes whose costs are covered by publicly funded provincial health systems. A 2012 study found that roughly one in ten Canadians does not take their prescribed medication due to cost, and that the rates of cost-related nonadherence were worse for more vulnerable groups (those with lower income, those without drug insurance) (Law et al., 2012). Thus, public cost-saving from not providing universal pharmacare- if there are any cost savings to be had (refer to points 1 and 2) - is likely negated by the increased costs of medical care for those without adequate access to medically necessary medications and require more intensive care as a result of untreated chronic conditions (Blanchard et al, 2013) . Incorporating financing for medications into financing for other medically necessary health care and developing a national drug formulary based on sound scientific evidence will lead to a rational approach to health care spending.

4) Safety and Efficacy

A National Drug Formulary tied to a national body tasked to evaluate medications based on safety, efficacy, and cost-effectiveness would ensure standardization across provinces, which currently each develop their own formularies. Canada already has an agency tasked with evaluating new drugs, as discussed in Section II, and developing a national formulary is a logical extension of this process. This will allow for information to be gathered for all prescriptions in Canada, as is done in British Columbia (Gagnon 2014).

V. Pharmacare in Other Countries

The information above illustrates that Canadians tend to pay more for their medications. We also have a much higher proportion of private insurance paying for prescription medications than comparator high-income countries. In New Zealand, the Netherlands, and Australia, private insurance accounts for less than 3% of pharmaceutical spending - compared to our 35% (OECD 2011).

Table 1: Comparative Analysis of Various OECD Nations' Pharmaceutical Programs

Country	2000	2010	Average growth rate, 2000-2010	Percentage funded by private insurance (2010 or closest year)	Share of total health care expenditure (2010 or closest year)
	Canadian dollar		*percent*		
United States	813	1,198	3.96	39.4	11.9
Canada	**603**	**903**	**4.13**	**31.1**	**16.7**
Germany	545	780	3.65	6.8	14.8
Australia	505	692	3.21	2.9	14.7
Netherlands	411	587	3.62	2.2	9.5
United Kingdom	391	481	2.10	N/A	11.8
New Zealand	304	348	1.35	2.2	9.4

Sources: OECD Health Data 2012, expenditure on pharmaceuticals and other medical non-durables. US National Health Expenditure Accounts (2011), expenditure on prescription drugs and non-durable medical products.

Source: Morgan SG, Daw JR, Law MR. Rethinking Pharmacare in Canada. Toronto (ON): C.D. Howe Institute; 2013 Jun. 28p.

New Zealand

Coverage: All New Zealanders are covered for medically necessary medications through District Health Boards, analogous to Canada's provincial health systems.

Patient Costs: A fixed co-pay of approximately $2 is paid with the filling of every prescription for drugs subsidized by the national formulary. If patients want to purchase a more expensive drug in a therapeutic class than the one covered by the national formulary, they must pay 186% of the difference in cost.

Drug Assessment: Medications are assessed for safety, efficacy, and cost-effectiveness by the Pharmacology and Therapeutics Committee (PTAC), and a national drug formulary is maintained by the Pharmaceutical Management Agency, also responsible for negotiating prices.

Costs: New Zealanders pays on average 79% of what Canadians pay for brand name drugs and only 23% for generic drugs.

United Kingdom

Coverage: All British Citizens are covered for necessary medical services and medications by the National Health Service (NHS). (Morgan, Daw and Law 2013)

Patient Costs: Wales, Scotland, and Ireland provide medications free of patient charge, while in England there is a €7.10 charge per prescription. However, many categories of patients are exempt from this charge, including children, people over 60, and people on social assistance. In fact, an estimated 88% of prescriptions in England are dispensed without co-pay. It should be noted that, per capita, the United Kingdom invests more in research and development than Canada (OECD 2012).

Drug Assessment: The National Institute for Health and Clinical Excellence (NICE), assesses medications that are considered controversial. Following NICE recommendations, there are no price negotiations. The UK drives medication prices down by setting a maximum profit level for pharmaceutical companies. (Morgan, Daw and Law 2013)

Costs: Prices for patented drugs are "18 percent lower than in Canada, and prices for generic drugs are approximately 30 percent lower". (Morgan, Daw and Law 2013)

United States

Coverage: The United States Government provides universal medication coverage for people covered by Medicare and Medicaid. Medicare covers those who are 65 or older who have worked a certain number of years and thus paid into the program. Those who have not worked a sufficient number of years can buy into the program through a premium. Medicaid covers people with income up to 133% of the poverty line. Neither program covers the total cost of pharmaceuticals. People not covered by Medicare or Medicaid can purchase health insurance, including drug plans, on the open market. Like in Canada, most people with coverage for medications get it through their employment.

Patient Costs: Significant co-pays exist with different private plans, and vary with public plans according to State. Millions of Americans are without pharmaceutical coverage at all, and 13.2% of Americans report paying more than $1,000 out of pocket for medications annually (Morgan, Daw, and Law, 2013).

Drug Assessment: The Center for Drug Evaluation and Research, under the Food and Drug Administration, is tasked with evaluating medications with regard to safety and efficacy.

Costs: Americans pay on average 169% of what Canadians pay for brand name drugs and 65% for generic drugs.

VI. Provincial Pharmaceutical Coverage

Please consult Appendix 2 for detailed information on each province's policies.

Executive Summary

Generally, special populations such as those on social assistance, seniors, and patients with specific diseases are covered by the province, though this greatly varies (for example, BC and Manitoba have no specific coverage for seniors). While there are 8 provinces with upper limits on drug costs geared to income (New Brunswick and Alberta do not), only 3 have limits below 5% of family income for all families; the threshold for coverage in some provinces is quite high. Quebec has a mandatory public plan that functions slightly differently than the coverage in other provinces. Of note, New Brunswick got its first catastrophic coverage within the last year.

Table 2: General and Catastrophic Public Drug Plans in Canadian Provinces

	General	Geared-to-Income (Catastrophic)
BC	Voluntary participation in plan with income-based deductible.	Yes, general plan is a geared-to-income plan with deductibles from 0 percent (min) to 4 percent of income (max.)
AB	Plan for seniors, social assistance recipients, and an income-based premium plan for others without private insurance.	No, income-based premiums in voluntary plan (Non-Group Coverage Benefit). Max. individual premium of $760 (with annual income above $21k); Max $25 co-pay for each prescription.
SK	Plan for low- and middle-income seniors and social assistance recipients.	Yes, max. costs of 3.4 percent of adjusted family income (Special Support Program).
MB	Income-based deductible plan for all without private group insurance.	Yes, max. costs of 2.97 to 6.73 percent of adjusted family income.
ON	Plan for seniors and social assistance recipients.	Yes, max. costs of 4 percent of net family income (Trillium Plan).
QC	Plan for seniors, social assistance recipients and mandatory plan for those without private group insurance.	Yes, max. costs of $1,029 annually (Mandatory public plan).
NB	Plan for low-income seniors and plan for social assistance recipients; voluntary plan for all others without private group insurance.	No, income-based premiums in voluntary plan (New Brunswick Drug Plan). Max. individual premium from $800 to $2,000 (with annual income above $22k); Max $15-$30 co-pay for each prescription.
NS	Income-based plan for seniors and plan for social assistance recipients.	Yes, max deductible from 1 to 20 percent of income, max copayment from 4 to 15 percent of income (Family Pharmacare Program).
PE	Plan for seniors and social assistance recipients.	Yes, max. costs range from 3 to 12 percent of income (Catastrophic Drug Plan).
NL	Plan for low-income seniors and plan for social assistance recipients.	Yes, max. costs of 5 to 10 percent of income; no max for those with annual family income above 150k (The Assurance Plan).

Source: Blomqvist A and Busby C. 2015. Feasible Pharmacare in the Federation: A Proposal to Break the Gridlock. *C.D. Howe Institute E. Brief*, October 21, page 5.

VII. Role for Federal Government

The federal government has a responsibility to ensure all Canadians, regardless of where they live, have equal opportunity to health. Unfortunately, the current system has resulted in major inequities in access to medications between provinces. The percentage of households that spend greater than 5% of income on prescription medications varies widely between provinces, ranging from only 2.2% in Ontario to 10.1% in Prince Edward Island (Statistics Canada, 2006). Due to differences in bargaining power, smaller provinces tend to pay more than larger provinces for the same medications (Morgan et al., 2013)

The federal government is uniquely positioned to negotiate drug prices on behalf of all Canadians. This significant purchasing power can lead to reductions in medication prices - a phenomenon we have already begun to experience with the Pan-Canadian Pharmaceutical Alliance.

Sometimes, the federal government does not involve itself in health care matters as provinces have constitutional jurisdiction over health care. The following quotation summarizes the constitutional federal role in pharmaceuticals:

"What role should Ottawa play? Is health care simply a provincial jurisdiction? One should note that this is not exactly what the Canadian Constitution says. Rather, the Canadian Constitution says that health care establishments come under the provincial jurisdiction (s.92(7)) while the criminal law regulating drugs and narcotics (including medicines) comes under the Federal jurisdiction. Patent law is also a Federal jurisdiction (s.91(22)). These constitutional elements explain why drug approval and the regulation of patented drug prices are done by federal organizations: Health Canada and the Patented Medicines Prices Review Board. Like it or not, the federal government is compelled by the Constitution to remain a central player in pharmaceutical policy." (Gagnon, 2014).

The CFMS recommends that the Government of Canada:

A) Establish a concrete plan and corresponding timeline for the exploration of how to create a national formulary, as a first step towards a national pharmacare program;

B) Demonstrate continued collaboration with provinces and various stakeholder groups and consideration of evidence-based reports when evaluating how to improve access to pharmaceutical care for all Canadians;

C) Work with pertinent stakeholder groups to ensure that this national formulary also has the capacity to develop and disseminate guidance about safe and appropriate prescribing practices.

Elements of an economically and socially effective pharmacare system may include the following:

1) Ensures universal coverage for medically necessary medications with limited patient charge
2) Integrates financing for medications with financing for other medically necessary services covered under the Canada Health Act
3) Adequately consolidates purchasing power to ensure the lowest possible drug prices
4) Works from a National Drug Formulary developed based on sound scientific evidence to ensure the best value-for-money for prescriptions

VIII. Entities Supporting National Pharmacare

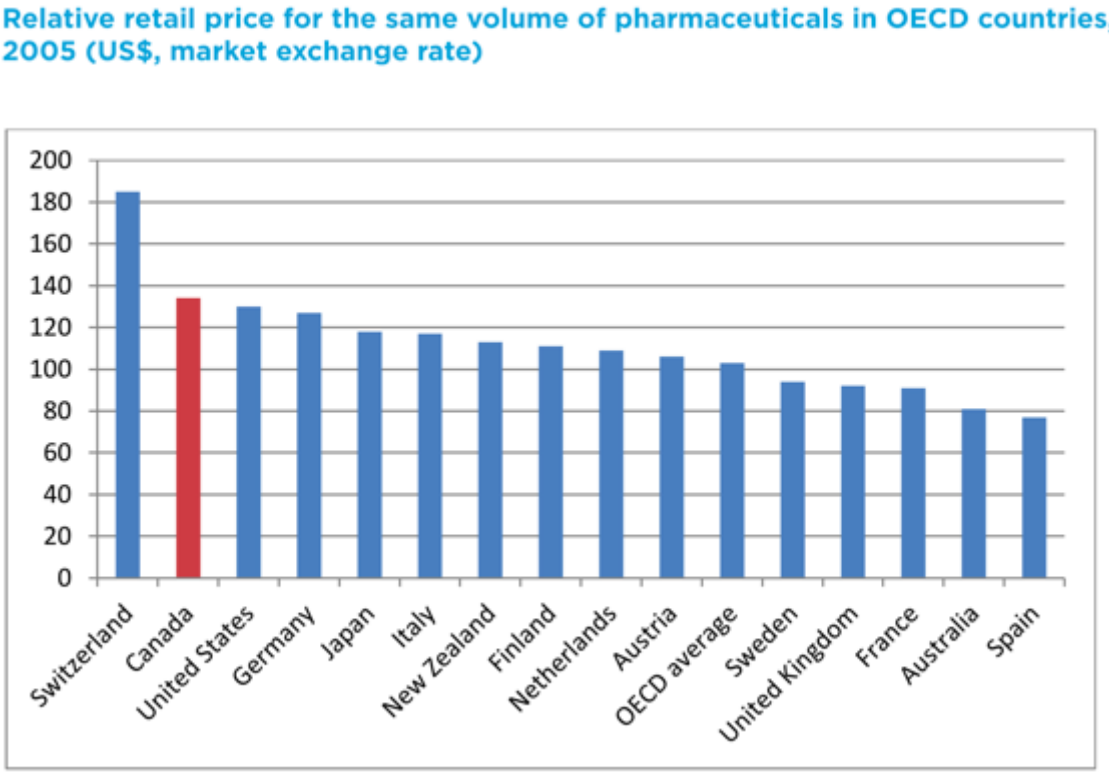
Please consult Appendix 3 for a comprehensive list of organizations and entities supporting national pharmacare.

Executive Summary

There is currently overwhelming support for national pharmacare by the Canadian public, with latest polls showing 91% of Canadians in favour of a universal system. Federal parties are consequently following suit with the Green Party and the New Democratic Party having publicly announced support for National pharmacare, while the Liberals and Conservatives favour an increase in bulk-buying among provinces. Recently, the current Liberal government united federally administered drug plans with the pan-Canadian Pharmaceutical Alliance in order to increase purchasing power and further drive down drug costs. Indeed, "exploring the need for a national formulary" is included in the Minister of Health Mandate Letter. At the provincial level, provincial and territorial health ministers recently agreed to support the creation of a working group to work towards national pharmacare. Nineteen Canadian municipalities and numerous organizations have all joined the call for a universal program.

Appendix 1: Comparative Figures on Canadian Pharmaceuticals

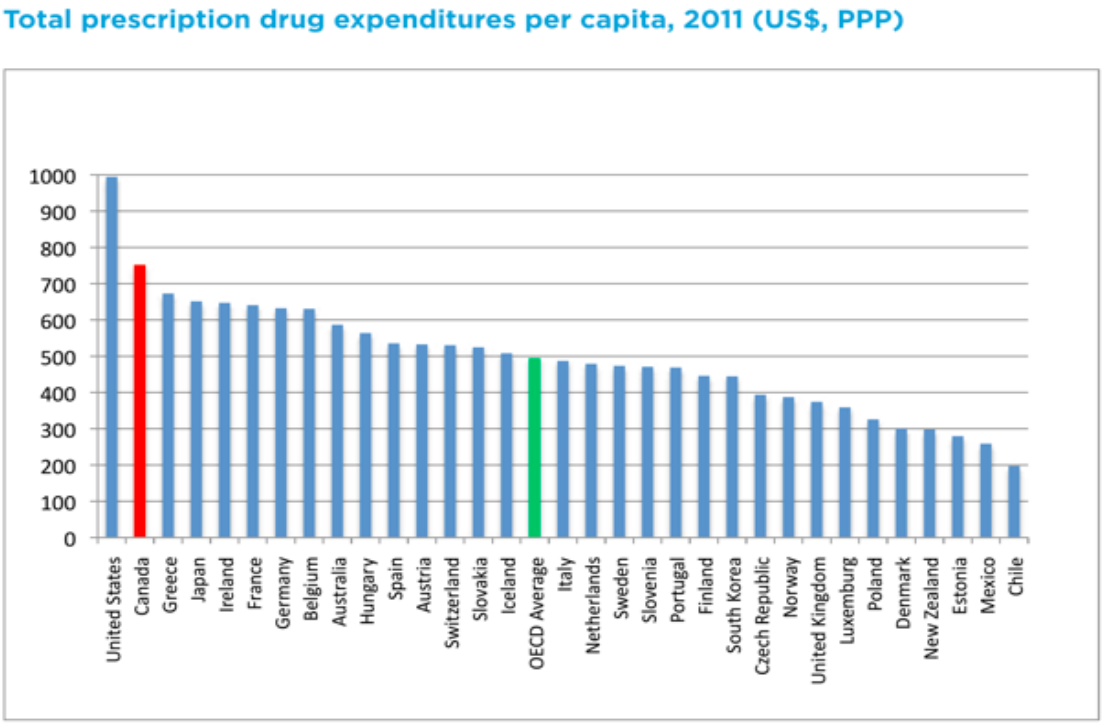
1) Pharmaceutical prices are higher in Canada as compared to other OECD countries with the exception of Switzerland.



Source: Gagnon, Roadmap to a Rational Pharmacare Policy in Canada, 2014

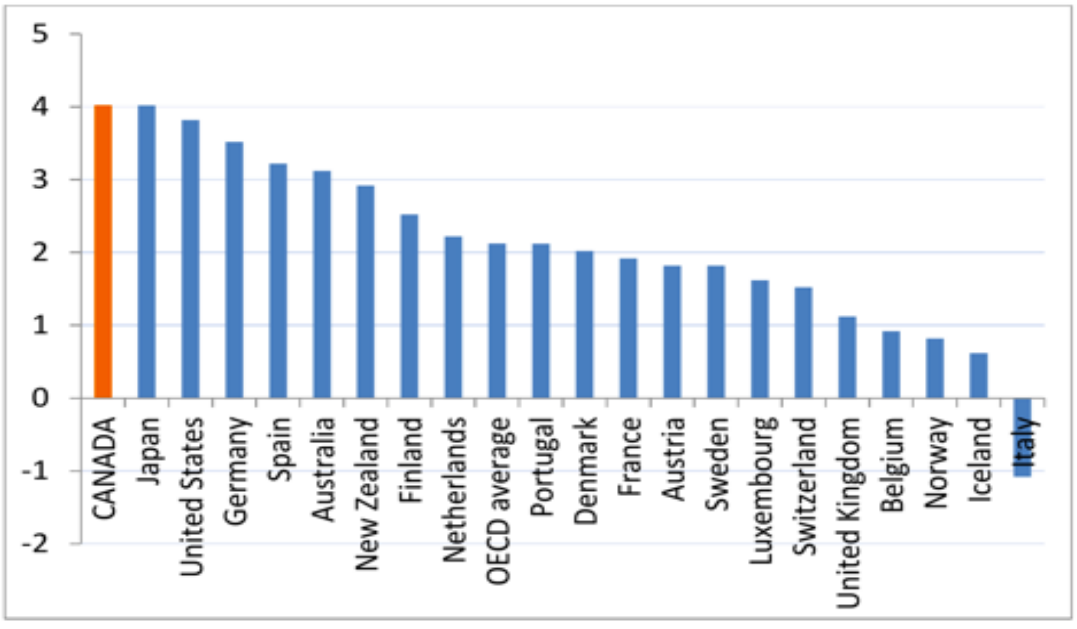
It should be noted that Switzerland's high pharmaceutical prices are largely due to deliberate price inflation to support Switzerland's strong pharmaceutical R&D industry (Gagnon, 2014).

2) **Compared to other OECD countries, Canada spends more per capita on prescription drugs than any other country other than the United States.**



Source: Gagnon, Roadmap to a Rational Pharmacare Policy in Canada, 2014

3) **Canada's prescription drug expenditures are growing faster than those of other countries.** (Note: all countries with less than 3% growth employ some form of national pharmacare)



Source: Gagnon, Roadmap to a Rational Pharmacare Policy in Canada, 2014

Appendix II: Detailed Provincial Pharmaceutical Coverage

British Columbia (Morgan, 2013)

- People on social assistance are covered under the Employment and Income Assistance Program. There is no special coverage for people over 65.
- Anyone in the province can apply for the Trillium Drug Program, which covers medication costs greater than 6.33% of income
- Anyone in the province can apply for Fair Pharmacare, an income-based program that provides coverage after deductibles, with cut-offs based on net family income ("PharmaCare for B.C Residents")
- Permanent residents of licensed residential care facilities that are on the designated list receive coverage
- Patients with cystic fibrosis are covered for drugs listed in the cystic fibrosis formulary
- Children in the At Home Program, for severely handicapped children who would otherwise rely on institution care, receive full coverage
- Psychiatric medications are covered to certain individuals demonstrating need registered with a mental health services centre
- Palliative care services at home are covered

Alberta (Alberta Health Services, 2016)

- Alberta offers "non-group" coverage to all Albertans, who pay a premium of between $82 and $118 dollars monthly per family, a $50 deductible, and up to $25 per prescription.
- For people over 65, a premium-free drug plan is offered, with no deductible and up to $25 per prescription.
- Palliative care is covered with a maximum co-pay of $25 and lifetime maximum co-pay of $1000
- People receiving income support from the Alberta government are eligible for prescription drug coverage.

Saskatchewan (Prescription Drugs, 2012; "Extended Benefits and Drug Plan")

- People who receive Guaranteed Income Supplement (GIS), Saskatchewan Income Plan (SIP), or Family Health Benefits (FHB) pay an annual deductible of $100-$200, and pay only 35% of drug costs on top of this. They are also eligible for the Special Support Program.
- Seniors over 65 and children under 14 have co-payments capped at $20 / prescription
- Anyone in the province can apply for the Special Support Program, which covers medication costs over 3.4% of income.
- People who are deemed by social services to qualify for Supplementary Health coverage receive medications with little or no out of pocket charge.
- The government can approve coverage for certain exceptional drugs not commonly prescribed

- A one-time emergency assistance can be provided for immediate treatment with prescription drugs for those unable to cover their share of the cost
- The Palliative Program covers drug costs for late-stage terminal illnesses

Manitoba (Manitoba Pharmacare Program, 2014)

- People on social assistance are covered under the Employment and Income Assistance Program. There is no special coverage for people over 65.
- Anyone in the province can apply for the Manitoba Pharmacare program, which covers greater than a certain percentage of medication costs, with this percentage dependent on income. Those who make under $15,000 have a deductible of 2.91% of drug costs. This percentage gradually increases with income until $75,000, after which is remains at 6.60% of drug costs. The minimum deductible is $100.

Ontario (Ontario Drug Benefit, 2014)

- People over the age of 65 and those on social assistance are covered under the Ontario Drug Benefit Program
- Anyone in the province can apply for the Trillium Drug Program, which covers medication costs greater than 4% of income
- The Special Drugs Program covers the full cost of certain drugs for specific diseases, and the Inherited Metabolic Disease Program covers certain drugs and treatments for specific condition ("Understanding the Inherited Metabolic Diseases Program")

Quebec (Régie de l'assurance maladie, 2016)
Residents must obtain private drug insurance from employers. Those who are ineligible register for a public pharmaceutical plan. The public plan covers those ineligible for employment plans, persons over 65 years, and those on financial assistance. Children of persons insured under the public plan are fully covered.

Annual Premium: $0 - $640 per year based on family income ("Prescription Drug Insurance")

Catastrophic Coverage / Maximum annual contribution

- Persons 18-64: $1,029
- Claim Slip: $0
- Over 65, No Guaranteed Income Supplement: $1,029
- Over 65, 1% to 93% of GIS: $622
- Over 65, 94% to 100% of GIS: $0

New Brunswick (Department of Health, 2014)
Several different drug programs exist through the New Brunswick Prescription Drug Program. The main ones are described below. Others include coverage for cystic fibrosis, multiple sclerosis, social development, special needs children, human growth hormone, HIV, organ transplant and nursing homes.

Seniors

- 65 years or older who receive GIS or meet low-income cut-offs ($17,198 for a single person and $26,955 for a couple, or where one member of the couple is over 65 and total annual income is less than $32,390) ("Prescription Drug Plan – Seniors")
- Copayment GIS: $9.05 / prescription, maximum of $500 per year
- Copayment Low Income: $15 / prescription, no maximum

New Brunswick used to be the only province without catastrophic drug coverage. It has a newly created New Brunswick Drug Plan to provide catastrophic drug coverage plan to be administered by Medavie Blue Cross (The New Brunswick Drug Plan, 2014). The New Brunswick Drug Plan is available to all those without drug coverage, those who have exceeded the yearly or lifetime maximums for their coverage, or require a drug not included in their drug plan formulary. ("Enrol in the Plan")

- Eligible: uninsured
- Co-payments: 30% up to $30 / prescription (or up to less, depending on income cut-off)
- Premiums: based on income

Prince Edward Island (PEI Health, 2014; "Health PEI: Drug Programs")
Several different drug programs exist. The main ones are described below. Another 20+ programs exist and include coverage for generic drugs, cystic fibrosis, human growth hormone, HIV, PKU, children under temporary or permanent care, transplant anti-rejection drugs, and many others.

Catastrophic Drug Plan: prescription costs exceeding a certain percentage of income are covered

- Income $ 0 - 20,000: 3%
- Income $20,000 - $50,000: 5%
- Income $50,000 - $100,000: 8%
- Income > $100,000: 12%

Family Health Benefit Drug Program: coverage for low-income families for parents and children. Assistance depends on family size and household income.

- Pharmacy dispensing fees are not covered
- Eligibility:
    - One child, and annual family income <$24,800
    - Two children, and annual family income <$27,800
    - Three children, and annual family income <$30,800
    - Four children, and annual family income <$33,800
    - More than four children: add $3000 for each additional child
- Coverage ends when you have no children under the age of 18 or under the age of 25 who are full-time students.

Financial Assistance Drug Program: for those eligible for financial assistance under the *Social Assistance Act*

High Cost Drug Program: income-based assistance paying for expensive medication for specific conditions, including ankylosing spondylitis, certain cancers, multiple sclerosis, Crohn's Disease, and others.

Senior's Drug Program: prescription drugs for those >65 years old

- For each prescription, $8.25 is paid plus $7.69 of the pharmacy professional fee are paid; the rest is covered by the program

Nova Scotia (Nova Scotia, 2013)
Seniors' Pharmacare Program
Premium: Maximum annual premium $1200 (Seniors earning $24,000 or less per annum pay $41 annually, while those earning more pay higher premiums)
Copayment: 20% of each prescription, maximum annual is $382

Family Pharmacare Program

- Families with high prescription medication costs and no private insurance
- Copayment and deductible maximums set based on family size and income

Department of Community Services Pharmacare Benefits

- Income Assistance clients, Persons with Disabilities clients, Children's Aid clients
- Full eligible prescription medication coverage

Newfoundland and Labrador (Department of Health and Community Services, 2014)
Five different provincial drug insurance plans exist, briefly described below.

Foundation Plan: 100% coverage of eligible prescription drugs for persons receiving income support, children under the care of Child, Youth, and Family Services, and individuals in supervised care.

65 Plus: coverage of eligible prescription medication for residents 65 years and older who receive Old Age Security Benefits and Guaranteed Income Support. Patients may dispensing fee up to a maximum of $6.

Access Plan: coverage of eligible prescription medications to families with low incomes

- families with children with net annual incomes of $42,870 or less
- couples without children with net annual incomes of $30,009 or less
- single individuals with net annual incomes of $27,151 or less

Assurance Plan: coverage of exceedingly high drug costs

- Income up to $39,999 pay maximum of 5% of net income towards medications

- Income $40,000 to $74,999 pay maximum of 7.5% of net income towards medications
- Income $75,000 to $149,999 pay maximum of 10% of net income towards medications

Select Needs Plan: full coverage for disease-specific drugs and supplies for those with cystic fibrosis and growth hormone deficiency

Appendix 3: Detailed List of Entities Supporting Pharmacare

Support for national Pharmacare has been growing rapidly over the past few years as the evidence for the program becomes more unequivocal. A 2015 study by the Angus Reid Institute showed that 91% of Canadians support Universal Pharmacare. Furthermore, political parties, recognized public figures, municipalities and provincial leaders have publicly expressed their support for Universal Pharmacare. Below is a list of some of these entities.

Political Parties

- Green Party: announced a National Pharmacare Plan during the 2015 federal elections
- New Democratic Party: announced support for the development of a National Pharmacare Plan during the 2015 federal elections

Government Reports and Initiatives

- Royal Commission on Health Services 1964: recommended universal drug coverage
- National Health Forum 1997: recommended universal drug coverage
- Kirby Senate Standing Committee on Social Affairs, Science, and Technology 2002
    - recommended families would pay no more than 3% of their income towards prescription drugs with the federal government paying 90% of expenses in excess of $5,000
- Romanow Commission on the Future of Health Care in Canada 2002: recommended catastrophic drug coverage (for those spending > $1,500 / year) as an initial step towards universal Pharmacare
- 10-Year Plan to Strengthen Health Care
    - National Pharmaceutical Strategy 2004: attempted to implement catastrophic drug coverage
    - National Pharmaceutical Strategy 2006: recommended national drug pricing and purchasing be established, but cancelled in 2008 as it was deemed to be unrealistic

Provinces

- British Columbia
    - Premier Christy Clark
- Ontario
    - Premier Kathleen Wynne
    - Health minister Eric Hoskins
- Manitoba
    - Premier Greg Selinger
- New Brunswick
    - Health minister Victor Boudreau
- Newfoundland and Labrador
    - Premier Paul Davis
    - Health Minister Steve Kent

- Nova Scotia
    - Health minister Leo Glavine

Municipalities

- Ajax, ON
- Burnaby, BC
- Durham Region, ON
- Cambridge, ON
- Hamilton, ON
- Inverness County, NS
- Marathon, ON
- Nelson, BC
- North Vancouver, BC
- Northwestern Ontario Municipal Association
- Oshawa, ON
- Port Coquitlam, BC
- Peel Region, ON
- Red Deer, AB
- Toronto, ON
- Union of Nova Scotia Municipalities
- Vancouver, BC
- Victoria County, NS

National Organizations

- Canadian Doctors for Medicare: recommends universal drug coverage
- **Canadian Federation of Medical Students: recommends universal drug coverage**
- Canadian Federation of Nurses Unions: recommends partnership with the Federal government to develop national Pharmacare
- Canadian Health Coalition: recommends universal drug coverage
- Canadian Medical Association: support the development of a national Pharmacare Program
- Canadian Pharmacists Association: supports a national Pharmacare policy
- C.D. Howe Institute: recommends feasible pharmacare policy
- Pharmacare 2020: recommends a national Pharmacare program by the year 2020; their report is endorsed by almost 300 professors of health care policy and practice across Canada

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