A Roadmap to a Rational Pharmacare Policy in Canada

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CFNU
CANADIAN FEDERATION OF NURSES UNIONS

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The Canadian Federation of Nurses Unions (CFNU)

The Canadian Federation of Nurses Union represents close to 200,000 nurses and student nurses. Our members work in hospitals, long-term care facilities, community health care, and our homes. The CFNU speaks to all levels of government, other health care stakeholders and the public about evidence-based policy options to improve patient care, working conditions and our public health care system.

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pei nurses www.peinu.com

Nova Scotia Nurses' Union

NBNU SUINB New Brunswick Nurses Union Syndicat des infirmières et infirmiers du Nouveau-Brunswick

ONA Ontario Nurses' Association

Manitoba nurses Union A COMMITMENT TO CARING

SASKATCHEWAN SUN UNION OF NURSES

United Nurses of Alberta

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Message from the CFNU

Linda Silas

For over two decades, the Canadian Federation of Nurses Unions (CFNU) has been advocating for a national pharmacare plan. Now, as the costs of prescription drugs continue to rise, putting pressures on a health care system that is already stretched to the limit, the CFNU is gaining some new allies. There is a growing consensus that prescription drug policies require reform. Advocates for reform include the C.D. Howe Institute (a well-known public policy think tank), the Canadian Life and Health Insurance Association, provincial and territorial governments, as well as patient advocates from coast-to-coast. Like our premiers, the CFNU is committed to tackling the issue of escalating drug costs, while ensuring access and quality care. The failure to contain the costs of pharmaceuticals is threatening Canada's ability to provide patients with the health care they need. A national pharmacare program is an urgent priority if our health care system is to provide patients with the medications they need.

A Roadmap to a Rational Pharmacare Policy calls for governments, insurers, policy makers, and pharmaceutical companies to recognize that the present hybrid system we are using to fund prescription drug purchases isn't working. As Dr. Marc-André Gagnon's paper makes clear, our current system is unfair, inequitable,

and wastes money in many different ways, from excessive administrative fees to government tax subsidies, to unnecessary and expensive treatments. Reform in the current context isn't radical; rather, it's the rational, responsible choice we need to make.

At the Council of the Federation meeting in 2004, premiers committed to the creation of a national pharmacare plan. We had the premiers on-board, but the federal government ultimately failed to deliver on its commitments. At that time, the CFNU was hopeful that its advocacy efforts would lead to a national pharmacare plan. Unfortunately, as this paper points out, despite the logic behind it, the lack of political will and vested corporate interests remain major stumbling blocks. Since then, there have been no steps taken to create a plan. As Ottawa continues to download costs onto the provinces, stretching their limited budgets even further, expanding cooperation on cost-effective measures like the bulk purchasing of prescription drugs makes for good fiscal and public policy.

In recent years, there have been some encouraging signs. The provincial premiers have formed the Council of the Federation Health Care Innovation Working Group and developed an alliance for the bulk purchasing of pharmaceuticals. These are good first steps. However, without more extensive reforms, as the paper details, this alliance is failing to realize its potential.

Billions in savings are ours for the taking to be reinvested in safe, quality patient care, and any political party which proposed national pharmacare would only be offering better health care to the public, with more money in their pockets at the end of the day. Given this fact, why aren't politicians seizing the opportunity? Each year, our health care system wastes billions by not moving forward with this long promised program. More importantly, millions of Canadians go without adequate access to medically required medications.

It's not like national pharmacare is an untried and untested idea. According to the report's author, Dr. Marc-André Gagnon, Canada is the only OECD country with universal public health care that does not also have a pharmacare plan. Every developed country with a universal health care system, except Canada, provides universal coverage of prescription drugs, and all such countries provide universal coverage at less cost than Canada.

As the title of this report indicates, Dr. Gagnon offers a roadmap to a rational drug policy so that Canada can move into the 21st century, alongside its OECD

counterparts. He suggests that governments need to seize the initiative and take advantage of the emerging consensus on the need for reform, and offers a series of a pragmatic, achievable steps that can be taken now to turn policy into practice. While Gagnon acknowledges that a universal pharmacare program will not solve all Canada's problems, it will help build the institutional capacity to improve access, diminish costs, improve practices and ensure the continued sustainability of our health care system. The CFNU urges stakeholders to read this paper closely. A national pharmacare plan will save billions for governments and patients while simultaneously improving health outcomes.

Given the evidence presented in this report, we have two questions for all governments: 1) What is the alternative to not acting? 2) Can we really afford not to consider national pharmacare when the cost of prescription drugs remains the second highest component of health care spending, exceeding even the cost of doctors?

It's been a long journey but we hope that decision makers will take a careful look at the evidence: fiscal prudence and the emerging consensus among both policy makers and the public suggest that now is the time to act. I recognize that it is a much longer and more arduous journey for patients and their families who cannot afford necessary life-saving medications, who must choose between feeding their families and buying the medications they need to lessen their pain. In a country like Canada, where public health care is one of the things we prize as Canadians, this is a choice no Canadian family should be forced to make.

In solidarity always,

Linda

Foreword

Steven Morgan, PhD

Experts from across the spectrum agree pharmaceutical policy in Canada is failing the nation. Lacking a strategic plan for integrating prescription drugs into our universal, public health care system, prescription drugs are simultaneously underused, overused, misused, and overpriced in Canada.

As Dr. Marc-André Gagnon explains in this report, no Canadian province provides drug coverage on par with international norms – let alone international best practices. All provinces rely on a patchwork of private and public drug plans that operate highly independently of each other and of the rest of the health care system. Patients' access to public drug coverage depends significantly on their age, occupation and health care needs in a system that leaves millions of Canadians with little or no drug coverage at all.

The federal government has taken the very narrow, constitutionalist stance that pharmaceutical policy is, for the most part, solely a provincial responsibility. It offers no financial assistance for provincial drug plans, nor has it passed laws that would ensure policy makers, health professionals, and patients have critical information about the safety, efficacy, and even the availability of drugs on the Canadian market.

Health care professionals and patients are left with limited scientific information about which drugs are best for their patients, and scarcely any independent information sources.

The result: Canada has one of the worst performing pharmaceutical sectors in the world. Despite the fact that we spend more on medicines than all comparable countries, literally millions of Canadians are unable to afford medications prescribed by their doctors. Millions more bear the cost of significant out-of-pocket expenses for prescriptions filled to address their families' health care needs. And far too many are harmed by preventable over- and under-use of medicines.

As Dr. Gagnon points out, even our scientific community is shortchanged. By international standards, our federal government is not an aggressive regulator of medicines or prices; and, as a nation, Canada spends more on medicines than any comparable country. Yet, the pharmaceutical industry invests in Canada just a fraction of what they invest in other countries.

It doesn't have to be this way.

A comprehensive public pharmacare program would improve the accessibility, equity, efficiency, security, and quality of prescription drug use in our health care system. Dr. Gagnon carefully explains how.

Universal coverage of cost-effective treatments – importantly, without co-insurance or deductibles – would increase access to necessary care, thereby improving patient health and reducing demands on the public health care system. A national approach to generic tendering and brand-name price negotiations – combined with a national formulary – would dramatically lower costs while increasing inter-provincial equity in access to medicines. Such an approach could also help to ensure the security of the supply of medicines for Canadians in the event of global shortages. Finally, better integration of medicines into the health care system – and more active participation of the federal government in pharmaceutical policy – would help to improve the prescribing appropriateness and real-world health outcomes.

There is virtually no downside to a well-designed universal, public pharmacare system – unless, of course, you are a stakeholder that benefits from the status quo.

Channelling Professor Robert Evans, Marc-André Gagnon reminds us that every dollar of income in the health care system is a dollar of someone's income.

According to Marc-André Gagnon's analysis, private insurers, pharmaceutical manufacturers, and retail pharmacy corporations have somewhere between $3 billion and $11 billion to lose if Canada were to implement a universal, public pharmacare program. So, even though the outcomes of the status quo are a national embarrassment – costing Canadians in money, quality of life, and even life itself – there are actors that will ardently oppose a better approach for Canada.

But wasting billions of dollars every year at the expense of patient health and well-being cannot be accepted any longer. The vast and growing body of evidence summarized in this report is undeniable. Canada's public health care system shouldn't end as soon as a doctor hands a patient a prescription to fill.

The tide of public opinion will turn as more organizations become involved by communicating the case for universal pharmacare. As this information is understood, shared, and acted upon by more and more Canadians, governments will finally have the political courage necessary to fulfill medicare's prescription. When prescription drugs are strategically integrated into our health care system, Canadians will enjoy better health care and better health.

Steven Morgan, PhD

Director, Centre for Health Services & Policy Research
Professor, University of British Columbia

Executive Summary

Marc-André Gagnon, PhD

A decade ago, the federal government, the provinces and the territories all agreed there were blatant problems with respect to Canadian drug coverage. Their response was the adoption of the National Pharmaceuticals Strategy (NPS). Unfortunately, in the last ten years very little progress has been made. The problems remain a lack of access to prescribed drugs, the lack of drug cost containment, money wasting and a fragmented drug system which means that costs savings at one point translate into cost increases elsewhere.

Universal, publicly funded pharmacare is the dominant standard among most OECD countries. The lack of drug coverage in Canada is an anomaly since medications are not integrated into our public health care system. Countries with integrated pharmaceutical coverage achieve better access to medicines and greater financial protection for the ill, at significantly lower costs than any Canadian provinces achieve. However, in Canada, drug coverage is offered on the basis of where a person works or lives, and not on the basis of his or her medical needs. Canada and the United States, with only around half of their population having access to public insurance, are outliers when it comes to drug coverage. These

two countries rely heavily on private drug insurance, and they have higher overall expenditures and spend much more for their medications than other OECD countries.

This report demonstrates how such a system is inefficient, inequitable, wasteful and unsustainable in the long run. It is inefficient because it is unable to adequately cover the whole Canadian population; it is inequitable because many Canadians pay amounts disproportionate to their income in order to access medications; it is wasteful because Canadians pay too much, needlessly, for patented or generic drugs; and it is unsustainable because governments are unable to contain cost increases.

There have been some recent developments which demonstrate how the absence of a universal pharmacare program acts as a barrier to progress and innovation. Over the past few years, generic drug prices as a percentage of the brand-name drug prices have dropped significantly in all provinces, but these price reductions in public plans were often offset by a price increase in private plans. Since 2007, we have also seen an increase in confidential agreements (Product Listing Agreements or PLAs) between pharmaceutical companies and provincial public plans. While these agreements enable some public plans to contain drug costs, those savings result in artificially inflated costs for patients, private plans, and provinces with less negotiating power. The Council of the Federation's creation of a Pan-Canadian Pricing Alliance in Canada (PCPA) in 2010 (including all provinces except Quebec) was an important first step to coordinate and streamline negotiations. However, it has limitations since the coordination process within the Alliance remains challenging, especially in the absence of a national formulary. Consequently, this new Alliance has not been able to realize its potential with few patented drugs being purchased and generic prices negotiated as a percentage of the patented drug price, rather than the absolute lowest price that could result from competitive bidding. Bulk purchasing also fails to ensure that savings for public plans necessarily translate into savings for all Canadians since private plans and people without insurance continue to pay their medicines at an increasing official price, without benefiting from the bargaining power of the Alliance. Drug shortages are also increasingly prevalent in Canada. Provinces and hospitals are being asked to manage the problem on their own when stock shortages are a complex global issue needing a comprehensive purchasing system with purchasing clauses to avoid shortages. All these factors point to our failure to ensure the sustainability of our drug insurance system, as well as the urgent need for a national pharmacare plan.

The role of private insurance in evolving pharmacare policy is frequently debated. Though some defend its role by arguing that it saves public funds, the evidence is clear: private insurance is part of the problem and not the solution. Having a hybrid

private-public insurance plan creates a fragmented system in which the involvement of multiple payers diminishes their purchasing power. Those funding silos limit the potential for health care managers and providers to consider the full benefits and opportunity costs of prescription drugs as an input into the broader health care system. Key issues associated with private plans are examined in this report. Among the issues identified are: skimming, i.e. accepting the "good risks" (richer, healthier, younger), and leaving the "bad risks" (unable to work, low-income, seniors) to the state; waste (52% in 2012) either through reimbursing more expensive medicines with no additional therapeutic value, or paying unnecessary dispensing fees; federal tax subsidies (at around 13%); and excessive administrative costs.

In 2010, *The Economic Case for Universal Pharmacare* report (Gagnon & Hébert, 2010) showed that a public and universal drug plan, based on first-dollar coverage, would not only improve access to drugs, but Canada would also save from 12% to 42% in total prescription drug expenditures. The current report updates some of the findings from 2010, and offers an analysis of the current policy climate given the rapid evolution of pharmaceutical policies in Canada in the past three years. It highlights the impact of industrial policy on pharmaceutical prices in Canada. The report also examines the growing consensus about the need for pharmacare reform and sustainability in light of our increasingly unsustainable system. More importantly, this work explores what must be done to implement the necessary reforms by offering a roadmap for building the institutional capacities needed to improve access, diminish costs, improve practices and ensure the longevity of our health care system.

There is an emerging consensus about the necessity of reforming our drug policy. The C.D. Howe Institute, a well-known public policy think tank, has endorsed the idea of a public and universal drug coverage plan. The Canadian Life and Health Insurance Association has called for urgent drug coverage reforms to ensure better public and private coverage. Provincial governments from coast-to-coast are grappling with the issue of containing costs, while ensuring access. And health care organizations are witnessing the direct impact that drug costs are having on their patients' health. There is a growing recognition of the urgent need for reform. The following four reforms offer a way forward for policy makers:

Reform #1: Improve access to drugs by including prescription drugs in the public health care system.

Every Canadian should have adequate and equitable coverage for prescription drugs. A national pharmacare program must be offered to the entire Canadian population, whether organized nationally or provincially/regionally. Potential measures to diminish the cost impacts on public health insurance include: fixed

co-payments (to be progressively eliminated); the social insurance principle (through pay deductions); risk pooling; and ending generous tax subsidies for private insurance.

Reform #2: Ensure equitable access to prescription drugs by establishing a national formulary.

Currently, Canadians' access to medications is dependent on their postal code. Provincial variability in access to prescription drugs is explained, in part, by the province's health budget and its power to negotiate with pharmaceutical companies to get confidential rebates called Product Listing Agreements (PLAs). Such a system is fundamentally inequitable. Therefore, the coverage offered to the entire population must be based on a national formulary.

Reform #3: Control costs by systematically resorting to bulk purchasing for patented and generic prescription drugs.

In the last three years, the main innovation to contain prescription drug costs in Canada has been the creation of a bulk purchasing agency, the Pan-Canadian Pricing Alliance, for some patented and generic drugs. Bulk purchasing is more efficient than increasing the number of PLAs (which often pit provinces against one another through whipsawing). Moreover, such an agency can help to ensure the safety of the supply through safety clauses in order to reduce drug shortages. To avoid indirectly taxing patients, deductibles and co-payments for patients need to be eliminated or, if this is not achievable, only a fixed co-payment per prescription (rather than one based on the official price of the drug should be permitted).

Reform #4: Ensure the appropriate use of prescription drugs by assessing the safety and efficacy of medications.

The security and safety of medications remains a major issue in Canada. Prescription drug deaths are high: half of these drug deaths are due to medical errors; the other half are due to adverse effects. The recent creation of the Drug Safety and Effectiveness Network, by the Canadian Institutes of Health Research, is a good first step, but it is insufficient. We currently don't have data to analyze the security and safety of medications. To generate such data, a national formulary and a public and universal drug plan are essential since they permit the establishment of a complete database of drug usage in Canada.

Conclusion

A universal pharmacare program would allow Canada to build the institutional capacity needed to improve access, diminish costs, improve practices and ensure the longevity of our health care system. As the data shows, it would lead to equitable access to prescription drugs while generating important savings for the Canadian population. It would have very few impacts on taxpayers other than to increase their net disposable income.

If Canada offered first-dollar coverage, a universal pharmacare program would generate savings of 10% to 41% on prescription drugs, representing savings of up to $11.4 billion per year.

The need for a universal pharmacare program is one of the rare issues creating consensus among analysts from across the political spectrum and among Canadians – 78% of Canadians support a universal pharmacare program, and 82% support bulk purchasing to reduce the costs of prescription drugs.

After presenting a pragmatic roadmap for a national drug plan policy, along with the institutional capacities necessary to obtain and implement rational and appropriate pharmaceutical policies, the evidence is clear: it's time the government heeded the public's will by putting in place rational policies to reform prescription drug funding.

A universal pharmacare plan would ensure better access to prescription drugs for all Canadians, bridge the gaps in our health care system, while increasing workers' disposable income. In summary, with a little political will, Canada could finally enter the 21st Century.

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Marc-André Gagnon, PhD

Professor, School of Public Policy & Administration, Carleton University

Chapter 1 Introduction

The Economic Case for Universal Pharmacare was published in September 2010. Based on conservative hypotheses, the report showed that a public and universal drug plan based on first-dollar coverage would not only improve access to prescription drugs but would also save Canada from 12% to 42% in total expenditures (Gagnon and Hébert, 2010).

The 2010 report generated considerable interest in the media by clearly demonstrating that resistance to implementing a public and universal plan was not a question of costs but rather a lack of political will. However, the report did not address important elements such as the role of the federal government in implementing a public and universal plan, nor did it explore the different financing options. This paper thus underlines the importance of integrating the latter elements while reaffirming the necessity for a universal pharmacare program.

Pharmaceutical policies have evolved rapidly since 2010, suggesting there is a need to re-examine the analyses provided in *The Economic Case for Universal Pharmacare* in light of what is happening now in the pharmaceutical sector. This report will provide an overview of the inefficiency of the Canadian drug coverage

plan and its failure to contain costs. It will put into perspective the recent evolution of pharmaceutical policies in Canada, as well as their impact on public and private drug insurance plans.

From an analysis of recent trends, we will show that a consensus is now emerging as to what reforms are needed to make pharmacare more efficient and sustainable. Specifically, we will examine the reforms to pharmacare recommended by the Canadian Life and Health Insurance Association (CLHIA, 2013), which are partially in line with the proposed public and universal drug plan reforms. We will then show how a universal public pharmacare plan is not only the best solution to contain costs and ensure better access to drugs for all, it is also a social program that could be put into place without any tax hike. The last section of this report provides a roadmap for building the institutional capacities needed to establish a rational pharmaceutical regime in Canada.

Chapter 2

Inefficient and unsustainable drug coverage

Drug coverage in Canada can be considered an anomaly. Although Canada adopted a public and universal health care system, it is the only country in the world where such a system does not cover prescription drugs, as if they were not an essential component of health care.

Consequently, the Canadian working population must rely on private insurance for prescription drugs. Provinces and territories do provide public coverage to two categories of people unable to work: seniors and welfare recipients. Most provinces also offer catastrophic drug coverage to the whole population to assist patients faced with disproportionate prescription drug costs (Daw and Morgan, 2012). The out-of-pocket deductibles and co-payments vary from one private plan to another, as well as from province to province. Coverage depends on where one works or where one lives, and not necessarily according to medical needs.

Public drug insurance plans are not offered solely by the provinces and the territories. The federal government also offers public coverage to Aboriginal people, the Inuit, the RCMP, Canadian Armed Forces members, prisoners in federal

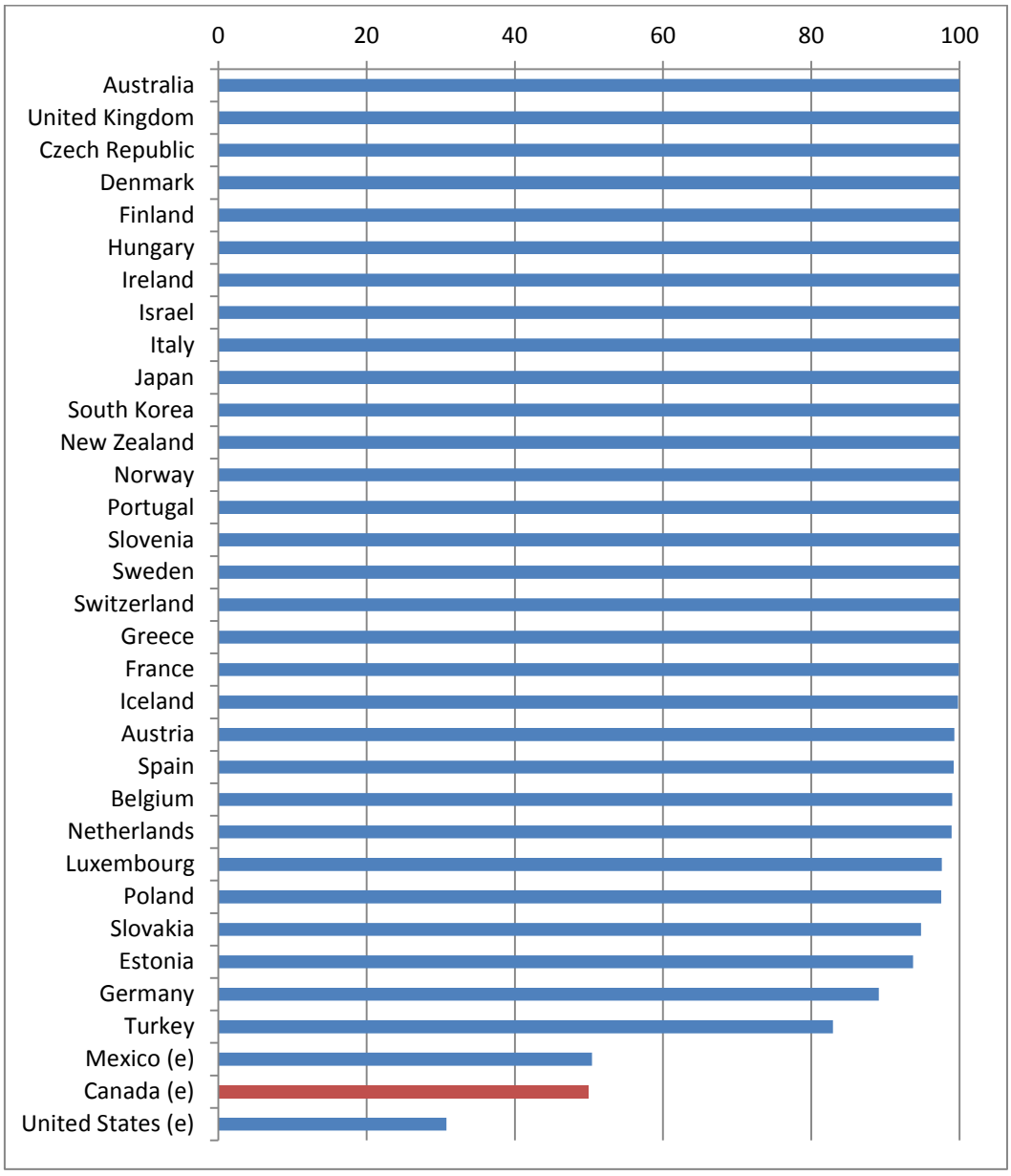
correctional institutions, and veterans (Gagnon, 2012b). The federal government also offered public drug coverage to refugees for a long time, but that program was eliminated in 2012 on the basis that it offered unfair privileges to refugees (Galloway, 2013). In short, the government used the absence of public coverage and access to prescription drugs for all Canadians to justify ending drug coverage for vulnerable members of the refugee population.

Most OECD countries offer universal coverage of prescription drugs to the whole population. For example, virtually all European countries offer public and universal prescription drug coverage, either through funding based on taxation (through income tax) or on a social insurance principle (through pay deductions). Universal pharmacare is no exception. It is the dominant standard among OECD countries (Figure 1).

North America (Canada, the United States and Mexico) stands out as barely half of the population has access to public coverage for prescription drugs. In theory, this lesser coverage is not an issue in itself since the population not covered by a public plan could be covered by a private plan. However, private insurance does not cover all those without public coverage: the results are rather disappointing. One Canadian in 10 reports not having at least one prescription filled in the last year because of the drug cost (Law et al., 2012). This rate is drastically lower in European countries: only 6% of Germans, 3% of the Dutch, and 2% of the British have found themselves in that situation in the last twelve months (Morgan, Daw, and Law, 2013). When questioned about the financial obstacles to accessing prescription drugs, 23% of Canadians said they did not have at least one prescription filled in the last five years because of money issues (EKOS, 2013). Among the OECD countries, the United States is the only country relying more on private insurance to cover drug expenditures (OECD, 2008). More than one American in five said they did not have at least one prescription filled in the last twelve months for financial reasons (Morgan, Daw and Law, 2013).

Figure 1

Percentage of the population covered by a public drug insurance plan in all OECD countries (%), 2010



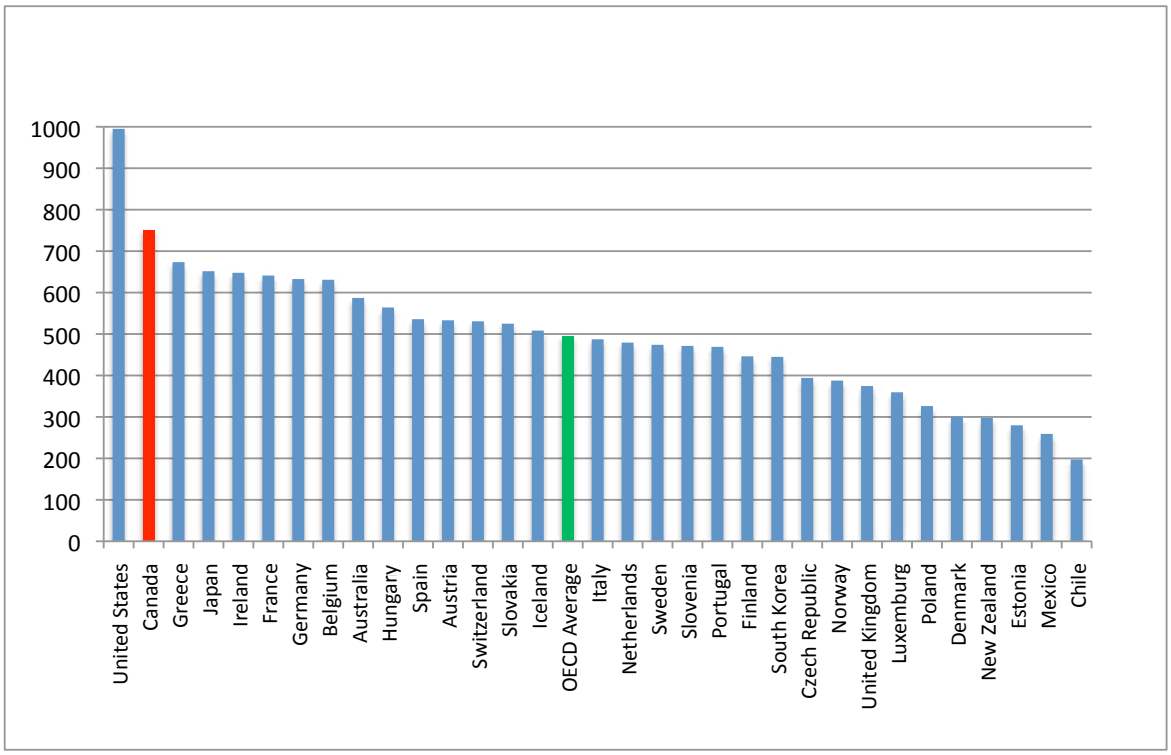
(e): OECD estimate

Source: OECD Health Data: Social Protection

Access to drugs is a significant issue in Canada, but the main problem remains Canada's inability to contain costs. Prescription drug expenditures per capita are high in Canada compared to other OECD countries. Total expenditures are based on two factors: price and volume of purchased drugs (Figure 2).

Figure 2

Total prescription drug expenditures per capita, 2011 (US$, PPP)



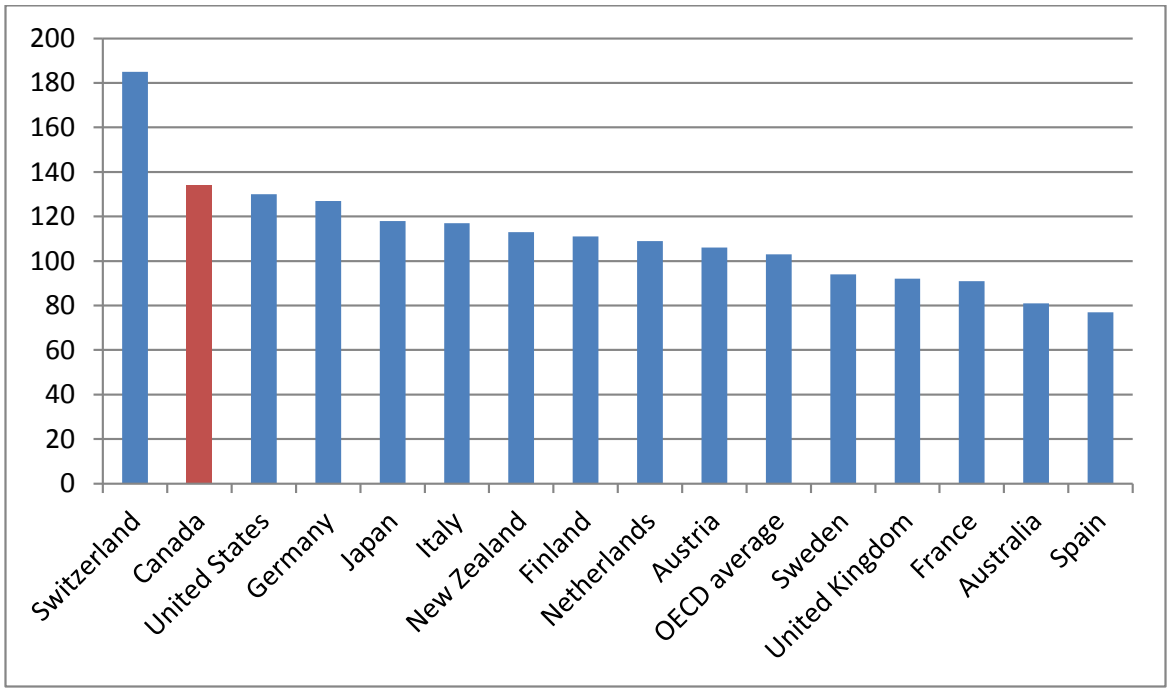
Source: CIHI, OECD Health Data 2013

Some may argue that higher expenditures simply mean higher consumption and better coverage, but such reasoning is incomplete. Canada is known for having significant drug access issues, and the situation is worse in the United States. On the other hand, we know that the United States and Canada pay a very high price for prescription drugs. Based on a 2005 retail price analysis done before the systematic implementation of pharmaceutical companies' confidential rebates (which now prevent comparisons), Canada and the United States rank in the top three in terms of the high price we pay for the same given volume of pharmaceuticals.[1] In fact, the US prices were lower than the Canadian prices because Americans rely more

[1] This was before the systematic implementation of confidential rebates (see section 3.2) offered by pharmaceutical companies (which now prevent us from making comparisons).

Figure 3

Relative retail price for the same volume of pharmaceuticals in OECD countries, 2005 (US$, market exchange rate)



Source: OECD 2008 - Eurostat OECD PPP Programme, 2007.

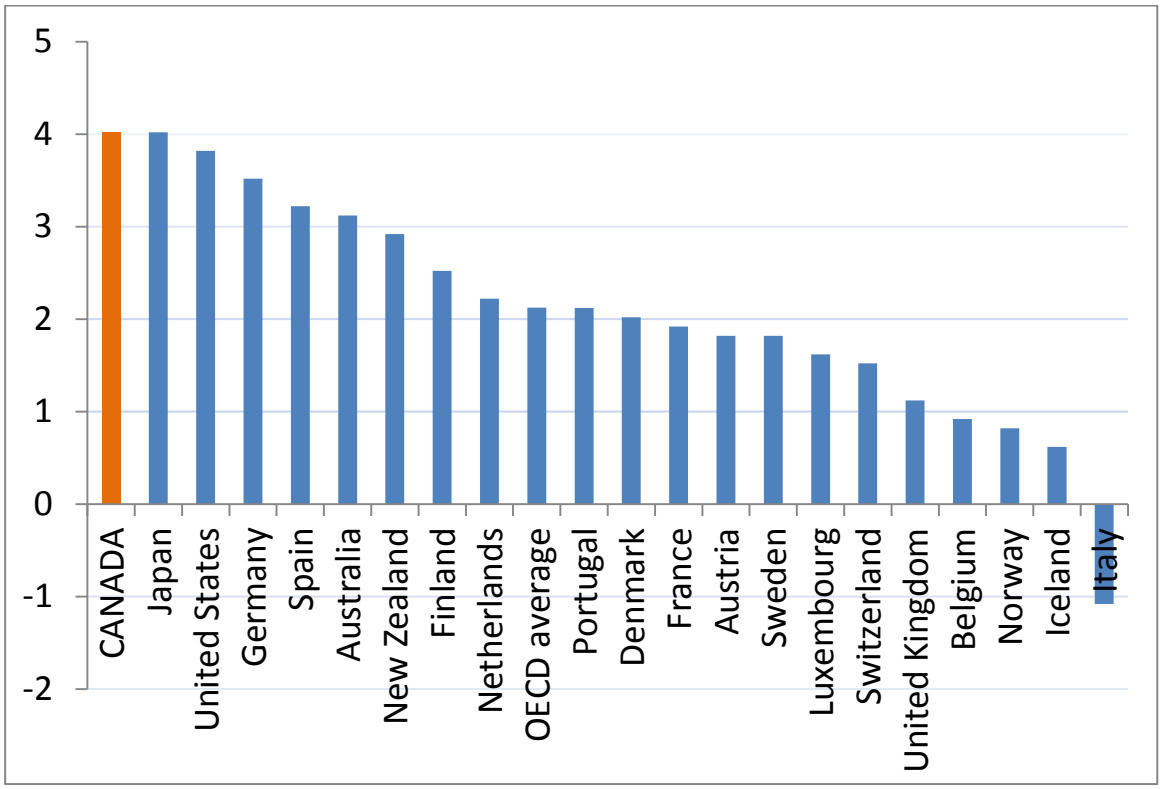
systematically on generic drugs which are priced significantly lower in the United States than in Canada (Figure 3).

The fact that Canadians pay more for their medications is not necessarily an issue. Canada's price inflation policy is related to the need for innovation policies to attract pharmaceutical investments, although these policies are a complete failure and, on an annual basis, very costly for taxpayers (Gagnon, 2012c). However, paying high prices would not be such an issue if we, at least, succeeded in containing the cost increases. Unfortunately, Canada falls short at price containment policies. From 2000 to 2010, the annual cost of prescription drugs increased more in Canada than in other countries with a similar level of economic development. Assessing the cost increase can be a complex process as the increase can vary according to demographic changes or differences in inflation rates. In order to avoid these

obstacles, we assessed the annual per capita cost increase, using purchasing power parity (PPP) and taking inflation into account.

Figure 4[2]

Yearly average per capita growth in prescription drug expenditures, 2000-2010 (%, international comparison using PPP)



Source: CIHI, OECD Health Data, 2013

Canada's annual average per capita growth in prescription drug expenditures was thus considerably higher than in comparable countries. Countries with less than a 3% annual increase all have a universal pharmacare program.

Public and private drug plans often cope with these cost increases by increasing the premiums of insured patients, by increasing co-payments or deductibles paid by patients or by reducing the number of treatments covered. In the end, we observe that out-of-pocket expenditures in prescription drugs increased on average by 33% (in constant dollars) between 1997 and 2009 (Sanmartin et al., 2014). Furthermore, the cost increase has been much more significant for low income households. In

2 Note that Figure 4 excludes Greece and Ireland due to those countries' purchasing power ratios significantly affected by the 2008 economic crises.

constant dollars, between 1997 and 2009, out of pocket expenditures for prescription drugs for the richest 20% have increased by 21%, while they increased by 64% for the poorest 20% (Sanmartin et al., 2014).

To summarize, Canadians pay more for their medications when compared to countries that offer a public and universal plan. Canadians' access to medications is not as good as in other countries, and the annual cost increase makes the Canadian regime unsustainable in the long run.

A May 2013 survey found that 78% of Canadians approved of the idea of a universal pharmacare program (EKOS, 2013). Such a plan is not a panacea and won't solve all the drug purchasing problems, and countries with this program are also facing challenges in terms of access and costs. However, a universal pharmacare plan would allow us to build the institutional capacities needed to improve access, reduce costs, and ensure the efficiency and longevity of the plan. The next section will discuss recent developments in Canadian pharmaceutical policies and demonstrate how our fragmented system is unable to adapt to the drug sector's new realities.

Canadian pharmaceutical policies: outcomes in a fragmented system

Chapter 3

The Canadian pharmaceutical sector has evolved rapidly since 2010. However, recent developments illustrate the need for more joint action, collaboration and standardization of pharmaceutical sector public policies. They also show how an efficient and well-adapted public and universal drug plan would better serve the interests of all Canadians, at a lower cost.

The recent trends that will be discussed include: 1) sharp generic drug price reductions; 2) the proliferation of confidential risk-sharing agreements (product listing agreements or PLAs); 3) the creation of a bulk purchasing organization for patented and generic drugs; 4) the proliferation in the number of drug shortages. These examples clearly illustrate the problems linked to a fragmented drug coverage plan. The following section will address each of those elements.

3.1. Reduction in the price of generic drugs

In 2010, we determined that a universal pharmacare program would enable us to eliminate the rebate system offered to pharmacists by generic drug manufacturers and, consequently, save $1.31 billion. Generic drug prices are set in each province as a percentage of the price of the brand name drug. Consequently, market competition over prices among generic manufacturers results in price reductions not for buyers, but for pharmacies. Manufacturers provide financial incentives to pharmacies because they are the ones that decide which generic drugs will appear on their shelves. Even if prices are set, generic drug manufacturers must still convince pharmacies to purchase their product by offering generous rebates in order to increase their market share. Therefore, generic drug price reductions benefit pharmacies rather than insurers or patients.

In the summer of 2010, Ontario announced it would significantly reduce the price of generic drugs in order to reduce the use of rebates. From 2010 to 2012, generic drug prices gradually went from 50% to 25% of the patented drug price (Moulton, 2011). The other provinces adopted a similar approach and significantly reduced the price of their generic drugs as well. Since May 1st, 2013, Alberta reimburses generic drugs at only 18% of the price of patented drugs, and Quebec followed suit by adopting the same rate through a policy requiring each drug manufacturer to give the province the best price available in Canada (Thibodeau, 2013).

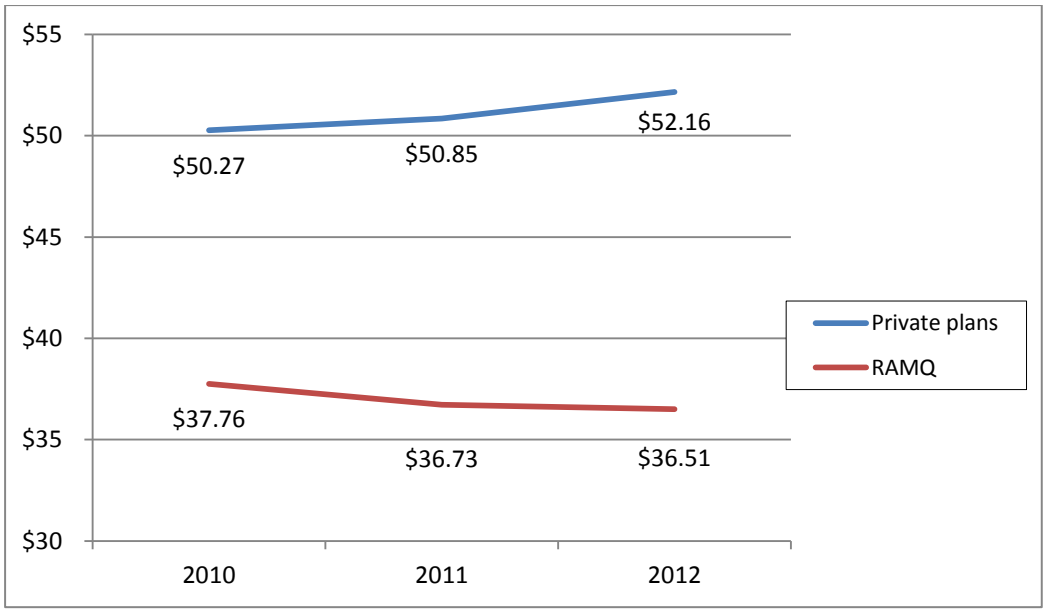
A priori, some may conclude that generic drug price decreases (and the elimination of the rebate system) are sufficient to generate substantial savings for Canadians, and eliminate the need for a universal pharmacare program or for minimal purchasing coordination mechanisms nationwide or within the provinces. However, *The Economic Case for Universal Pharmacare* (Gagnon and Hébert, 2010) already raised a red flag by showing that a generic drug fixed price policy remains problematic because, independent of the set percentages, one could not benefit from market competition (Hollis, 2009). The report also concluded that without a public and universal plan, or without coordination between provinces, reduced generic drug prices within the public plan would not necessarily generate savings for all Canadians. One of the reasons is the fragmentation of the reimbursement system because of the private-public duality within the provinces. In a fragmented system, pharmacies can offset the decrease in their profits, stemming from public plan price setting, by

increasing the costs for private plans or individuals with no coverage. This is exactly what happened in Ontario in 2006 (Silversides, 2009a; 2009b; Nguyen, 2012).

Therefore, it was not surprising when in June 2013 leaked internal documents belonging to a benefits manager (Telus Santé) revealed that the decrease of generic drug prices never occurred in Quebec (Couture, 2013). While officially the price of generic drugs (representing 60% of all prescriptions) was halved between 2010 and 2012, from 50% to 25% of the patented drug price, the average cost of a drug prescription increased slightly. To be more precise, the average cost to the public plan for a prescription decreased 5.5%[3] for the Régie de l'assurance-maladie du Québec (RAMQ), while the average cost for a drug prescription did not decrease but rather increased, 6.4% for private drug plans in Quebec. Therefore, pharmacies compensated the price decreases by increasing drastically the dispensing fees for private plans. Similar tactics appear to be in place in the Western provinces and the territories where average dispensing fees for private plans increased up to 5.5% from 2011 to 2012 (Express Scripts Canada, 2012).

Figure 5

Average prescription cost in Québec (public or private plans) from 2010 to 2012



Source: Telus Santé

3 It is worth noting that the average cost of a prescription includes the manufacturer's price, wholesaler's margin, and pharmacist's regular dispensing fees. Dispensing fees reimbursed by the RAMQ are a fixed amount for each prescription, established according to agreements between the Ministère de la Santé et des Services sociaux and the Association québécoise des pharmaciens propriétaires. Dispensing fees per prescription went from $8.44 in 2010 to $9 in 2012.

A study conducted in October 2011 by the French magazine *Protégez-vous* (Meilleur and Lambert-Milot, 2011) showed that in Quebec pharmacists' profit margins for generic drugs purchased by private drug insurance plans remain extremely generous. The survey targeted 320 pharmacies and analysed the price paid by private insurance drug plans for generic versions of Pantaloc, Lipitor, Glucophage, Norvasc and Effexor. When the average cost price (cost of the drug + wholesaler's margin) was $17.77 for the pharmacies[4], their average retail sale price was $43.53 representing an average dispensing fee of $25.76 and a profit margin of 145%. It is important to note that the public plan only paid a dispensing fee of $8.44 for the same products, less than a third of what the private plans paid.

The example above demonstrates how in a fragmented health care system (public/private) cost savings at one point in the system can often translate into cost increases elsewhere in the same system. In fact, in such a context, savings for some simply means transferring costs to others. Working in silos is not an efficient way to stop annual cost increases.

3.2. Increase in confidential agreements (Product Listing Agreements)

Since 2006, we have observed significant changes in the business model adopted by pharmaceutical companies to establish the price of patented drugs. We have gone from a transparent world where the listed price was the price paid, to a world of confidentiality and secret agreements. The reason for this strategy is that many countries, including Canada, regulate the price of patented drugs by comparing them to the official prices paid elsewhere in the world. To bypass these control mechanisms, pharmaceutical companies now inflate the suggested official international price and negotiate rebates with different buyers through confidential agreements. The official prices remain high because of the confidentiality of the negotiated rebates. These types of agreements are the new norm for public drug insurance plans worldwide and can take many forms, like price-volume agreements or risk-sharing agreements. Most of the time, however, these agreements simply take the form of simple rebates offered to buyers (Bourassa-Forcier and Noël, 2012; Chown, 2010).

Not negotiating rebates can be costly. In the United States, the Medicare plan (covering seniors) refuses to negotiate the same rebates as the Medicaid program

4 Note that legally in 2011, up to 20% of this cost could go back to pharmacies in the form of rebates.

(covering low-income families) in order to protect the interests of pharmaceutical companies. Such an approach encourages companies to inflate the official price, even if it means entering into rebate negotiations with other purchasers. According to the U.S. Congressional Budget Office (2011), Medicare's refusal to negotiate will cost American taxpayers $112 billion more in the next ten years.

Most public drug insurance plans have adopted confidential agreements called Product Listing Agreements (PLAs), which consist of reimbursing the official (high) price of the drug, in exchange for confidential rebates. Thus many assume that the problem is solved since Canadian public buyers are using their purchasing power to secure confidential rebates. But, in fact, getting these rebates is possible only because the cost is shifted or transferred to others. Cost shifting happens in three ways: increased costs for patients; increased costs for private plans; and increased costs for other provinces unable to negotiate equally substantial rebates.

Provinces such as British Columbia, Nova Scotia, Alberta, Quebec and Saskatchewan ask patients to share 30% to 35% of the cost of drugs or bear the total price of the drugs until their expenses reach a certain percentage of their annual income. When the province lists a new medication on its provincial formulary (or drug benefit list),[5] because it succeeded in getting a substantial rebate, the patient still has to pay his co-payment or deductible according to the official price, not according to the price negotiated behind closed doors. In other words, if the province gets a 75% rebate on a specific medication, the patient's co-payment remains 30% of the official drug price. In the end, the co-payment or deductible paid by the patient can be, at times, higher than the real price of the product. Here, the public plan saves money at the expense of sick people who remain unaware of the existence of official or negotiated prices.

Normally, private drug insurance plans do not negotiate rebates. In fact, 95% of private plans in Canada have open drug reimbursement lists (formularies) and reimburse any new medication on the market, whatever the price, without an assessment of its therapeutic value (Martinez, 2011). More restrictive private plans generally rely on the provincial public formulary to reimburse medications when their therapeutic value is considered sufficient relative to the cost of the product. PLAs create confusion because high-priced new medications without great therapeutic

5 The provincial formulary delineates the drugs and medications the province's public insurance plan reimburses.

value could now be listed on the formulary. In any event, private plans pay an artificially inflated official price.

Physicians also often consider the provincial public formularies as a guarantee of a medication's good therapeutic value. PLAs thus create the ''illusion of value'' for physicians who might then adopt irrational prescribing practices (Canadian Leadership Council Drug Evaluation, 2012).

Therefore, as a result of PLAs, private plans have to pay an artificially-inflated official price for medications, and everyone pays more for costly prescribing practices.

Finally, PLAs are an efficient way of setting provinces against each other through a strategy known as "whipsawing." For example, Ontario has the most important public drug insurance plan and can, therefore, negotiate the most substantial rebates. Let us assume Ontario gets a confidential rebate of 60% on a new anti-cancer medication which costs $50,000 for each drug treatment but offers little therapeutic value (e.g., life expectancy extended by an average of five months but with significant side effects and diminished quality of life). Ontario's cost is reduced to $20,000 because of the rebate. The province can then consider that the drug's therapeutic value is worth the price. On the other hand, let us assume Nova Scotia or Manitoba only have access to confidential rebates of 20% for the same drug. The drug then costs those provinces $40,000. It may be reasonable for those provinces to think that the value for money does not justify reimbursement of the medication and that it would be better to invest the money in other anti-cancer therapies. That being said, such a rational decision does not put an end to the difficulties – quite the contrary. Chances are that some patient associations, often largely sponsored by the pharmaceutical companies, will put pressure on the provinces to reimburse the same medication as Ontario, even if it costs 200% more than in Ontario. Because of the media pressure coming from some of these groups, the province's Health Minister often has no other choice than to reimburse such medications even if the value for money is simply disproportionate (Gagnon, 2012a).

Presently, PLAs are unsustainable strategies in terms of putting an end to escalating drug costs in Canada. Given many public and private organizations work in silos, PLAs can be a way to balance the public budget of the provincial drug insurance plan by shifting the costs elsewhere in the system. These PLAs are thus very attractive to public plans because they are a way of diminishing costs. Also,

when there are price-volume agreements,[6] the PLAs enable better cost planning. Under these circumstances, PLAs seem to be here for the long run.

In an ideal world, all countries would negotiate the price of patented drugs in a transparent way. In light of the situation described above, and the difficulties created, and recognizing that PLAs cannot be eliminated, they must, at the very least, be made democratically acceptable. To do so, four conditions must be met:

1. Deductibles must be eliminated and co-payments must not be set proportionally to the official price. Eliminating the co-payment, as was done in Scotland, Northern Ireland and Wales, in order to reduce administrative costs as much as possible, is the optimal choice. If the public plan insists upon a co-payment, then only a fixed co-payment by prescription, or linked to the real price, would be acceptable.

2. The same price should apply to all within a province in order to avoid passing the buck.

3. The same price must apply to all provinces in order to avoid "whipsawing" strategies that set provinces against each other and lead to inequities.

4. We must ensure that such agreements do not create biases in physicians' prescription practices by sending the wrong signal about the real therapeutic value of the product.

In other words, such confidential agreements could have merit if we had a universal pharmacare program, without any co-payment proportionate to the cost of the drug, and if we could also ensure that physicians prescribe drugs based on clinical evidence, not on the companies' marketing campaigns. If the universal plan is not unique and pan-Canadian, provinces must then, at the very least, have the necessary institutional capacities to collectively negotiate confidential rebates to prevent "whipsawing" which pits one province against another. A bulk purchasing alliance could be an excellent way to encourage such interprovincial collaboration. The following section addresses that topic.

6 Volume pricing agreements consist of a public organization agreeing to reimburse the cost for a drug's officially inflated price in exchange for rebates in the form of spending limits. This means the negotiations dictate not only the cost but also the sales volume. If the latter is surpassed, the manufacturer is responsible for reimbursing the difference.

3.3. Bulk purchasing for patented and generic drugs

In September 2010, the Council of the Federation, made up of Canada's provincial and territorial premiers, announced the creation of a pan-Canadian purchasing alliance to purchase expensive brand name drugs. In 2012, the Council of the Federation announced it would extend the bulk purchasing alliance's (renamed Pan-Canadian Pricing Alliance) role to include the purchase of certain generic drugs. Since then, the Canada-wide alliance[7] has only purchased six generic drugs in 2013 (Council of the Federation, 2013), four generic drugs in 2014 (Council of the Federation 2014), and seven brand-name drugs. Negotiations are underway for the bulk purchase of 13 other brand-name drugs (MacArthur, 2013).

Bulk purchasing is probably one of the best strategies implemented in Canada to contain drug costs. Not only can the strategy substantially reduce generic drug prices, it enables the purchase of brand name drugs at a price that better reflects the added therapeutic value of the product and allows for negotiated PLAs without passing the buck to other provinces. However, cost shifting to patients and private drug plans remains an issue.

In the last few years, the pharmaceutical sector saw the emergence of a new business model based on very expensive niche drugs (often called "niche busters"), and rapid price increases in biological drugs for which we cannot produce generics. A bulk purchasing alliance with a reference-pricing system remains the most commendable strategy to ensure access to new treatments for all Canadians at an affordable price (Grootendorst and Hollis, 2011).

According to Diane MacArthur (2013), Assistant Deputy Minister responsible for Ontario's public drug plan, joint purchasing comes with many obstacles including: 1) purchase coordination is difficult because of the diverse and numerous regulatory structures and the lack of a national formulary; 2) provincial participation is voluntary with no dedicated resources to assist in negotiations; and 3) governance structures and logistics need to be developed. Another potential obstacle is the fact that Ontario is a key participant in the purchasing alliance, since the province represents 56% of the market share of this alliance that excludes Quebec. Therefore, the purchasing alliance essentially relies on Ontario's goodwill and its willingness to share its negotiation power with the other provinces. However, if in the end Ontario could

[7] The Pan-Canadian Pricing Alliance does not include Quebec as this province refuses to join this initiative.

negotiate more significant rebates on its own by focusing on provincial PLAs, then the purchasing alliance would be rapidly compromised.

That being said, bulk purchasing is a step in the right direction. Even pharmaceutical companies are in favour of a better coordination of the price negotiation process. Canada represents a small market and the fragmented negotiating process (each province and territory negotiates on its own) is annoying for those companies. For example, in a presentation on the fragmentation of the Canadian drug reimbursement system, made in February 2013, Claudia Neuber, director of pricing and contracting at AstraZeneca, explained how the great complexity of the Canadian reimbursement system was becoming a real barrier to putting new medicines on the market. Some companies simply don't deem it worthwhile anymore to invest in all the necessary resources to negotiate access to such small markets (Neuber, 2013).

Bulk purchasing is essential in order to standardize the purchasing process for patented drugs in Canada and to ensure all provinces benefit from maximum rebates. However, these rebates remain confidential, as is the case with PLAs. Bulk purchasing does not ensure the savings for public plans will necessarily translate into savings for all Canadians since private plans and people without insurance will continue to pay their medicines at an increasing official price.

In the case of generics, the lack of uniformity among the provincial plans also undermines the whole group negotiation process. For example, the differences between reimbursement methods and between stakeholders in each province force the bulk purchasing alliance to always negotiate a price that is a percentage of the patented drug price (currently 18%), rather than the absolute lowest price resulting from competitive bidding. Setting the price of generics as a percentage of the price of patented drugs is not the best policy in a sector where there is market competition (Hollis, 2009). Moreover, generic drug prices in Canada remain extremely high in comparison to countries using the strength of the market to get the best prices, as is the case in the United States or New Zealand. If interprovincial coordination problems prevent the efficient negotiation of generic drug absolute prices, and if we continue to maintain generic drug prices as a function of a percentage of the patented drug price, we could then explore regressive pricing (reducing the percentage of the price of the patented drug with the increasing number of generic competitors) (Cambourieu et al., 2013).

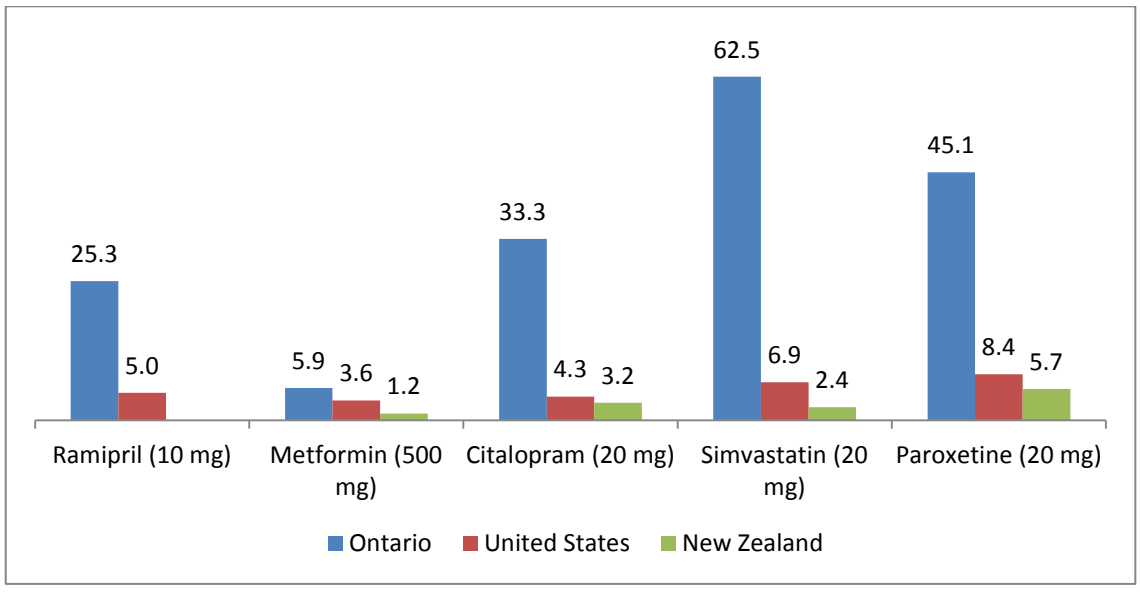
Compared to other countries, generic drugs are still very costly for Canadians. A systematic study of overall generic drug prices by the National Prescription Drug

Utilization Information System (NPDUIS 2013) showed that in 2011, the cost of generic medications was 54% higher in Canada than in the United-Sates, Germany, France, the United Kingdom, Sweden and Italy. While the price of generics in Ontario had already decreased in cost to 25% of the price of the brand-name drug, the 50 most commonly sold generic drugs in Ontario were priced 82% higher than in the United States (NPDUIS 2013).

A recent study compared the price of 82 of the most popular generic drugs in Ontario, the United States and New Zealand (Law, 2013a). Although Ontario was the Canadian province paying the lowest price for generics, the province still paid, on average, twice the price of the best price available in comparative countries. Ontario paid 5 to 25 times more than the best price available for the top five generic products.

Figure 6

Comparison between the price of the five generic drugs sold the most in Ontario and the price of the same drugs in the United States and New Zealand, in cents (¢), 2012



Source: Law, 2013b

Had Ontario built the institutional capacities to better use the strength of the market, as the other countries have, the province could have saved up to $244 million on the price of generic drugs (Law, 2013a). We don't know what the potential savings would be for Canada. However, if we consider that Ontario represents 38% of the sales of prescription drugs in Canada, we can estimate a potential saving of $642

million for all of Canada from the systematic purchase of generics, relying more on the strength of market competition.

3.4. Increase in drug shortages

Drug shortages have steadily increased in Canada since 2008. In 2012, some shortages of injectable generic drugs revealed the scope of the problem, particularly after a fire in one of Sandoz's plants (Gagnon, 2012d). Inventory shortages are not just a Canadian issue; they are a global issue although regulatory and institutional criteria have made the problem worse in Canada.

Some have tried to blame price control measures for the shortages since looking for the best price would, they suggest, lead to the creation of monopolist manufacturers who could, in part, be responsible for the shortages (Labrie, 2013). This explanation remains problematic because even though Canada pays, on average, much more than many developed countries, it still experienced more inventory shortages in 2012. Others highlight the importance of recent plant inspection regulatory changes in North America, as well as the ongoing global restructuring of the generic sector due to a series of major mergers and acquisitions (Gagnon, 2012d). The causes are multiple and complex but one thing is clear: the procurement process can increase or mitigate such shortages (Barthélémy, 2013; Cambourieu et al., 2013).

The procurement of drugs is based on a precarious drug supply chain consisting of raw materials, active ingredients, manufacturers, wholesalers, distributors, hospital pharmacies and retail pharmacies. Any disruption along the chain can cause significant stock shortages. The Canadian Pharmacists Association (2010) clearly highlighted the current problem in Canada:

> *What is missing in the drug supply chain is any organization or party that holds accountability for the supply chain from a system-wide perspective. Neither government nor any third party has an oversight function for the drug distribution system, and therefore drug supply is dictated in large measure by the market. Due to the reluctance of individual manufacturers to share information on supply and manufacturing problems, it is difficult to predict when shortages will occur, for how long, and affecting which drugs.*

Such a situation brings us back to the problem generated by the fragmented drug purchase method in Canada. Each province buys its own prescription drugs and negotiates the price. Hospitals, on the other hand, must negotiate their drug purchases through their own local bulk purchasing alliances using a tendering

process. Many would like more coordinated efforts by Health Canada to require companies to provide notice of potential stock shortages. However, the federal government refuses to intervene and places the blame on the different, fragmented stakeholders. The government cites the provinces' and hospitals' procurement methods as the primary cause for shortages. As clearly enunciated by the Honourable Kellie Leitch, Conservative MP (as quoted in Kondro, 2012): "I want to be very clear that I think we understand that this health care and the provision of those medications is a provincial responsibility, a provincial negotiation, a hospital negotiation."

The federal government's position is problematic since each province, even each hospital, is asked to manage the problem on its own at a time when stock shortages are a global issue. With limited resources, it is particularly difficult for hospitals or their bulk purchasing agencies to build the institutional capacities to mitigate the shortages. In Canada, the federal government has not done anything to solve the problem and, as a result, hospitals have to fend for themselves.

Stakeholders within the supply chain try to protect themselves from shortages. Some bulk purchasing agencies like MedBuy, or wholesalers like McKesson inform their clients about the existing shortages, but the information is generally incomplete and not available to all (Ottino et al., 2012). In Canada, SigmaSanté, a bulk purchasing company for different hospitals in Montreal and Laval, has done more than others on this issue. In order to prevent or mitigate stock shortages, SigmaSanté included clauses in its tendering process requiring manufacturers to disclose any potential stock shortages. This strategy enabled SigmaSanté to post on a website (http://fridaypm.ca/) complete public information on all the manufacturers and all known stock shortages.

Such a system is far from ideal since manufacturers are often unwilling to announce potential stock shortages. In order to solve the shortage issues, in 2004, France implemented a mandatory disclosure of potential stock shortages (Ottino et al., 2012). The United States followed suit in 2012 (Stanbrook & Killeen, 2012). In Canada, disclosing stock shortages is not mandatory and is only required under the purchase clauses of the group SigmaSanté. Consequently, manufacturers unwilling to announce potential stock shortages can easily bypass these measures by refusing to sell their product to a specific purchasing group. Fragmentation of the system not

only leads to the absence of more efficient measures to prevent stock shortages but, in fact, penalizes the buyers who adopt more responsible behaviours.

In comparison, the case of France is particularly interesting. Since 2004, manufacturers are required by law to inform the Agence française de sécurité sanitaire des produits de la santé (AFSSAPS) of any procurement issue, especially with respect to essential prescription drugs on which the agency and the manufacturers collaborate to find acceptable solutions. Since 2007, manufacturers must report stock shortages six months in advance (Ottino et al., 2012). The results are convincing. In March 2012, when Canada had an average of 347.3 stock shortages during the month, France only had 46.8 (Barthélémy et al., 2012).

Bulk purchasing agencies are sometimes blamed for creating monopolies among generic drug manufacturers (Labrie, 2013). If this is the case, would a unique bulk purchasing agency, such as the one in New Zealand, lead to more stock shortages? We have already shown that bulk purchasing agencies are not the problem. Instead, it is the legislative and regulatory structure behind the purchasing method. For example, invitations to tender and subsequent agreements need to include indemnity and contingency clauses. A bulk purchasing agency could, indeed, be more successful with stock shortage clauses, for example, by identifying which drugs are more likely to go out of stock and identifying other manufacturers.

Would a unique bulk purchasing agency lead to greater industrial concentration among generic manufacturers? That hypothesis is based on a misconception of the global generics' market. In the last few years, the major generic drug companies have seen a series of particularly significant mergers and acquisitions. This is due to the explosion of the generic market in a period where important patents are reaching their expiry date due to a "patent cliff." The four dominant generic sector companies – Teva, Mylan, Sandoz (owned by Novartis) and Watson – represent 40% of generic prescriptions around the world. All rely on mergers and acquisitions as a primary strategy to grow their share of the market (Harding, 2010). Given the growth of the sector, and the fact that plants function at full capacity, these mergers and acquisitions often require significant assembly line restructuring, and are often an important factor in the increase in shortages (Gagnon, 2012d).

The increasing monopoly power in the generic sector is now worldwide, and is not contingent on the purchasing method in place in Canada. In fact, bulk purchasing, combined with conservative purchasing clauses to ensure procurement stability,

could be the best way to diminish the shortages, while keeping an important bargaining power in a time of generic companies' growing monopoly power.

Moreover, the fear of sole manufacturers for certain generic products seems irrational when we consider that sole manufacturers dominate the patented drug sector. To avoid the potential risks related to the emergence of sole generic manufacturers, Canada could follow the example of Sweden and adopt a public generic company, thereby avoiding any abuse in pricing by private manufacturers while solving the problem of some stock shortages (Gagnon, 2012d).

What is happening right now in the pharmaceutical sector clearly shows the problems generated by the fragmentation of the drug insurance system and our drug procurement methods. From the perspective of Canadian pharmaceutical policies, it seems that the transfer of costs and responsibilities to others has become a national sport. The decrease in generic prices for public plans was made, in part, by increasing prices for private plans. Confidential agreements might permit public plans to balance their budgets but they do so by passing the buck to patients, private plans and other provinces. Bulk purchasing is a step in the right direction for the provinces, but up until now it has not been used to its full potential to achieve market advantage. The drug shortages are a clear demonstration of the need for improved regulatory structures and greater standardization of the purchasing methods in the whole country. **More than ever, Canada must build the necessary institutional capacities to face the challenges presented by pharmaceutical policies. It is time for Canada to enter the XXI century.**

Chapter 4
The Collective Cost of Private Insurance

This section will first address the emerging consensus on reforming drug insurance. Second, it will demonstrate how existing private drug plans are part of the problem and not the solution through the analyses of four structural problems associated with private medical insurance: skimming, waste, tax subsidies and administrative costs.

4.1. Emerging consensus

As underlined by André Picard (Globe and Mail 2013), a consensus is beginning to emerge regarding necessary drug insurance reforms. In June 2013, The C.D. Howe Institute, a well-known public policy think tank, endorsed the idea of a public and universal drug coverage plan when it requested the integration of prescription drugs into the current Canadian public health insurance plan (Morgan, Daw and Law, 2013). We totally agree with the conclusions of the C.D. Howe Institute in this respect. This was followed by a report from the Canadian Life and Health Insurance Association (CLHIA, 2013) recommending urgent drug coverage reforms to ensure better public

and private coverage. In many respects, we share their conclusions. The CLHIA report deserves further consideration to determine what reforms are essential and may be implemented through consensus.

Although CLHIA is not demanding the implementation of a universal pharmacare program, their proposed reforms are a step in that direction. CLHIA wants affordable access to prescription drugs for all Canadians, regardless of their income or health condition. The twenty-three reforms proposed by the CLHIA (2013) are, in many respects, the same as those proposed by those advocating for a universal pharmacare program, except that the CLHIA advocates for a mixed private-public system in which private insurers will be able to keep the best share of the market.

There is a consensus among advocates for a public and universal drug plan and private insurers in that they both conclude that the current system is completely fragmented, inefficient, unfair, and financially unsustainable in the long run (Picard, 2013). We must make sure no Canadians fall between the cracks. Because of the soaring costs, public and private insurers must control costs by limiting the coverage and access to drugs, or by passing the buck elsewhere in the system, too often to the patients. Yet, if Canada could drive down its costs to the average level of OECD countries, the bill would drop by $9.6 billion a year (CLHIA, 2013).

On June 25, 2013, in a CLHIA press release, Frank Swedlove, president of the CLHIA, said:

> *There is no question that the prescription drug system that exists today is badly in need of reform. The current patchwork of systems across the country inflates costs, creates a great deal of confusion, and even worse, results in significant financial hardship for some Canadians resulting from the cost of drugs.*

According to the CLHIA (2013), the price of prescription drugs should be the same for everyone. That means an end to resorting to PLAs in their current form, because they set buyers against each other through “whipsawing” strategies and transfer costs to patients and to private plans (see Section 3.2). CLHIA is also calling for greater transparency in pharmacies’ dispensing fees and profit margins. We are in total agreement with the CLHIA on the need for a standard price and greater transparency regarding pharmacies’ revenues.

The CLHIA report (2013) also calls for a fundamental reform of the price regulation process for patented drugs in Canada. For example, rather than set a price

ceiling to avoid paying excessive prices, it would be better to ensure consumers pay the lowest price possible. That approach is similar to the reform explored in *The Economic Case for Universal Pharmacare* (Gagnon & Hébert, 2010). For too long Canada has set very high prices for patented medicines, in the hope that this strategy would create a business environment favourable to the pharmaceutical industry's development. However, the economic strategy failed. There is no reason Canadians should pay 25% to 30% more for their patented drugs than in France or the United Kingdom (PMPRB, 2013). In fact, it is simply unreasonable to use health budgets as industrial policy tools, to the detriment of drug access, particularly when these expensive policies do not contribute in the least to increased investments in the Canadian pharmaceutical sector (Gagnon, 2012c).

In addition, CLHIA recommends the implementation of a national formulary to ensure greater consistency and equity within the reimbursement system. However, the Association requests that the formulary should be "minimal," that is to say a private insurer would retain the right to choose to cover more medications if desired. This also means private insurers would reserve the right to cover medications when their therapeutic value does not justify the cost.

It makes sense to have a national formulary with the flexibility to meet the different needs of specific populations in different provinces. However, it is difficult to understand under which principle private insurers can continue to reimburse drugs when their therapeutic value does not justify the costs. If private insurers ask provinces to lead the way and encourage greater collaboration to contain drug costs, they must also contribute to the collective effort, rather than undermining those efforts by setting unnecessarily high prices for some medicines.

4.2. Why private insurance plans are part of the problem and not the solution

The reforms proposed by CLHIA are sound and rational but do not go far enough. CLHIA asks government to take all necessary measures to contain the increase in drug costs, and ensure equitable access to drugs for all. Yet private insurers would not change anything on their side, although many of the problems arise from the way private insurance is structured.

None of the CLHIA recommendations are aimed at reforming that structure. The CLHIA report cannot provide any rationale of why we need to preserve a hybrid plan (private-public) rather than an entirely public plan. Moreover, are there really

additional benefits to private, rather than public drug coverage, for the 23 million Canadians currently covered privately (CLHIA, 2012)? In fact, private insurance plans are linked to four important problems: skimming, money-wasting, tax subsidies, and administrative costs.

4.2.1. Skimming

The CLHIA report asks for more equitable access to drugs but is silent about the practice of skimming in health insurance plans. The problem is well known – private plans generally accept the "good risks," namely workers generally richer and healthier. The State is left with the "bad risks," namely people unable to work, low-income individuals or seniors. If the CLHIA report could explain how private insurance plans could provide more equitable access to drugs, for example, by accepting anyone requesting coverage, as well as pooling financial risks across all the insured, then, maybe, a more progressive role for private insurance plans could be foreseen. In the present situation, a hybrid plan (public-private) is based on the idea that risk pooling, central to the concept of insurance, must differentiate between "good" and "bad" risks.

As noted by health economist Robert Evans (2013), it is in the interest of the rich and healthy to maintain a drug insurance plan where they pay according to their drug consumption (within the workplace) rather than their income. In a universal pharmacare plan, all the risks are pooled and the coverage can be financed more equitably through income taxes based on a percentage of income. In the current system, we often encounter situations where workers in a richer and healthier workplace contribute less than workers in a poorer and less healthy workplace. The major difference in a universal pharmacare program is that the overall risks are pooled, and the financing, based on a percentage of income, is more equitable.

4.2.2. Waste

Another problem is the amount of money wasted through private drug plans. According to Express Scripts Canada (2013), private drug plans wasted $5.1 billion in 2012 because they either reimbursed medicines that were more expensive without providing additional therapeutic value, or because they paid unnecessary dispensing fees. Private insurers spent $9.8 billion on prescription drugs in 2012 (CIHI, 2013a), and of that amount, 52% can be considered a pure waste of money. By calling for a minimal national formulary and, on the other hand, allowing more expensive coverage

by private plans, CLHIA is failing to target the issue of waste. Instead, it is simply asking the government to take measures to reduce the price of patented and generic drugs. The request makes sense but it rests on the concept of a "minimal" national formulary, which does not solve the problem of money-wasting within private plans. For example, if all prices were reduced by half, private plans would then spend half of what they do now but the level of waste would remain at 52%.

CLHIA does recognize the systemic problems generated by physicians' prescribing practices, often driven by pharmaceutical companies' promotional campaigns, rather than clinical evidence (Gagnon, 2013). Consequently, CLHIA recommends improving physicians' prescribing practices by creating prescribing committees; by conducting (public?) clinical trials comparing similar types of medications, instead of placebo comparisons; and finally by improving post-marketing monitoring to reduce off-label use. Although we agree with those recommendations, they come at a cost, and private insurers are careful not to mention how they will contribute to their funding. We can infer that private insurers will ask the government to finance measures to improve drug coverage in order to enjoy the benefits without sharing the costs.

4.2.3. Tax subsidies

CLHIA's demands are based on the guiding principle that all Canadians should, when in need, have access to prescription medicine of proven value. Since private insurers cannot cover the entire population (unless obliged by law, as is the case with "Obamacare" in the USA), the rationale behind the guiding principle is to provide universal access to public drug coverage for all those who cannot get private coverage. However, the CLHIA report does not call for such universal coverage. Rather, it asks for more equity for private plans, not measures to ensure coverage for all Canadians.

Such a position raises a fundamental question: if we could offer everyone the alternative of less expensive public coverage – less prone to money wasting among other things – why would employers' benefits programs continue to offer a drug plan to their employees? Why wouldn't they tell their employees to simply migrate toward public coverage? That question is fundamental in order to better understand what is at stake.

Private drug coverage exists in Canada because workers cannot generally benefit from public coverage. Employers accept the responsibility of drug coverage because

Canada offers generous financial incentives through tax subsidies. The tax subsidies are simple: the employer's contribution to the drug plan (corresponding to a part of the salary) is tax free. Therefore, there is no income tax on that portion of the salary. Consequently, the more you earn, and the higher your marginal tax rate is, the more you benefit from this tax subsidy. The final result is a tax subsidy system that is completely regressive, where the richer you are, the more you benefit from tax subsidies. In 2009, tax subsidies offered by the federal government represented around 13% of the costs of private plans, amounting to $1.2 billion in 2009 (Gagnon, 2012b). At the provincial level, however, the level of tax subsidies is unknown.

It must be emphasized that Quebec is different[8] in offering public drug coverage to everybody without private coverage. Moreover, Quebec does not offer any tax subsidy to companies whose benefits' programs include drug coverage. Then, how can private drug insurance survive in Quebec? It survives because it is mandatory: all employers' insurance programs covering accidents, health or disability must necessarily include drug coverage. And all employees must participate and cover their dependents as well. However, it must be stressed that it is advantageous for Quebec since employees participating in the private plans must pay a 9% tax on premiums (Union des consommateurs, 2009).

To summarize, private drug insurance survives in Canada because of the generous financial advantages offered by the State or because, in the case of Quebec, it is mandatory.

4.2.4. Questionable administrative costs

The CLHIA also fails to raise the issue of high administrative costs for private insurance. In *The Economic Case for Universal Pharmacare* (Gagnon and Hébert, 2010), administrative costs within public and private plans were compared. Based on data from the mid-90s, it was estimated that the private drug plans administrative costs were 8%, and 2% for public plans.

A 2003 study showed that administrative costs for private health insurance plans in Canada increased to 13.2% while those of public plans did not change (Woodhandler et al., 2003). More recent data indicates that administrative costs

8 New Brunswick will follow suit with the Quebec model starting April 2015 by making private coverage obligatory when available. Other New Brunswick residents will benefit from public coverage (CBC, 2013).

for for-profit private health insurance plans in 2011 had gone up to 23% (Law et al., 2014) while public plans were estimated at 1.8% (CIHI, 2013b). Note that in the U.S., it is illegal for a health insurance company to charge more than 20% in administrative costs for group insurance (Law et al., 2014). If U.S. health insurance companies charged fees of 23%, as is the case here in Canada, they would immediately be subject to legal proceedings for abusive pratices and would face important financial penalties.

In the past 20 years, for-profit private insurance administrative costs have almost tripled for for-profit private plans in relation to health services reimbursements. The differential administrative costs between the public and private plans has gone from 6% to more than 20%. The change in the insurance business model following demutualization by the large insurance companies in the late 90s explains the rise in administrative costs (Lombardi, 2000). The new corporate governance of insurance companies is now focused only on the well-being of shareholders and not anymore on the well-being of the insured members.

Private insurers (including for-profit and not-for-profit private insurers) spent $9.5 billion on drugs in 2011 (CIHI, 2013b). By looking not only at for-profit private heath plans, as analyzed by Law et al. (2014), but also to private not-for-profit health plans, the Canadian Institute for Health Information estimates that administrative costs for all private health plans in Canada represent 16% of all costs (CIHI, 2013b)[9]. One can thus consider that Canadians paid $1,520 million in administrative costs on their private drug coverage through insurance premiums. A universal pharmacare program would reduce these administrative costs from 16% to 1.8%, or by $1,349 million. This amount represents an additional savings of $789 million as compared to the 2010 estimates[10] (Gagnon & Hébert, 2010).

The proportion of administrative costs for all private plans (for-profit and not-for-profit) doubled in 20 years. However, it seems the CLHIA is not trying to reduce those

9 The Canadian Institute for Health Information report (CIHI 2013b) includes reference to private administration costs being 6.4% of all private health care spending, including private spending that did not flow through private insurance companies. The appropriate statistic is the share of private health insurance spending in Canada, which is attributable to private insurance administration: 16%.

10 The elimination of the administrative costs at that time was based on a 6% difference for private health plans and represented savings of $560 million. Additional savings are based on a new calculation based on a difference of 14.2%.

costs in any way, particularly if we consider that administrative costs include the insurance companies' profit margin.

Private health insurance plans are not only costly and inefficient, their mere existence prevents an effective coordination of pharmaceutical policies that would ensure equitable and necessary drug access for all Canadians while preventing cost increases. For all these reasons, we believe that it is time to consider the implementation of a universal pharmacare program to benefit all Canadians.

Future scenarios for Canada

Chapter 5

This section presents an update of the estimated financial impact a universal pharmacare program would have on Canada, while also identifying its potential funding scenarios.

5.1. Costs and benefits associated with a universal pharmacare program

In *The Economic Case for Universal Pharmacare* (Gagnon & Hébert, 2010), it was shown that the implementation of a public and universal drug plan in Canada, even with first-dollar coverage for the whole population, and without reducing the price of patented drugs, could lead to savings of up to $2,947 million or 12% of the cost of prescription drugs in Canada. In the 2010 report, the costs and benefits of a universal pharmacare program were based, in part, on the 2008 edition of the *Canadian Rx Atlas* (Morgan et al., 2008). Figure 7 shows the results of the 2010 analysis (Gagnon and Hébert, 2010).

Figure 7

Estimate (from 2008 data) of costs and savings generated by a universal pharmacare program, keeping the same industrial policies in terms of drug costs

1. Prescription drug expenditures in 2008	$25,141 million
Distribution of prescription drug costs/benefits	
2. Growth in expenditures from increase in use	+10% of current expenditure
3. Reduction in expenditures from decrease in dispensing fees	**-2% of current expenditure**
4. Reduction in expenditures from drug assessment	-8% of current expenditure
5. Elimination of the monthly deductible in Quebec	**-$144 million**
6. Elimination of rebate systems for generics	-$1,310 million
Total savings on prescription drugs	**-$1,454 million**
Total prescription drug expenditures with a universal pharmacare plan	$23,687 million
Additional impacts other than for prescription drugs	
7. Elimination of extra administrative costs of private plans	-$560 million
8. Elimination of tax subsidies	**-$933 million**
Total of additional impacts	-$1,493 million
Total net savings	**$2,947 million**

Source: Gagnon & Hébert, 2010

Recent pharmaceutical policies changes in Canada suggest this estimation requires an update in order to better understand the relevance of a public plan. Such an update is now possible with the publication in 2013 of the third edition of the *Canadian Rx Atlas* (Morgan et al., 2013) which offers a complete picture of cost factors throughout different Canadian provinces and of age-standardized spending variations (in order to eliminate bias between provinces). **Annex 1** illustrates the 2013 *Canadian Rx Atlas* main findings for per capita spending and further enables this update.

An itemized update of each element of Figure 7 shows:

1. **Drug spending**: Total prescription drug spending in Canada for 2012 is estimated at $27,734 million (CIHI, 2013a).

2. **Increase in drug consumption**: In 2010, it was estimated that a public and universal drug plan based on first-dollar coverage would not only improve access to drugs, but would also reduce the amount of prescription drugs not obtained because of financial issues. Research on the impact of out-of-pocket deductibles and co-payments has not evolved since 2010. We estimate that the increase in drug consumption could be approximately 10% based on actual drug consumption data for the same reasons as those stated in the 2010 report (Gagnon and Hébert, 2010). However, it is important to note that developing a universal pharmacare program, at least in its first phase, would likely involve maintaining a co-payment insurance plan for patients, as exists in most universal drug programs across Europe. Co-insurance strategies would reduce price hikes caused by an increase in consumption, but would do so to the detriment of better access to drugs for all, while maintaining non observance of prescriptions for financial reasons. In the long run, the elimination of co-payments remains the best strategy to improve access to medications.

3. **Dispensing fees**: Estimations relating to reductions in dispensing fees costs are based on a study by Palmer D'Angelo Consulting Inc. (1997). Some pharmacists' representative groups had criticized our 2010 report, maintaining that a universal pharmacare program was a strategy to impose disadvantageous rules for pharmacists. This is not the case. The logic behind a decrease in dispensing fees relates to the fact that there is a significant amount of consultation time by the person's insurance plan in order to determine the type of applicable coverage (primary coverage or

secondary/partner/spousal co-payment; also co-payment cards applicable to certain types of drugs to reduce the patient's deductible), since currently these insurance plans vary greatly from one person to another. A universal pharmacare program based on first-dollar drug coverage would standardize each person's coverage and streamline the process, reducing the time wasted in determining payment structure. This reduction in prescription time processing would not only translate into savings for the insurance plan, but savings in time management and resources for the pharmacist. We maintain the estimation of dispensing fees reduction at 2%.

4. **Drug assessments:** In 2010, we showed how British Columbia could be considered a model for Canadian therapeutic choices. BC prevents the tracking of prescriptions, which allows companies to influence the prescribing practices of doctors more effectively. It is also the only province that uses a complete public database (BC PharmaNet) listing prescriptions from private and public sources. It also lists reference prices to encourage patients to choose the lower-priced comparable product while also benefiting from analyses by Therapeutics Initiative, an independent drug assessment group that allows comparative choices and purchases based on available clinical evidence.

   Because of these more rational therapeutic choices, British Columbians not only pay less per capita for their drugs, they also pay less than the Canadian average for hospitalization and physician office visits (CIHI 2013b). Less health care spending does not mean less health: according to Statistics Canada (Table 102-5012), British Columbians also enjoy the longest life expectancy in Canada.

   For 2007, the therapeutic choice effect allowed BC to save 8.2% per capita compared to the Canadian average. Between 2007 and 2013, a large decrease in the therapeutic choice effect (from 8.2% to 4.7%) was observed (see Annex 1). This decrease is explained by the following two main reasons: the expiration date for several "blockbuster" patented drugs since 2010, and the termination of drug assessments by the Therapeutics Initiative group. In British Columbia, generic drugs are sold at 35% of the patented drug price. The recent arrival of several generic "blockbuster" drugs greatly diminishes the therapeutic choice effect since the price difference margins are tightened.

Another factor to consider in the therapeutic choice effect decrease is the drug assessment activities stoppage. In a 2008 report, the Pharmaceutical Task Force (2008) put into place by the Liberal government in British Columbia, hoping to improve the province's pharmaceutical policies, recommended the dismantling of the Therapeutics Initiative and the implementation of other policies more favorable to industry. This fact is not surprising if we consider that five out of nine panel members showed obvious conflict of interest issues within the patented drug industry (MacLeod, 2007), and if we also consider that the sole two patient groups involved in the consultation were largely financed by the industry itself.

However, the government was not as successful in abolishing the Therapeutics Initiative in the face of the medical field's opposition to the decision. Since 2008, experts working for the Therapeutics Initiative have had difficulty in obtaining the necessary financing to pursue clinical drug testing. The provincial government even suspended all clinical drug evaluations in September 2012 (Webster, 2013). After a campaign by health professionals in favor of the organisation, the BC Government reinstated its financing in October 2013 (Kermode-Scott, 2013).

The decrease in British Columbia's therapeutic choice effect may be attributable in part to the weakening of institutions defending medical care rooted in clinical evidence. However, since it is impossible to separate the decrease of therapeutic choice effect due to patent drug expiration from the weakening of B.C.'s institutional capacities and strong belief in clinical proof, we chose a more conservative view and assume that the overall therapeutic choice effect decreases are caused only by patent drug expirations. Therefore, we estimate that a revised therapeutic choice effect would be -4.7%, knowing that the improvement of therapeutic choices based on improved drug testing could generate at least 4.7% in average savings for other provinces. By adjusting these figures, and taking into account the fact that the RxAtlas 2013 compares the costs effects in each province in relation to other provinces' averages (rather than comparing to Canadian averages as done in the past), a more sound drug assessment based on the BC model would incur a drug cost decrease of 4.3% across Canada.

5. **Monthly deductibles**: In Quebec, the application of monthly deductibles and co-payment formulas drives prescription refills after 30 days, in spite

of the fact that many health conditions may require prescription refills only every three to six months, thus eliminating unnecessary monthly dispensing fees. Since Quebec benefits from the best available price in Canada, the 5.5% positive price effect shown in Annex 1, in the case of Quebec, can be explained only by the higher proportion of dispensing fees associated with the monthly refill policy. Total prescription costs for Quebec were $6,610 million in 2012, and if this province were to stop enforcing obligatory monthly refills, it would save $364 million. Note that the total out-of-pocket expenditures in co-payments and deductibles for 2012/2013 were $760 million (RAMQ, 2013). This indicates that close to half the monies paid out of pocket by patients covered by the public plan (without considering that these payments create serious treatment non-observance resulting from financial issues) come down to a waste of money due to the proliferation of monthly renewal prescriptions.

6. **Generic prices**: Since 2010 and the successive price reductions of generics, estimated savings are no longer applicable. We have, however, shown in Section 3.3 that a bulk purchasing alliance based on competitive bidding could reduce annual generic drug costs by $642 million. We also have shown in Section 3.4 that bulk purchasing alliances could serve to reduce rather than exacerbate stock shortages.

7. **Private plan administrative costs**: In section 4.2.4, we estimate that the extra administrative costs in private plans could now be estimated at $1,349 million.

8. **Tax subsidies**: We had estimated tax subsidies at 10% of the private plans, or $933 million. Since then, we have shown (Gagnon, 2012b) that these tax subsidies were in the amount of $1,204 million, where applicable to the federal government, or 13% of the private plans costs, without even taking into account the elimination of tax subsidies offered by the provinces.

By considering the above-mentioned points, we can therefore update the costs and benefits analysis for a universal pharmacare program for all Canadians, using the 2012-2013 estimates. Details of those figures by province are available in **Annex 2**.

Figure 8

Estimation of the costs and benefits generated by a Canadian universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

1. Prescription drug expenditures in 2012	$27,734 million
Distribution of prescription drug costs/benefits	
2. Growth in expenditures from increase in use	+10% of actual expenses
3. Reduction in expenditures from decrease in dispensing fees	-2% of actual expenses
4. Reduction in expenditures from drug assessment	-4.3% of actual expenses
5. Elimination of the monthly deductible in Quebec	-$364 million
6. Generic drugs tendering process	-$642 million
Total savings on prescription drugs	-$155 million
Total prescription drug expenditures with a universal pharmacare plan	**$27,579 million**
Additional impacts other than for prescription drugs	
7. Elimination of extra administrative costs of private plans	-$1,349 million
8. Elimination of tax subsidies	-$1,204 million
Total of additional impacts	**-$2,553 million**
Total net savings	**$2,708 million (10% of expenditures)**

Source: Author's figures; Gagnon and Hébert, 2010

After updating data, we can therefore estimate that the implementation of a universal pharmacare program, based on a first-dollar coverage, set up conjointly with a national formulary and a bulk purchasing alliance for generics, and efficient institutions that make optimal use of the medication, could achieve savings of $2.7 billion in prescription drugs (or 10% of expenses) per year while allowing equal drug access and improved health for all Canadians. These savings would not incur additional costs in other health system areas. On the contrary, universal and improved access to medications would ensure proper observance of medical prescriptions and a more rational use of drugs, two factors that would significantly reduce hospitalization costs and physician visits.

5.2. An end to artificially inflated patented drug price

This estimation does not take into account the additional savings that could be obtained by revising downward the cost of patented drugs in Canada. *The Economic Case for Universal Pharmacare* (Gagnon and Hébert, 2010) showed how Canada artificially inflated patented drug prices in order to attract investments by pharmaceutical companies. These policies have been a complete failure. In spite of the artificially inflated costs paid for patented drugs and, in spite of the fact that our patented drug prices are amongst the highest in the world, Canadians have seen research and development expenditures reduced bit by bit to almost nothing in the last 10 years. The patented drug industry has even forsaken its commitment to invest 10% of its sales into research and development (Gagnon, 2012c). According to a study underwritten by the patent pharmaceutical industry lobby (PriceWaterhouseCooper 2005), Rx&D member companies employed 22,332 persons in 2003. Rx&D website now indicates that the industry employed only 14,990 persons in 2012, a drop of 1/3 of employees over 10 years.

The Patented Medicine Prices Review Board (PMPRB), which regulates patented drug prices in a way considered favourable to the industry, is now saying that the concept of patented drug price increases leading to investments in research and development is a faulty claim (PMBRB, 2013):

> *Several comparator countries, which have patented drug prices that are, on average, substantially less than prices in Canada, have achieved R&D-to-sales ratios well above those in Canada. Increasingly, the impact of the prices of medicines on companies´ decisions on where to locate investment or conduct research is being questioned. Other factors such as where companies can find*

the best science base at reasonable cost, taxation incentives, flexible labour markets and economic stability are seen as being important.

In other words, the PMBRB now claims that the industrial policy, which artificially inflated patent drug prices in order to attract investments, is, in fact, an inefficient and costly practice. One must note that the elimination of industrial policies artificially inflating patented drug prices does not require the implementation of a universal pharmacare program. However, this type of plan could allow for better coordination of purchasing policies for improved patented drug price negotiations. New Zealand is an example of this situation. This country not only benefits from potential savings due to the implementation of a universal public plan but also utilizes its negotiating leverage to maximize reductions in drug costs.

The Economic Case for Universal Pharmacare (Gagnon and Hébert, 2010) showed that, in Canada, the implementation of a universal pharmacare program similar to New Zealand's, and the introduction of the same cost-reduction strategies, could generate savings of 51% on ex-factory prices, or savings of 40% on the total costs for medication in Canada. In 2010, we estimated that if Canada, like New Zealand, armed itself with a similar drug assessment system, while implementing negotiation mechanisms to maximise drug cost savings, the total savings could reach $10.2 billion.

After updating this data, the differences between the two countries have evolved. Traditionally, New Zealand was more successful at containing cost increases. For example, from 1997 to 2007, real per capita drug price growth was on average 5.2% per year in Canada, while only 0.8% yearly in New Zealand (CIHI, 2012). Since 2007, the trend has been altered for the same reasons behind the decrease of the therapeutic choice effect in BC (see Section 5.1.4). OECD Health data between 2007 and 2011 indicates that the real per capita cost of medication in Canada increased on average by 1.2% (which benefitted from patented "blockbuster" drug expiry, in addition to significantly reducing the cost of generics), while the real per capita cost of medication increased by 2.1% over 4 years in New Zealand. In fact, New Zealand already enjoyed lower prices for generic drugs and less use of patented drugs. While taking into account the potential savings for Canada, if we adopted the New Zealand model, we could enjoy savings of $9.92 billion on the total costs of medication on an ongoing basis. Figure 9 updates the potential financial impact from the implementation of a universal pharmacare program that takes advantage of savings

maximisation strategies for drug costs through utilizing institutional capacities as in the case of New Zealand.

Figure 9

Cost and savings estimations from implementation of a Canadian universal pharmacare program with repeal of industrial policies associated to drug costs based on 2012-2013 figures

1. Current expenses in prescription medication	**$27,734 million**
Allocation of costs/profits in prescribed medications	
Savings per competitive pricing	-$9,920 million
2. Expenses increase by consumption increase	+10% of expenditures
3. Expenses decrease according to decrease in dispensing fees	-2% of expenditures
5. Elimination of monthly deductible – Quebec	-$364 million
Total savings for prescription drugs	-$8,895 million
Total expenses for prescription drugs within a universal pharmacare program	**$18,839 million**
Additional impacts (other than prescription drugs)	
7. Eliminating private plan administrative costs	-$1,349 million
8. Eliminating tax subsidies	-$1,204 million
Total additional impacts	-$2,553 million
Total balance of savings	**$11,448 million (41% of expenditures)**

Source: Author's figures; Gagnon and Hébert, 2010

The implementation of a universal pharmacare program based on first-dollar coverage, along with the repeal of artificial and useless price inflation as industrial policy, the application of sound institutional capacities for maximising drug purchase savings (as in the case of New Zealand) would allow for $11.4 billion in savings, or 41% of present day prescription drug spending.

Note that highlighting the New Zealand model does not indicate a call for its complete implementation in Canada. The model is useful here to demonstrate the wide range of options possible under a universal pharmacare program that maximises a population's medical spending benefits. Conservative fiscal policy in the health field does not necessarily mean that we have to reduce government spending; it merely

upholds the idea that Canadians have a right to demand value for their money spent in health care.

Canada, one of the world's most expensive countries when it comes to drug costs, has a lot to learn. For example, the UK, with a population twice that of Canada's, has a universal pharmacare program. Three of the constitutive nations of the United Kingdom (Wales, Scotland, and Northern Ireland) enjoy first-dollar coverage (Abraham and Davis, 2013). With its own universal pharmacare program, the United Kingdom represents 2.5% of the world drug markets (PMPRB, 2013). On the other hand, Canada, with its fragmented system, its drug access problems and its smaller population, still represents 2.6% of the world drug market, not including its disproportionate 23% administration costs for its for-profit private plans. A Canadian universal pharmacare program will not only facilitate better access to medication, but has the potential to become a powerful tool for containing drug costs, offering higher returns on its health investments and, accordingly, increasing available income for all Canadians.

Meanwhile, it still costs more for Canadians, drug costs continue to increase at a faster rate in Canada, and our country is offering less generous drug coverage than countries that enjoy the benefits of a universal pharmacare program.

5.3. Would universal pharmacare be fiscally responsible?

A public and universal plan can generate significant savings for all Canadians but would add to public costs since the funding of such coverage would shift from the private to the public sphere. We must now examine the main reasoning of those who want to protect private drug insurance in Canada: private insurers bear some of the costs of social protection and, consequently, contribute to lightening taxpayer's tax burden. A public and universal plan is thus often considered an impracticable alternative policy in the current fiscal environment where any tax increase is deemed unacceptable even if, in the end, it increases the disposable income of workers.

Let us be clear, the most rational policy to reform drug insurance would be doing what the C.D. Howe Institute proposed and including prescription drugs in the public and universal health care system (Morgan, Daw, and Law, 2013). However, the public cost of such a measure would cause difficulties at the political level. Therefore, we need to determine the most pragmatic options to implement such a plan without any tax increase.

From the practical point of view, the Quebec plan has adopted an interesting financing method. The general drug insurance plan, put into place by the Régie de

l'assurance-maladie du Québec (RAMQ), is based on a hybrid financing method combining social insurance and funding though income taxes. The plan targets two categories of persons: those unable to work who do not depend financially on someone able to work (seniors and welfare recipients), and those able to work, and their dependents (which includes everybody else not covered by a private drug plan) (RAMQ website, 2013). Drug coverage for people unable to work rests on a rationale of social assistance. As in the other provinces, Quebec's drug coverage funding for this category comes first from taxes.[11]

Any person able to work and covered by the public drug plan (the participants) must have a premium based on his or her income, up to a maximum of $579 per year (as of December 2012). The amount of the premium for the participants is determined in such a way to cover all expenses for participants. The average premium of private drug plans is unknown, but the mean cost of participants' claims is $833 per year (Express Scripts Canada, 2012). On average, the premiums must cover that amount for each person as well as the additional administrative costs. We can then conclude that premiums are higher for private plans than for public plans, that is to say, at least $300 more, on average, by person.

What would happen if tomorrow Quebec extended its coverage to all workers? Would the financial burden be transferred to taxpayers and, thus, the fiscal load or the deficit of the province increase accordingly? Would such a decision be irresponsible in terms of public finance? Not in the least. Every worker paying premiums within their private plan (through a mandatory deduction at the source) would now still pay a premium through a mandatory deduction at the source. For the worker, the big difference would be a premium significantly lower, and he or she would see a significant increase in his or her disposable income. Of course, we would need to compensate for the lost tax revenues from taxing premiums in private plans (9% for employees and 2.35% for employers). Quebec could then determine a maximum amount of $665, rather than $579 for the premium, calculated as a function of income. The result would be the same for the workers: they still would have drug coverage but their disposable income would increase.

Would the employee lose on the exchange since he or she now pays the premiums without the employer's contribution? The argument does not hold because the employer's savings could be recouped rather easily by employees through other

[11] In Quebec, however, seniors who do not benefit from an income supplement must pay a premium for their drug coverage, according to their income. Seniors who benefit from 94% or more in income supplement, as well as people on social assistance, do not pay any premium.

elements in the collective agreement. Another possibility is, instead of offering drug coverage as part of the benefits program, the employer could cover the amount of the premiums within the public plan. There is no major institutional barrier to prevent such an adjustment.

In the end, the employee would still have drug coverage, pay less for premiums, and enjoy more disposable income. Quebec would not have to increase taxes and would be better positioned to build the institutional capacities it needs to more effectively control costs, for example by establishing a bulk purchasing agency and ensuring it purchases medicines of proven value for money.

Using Quebec as an example of a hybrid financing structure, funded through income tax for people unable to work and through social insurance principles (premiums) for people able to work, could enable us to smoothly make the transition to a public and universal plan without increasing anyone's tax burden while increasing workers' disposable income.

Any political party proposing the implementation of a universal pharmacare program could include in its electoral campaign the proposal to ensure better access to drugs for all Canadians and to bridge the gaps in our health care system while increasing workers' disposable income. In summary, with a little political will, Canada could finally enter the XXI century.

Yet should a universal plan be unique and pan-Canadian? Not necessarily. Obviously, the simplest way would be to include prescription drugs in the current public health care system. However, such a plan could also be implemented in one province only or in a region, for example, the Prairies or the Maritimes. That being said, cooperation and collaboration between provinces remains fundamental to ensuring efficient and equitable coverage for all.

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.

However, in the current political situation where the federal government seeks to transfer all responsibility related to health care to the provinces, such federal leadership in establishing universal pharmacare is unlikely. Such a position from the federal government is disappointing because it means that, while the federal government acknowledged the major problems associated with drug insurance when it established the National Pharmaceuticals Strategy in 2004 (NPS 2006), it now refuses to take any measures to improve the situation. As we wait for Ottawa to assume its responsibilities for drug insurance reforms, we must be realistic, only hoping for one thing from the federal government: do no harm!

In fact, it seems the federal government is more eager to increase drug costs in order to serve its industrial policy objectives, rather than increasing access to drugs. For example, the federal government seems on the brink of extending intellectual property protection within the framework of international free trade agreements (Lexchin & Gagnon, 2013).

The federal government should also stop being counter-productive and end financing for private drug plans through generous tax subsidies estimated at $1.2 billion. We suggest the federal government instead use that money to encourage provinces to adopt public and universal drug plans (Gagnon, 2012b). Moreover, since more than 600,000 federal public service employees are covered by private drug plans financed by the federal government, we recommend that the money, $690 million (Gagnon, 2012b), be used to also encourage the provinces to adopt a universal pharmacare program.

It is important to remember that 78% of Canadians are in favour of establishing a universal pharmacare program in Canada (EKOS 2013). The federal government has all the tools necessary to assume leadership for drug insurance, implement the necessary reforms to ensure better access to drugs, offer a more efficient plan, and control costs. However, from a pragmatic perspective, since the Conservative federal government is trying to abandon all responsibility for health care, we hope it won't put obstacles in the way of Canadians wishing to finally be covered by a universal pharmacare program worthy of the XXI century.

Roadmap to a rational drug policy

Chapter 6

The Canadian drug insurance system is an anomaly among OECD countries because medications are not included in the public health care system. Moreover, the Canadian system is unique because of the fragmented institutional structures of each province, and the fact that it relies on private insurers to cover most of the population. Such a system is inefficient, inequitable, wasteful and unsustainable in the long run:

1. **It is inefficient:** it does not adequately cover the entire Canadian population.
2. **It is inequitable:** many must pay amounts disproportionate to their income in order to get medications.
3. **It is wasteful:** we pay too much, needlessly, for patented or generic drugs.
4. **It is unsustainable:** we are unable to contain the cost increases.

There is now a consensus among people from industry, civil society, government and academia: we must reform the current system and build the necessary

institutional capacities to adapt to the pharmaceutical sector's new realities, to make the system more efficient, equitable, rational and sustainable in the long run.

It is not surprising such a consensus has emerged given the fact that the 2002 Romanow Commission reached the same conclusions about the lack of access to drugs and the unsustainability of drug insurance plans. Following the recommendations of the Romanow Commission, the federal government, the provinces and the territories agreed on a National Pharmaceuticals Strategy (NPS). The NPS (2006) was to have established a national formulary, a national health technology assessment system, national catastrophic drug coverage, and a national drug purchasing and price-setting system. All these policies would have constituted the key elements for a universal pharmacare program.

Except for the health technology assessment system, which is the Canadian Agency for Drugs and Technologies in Health, most of the recommendations of the NPS have been abandoned one by one, leaving any national drug insurance project on the shelves, even programs aimed at covering solely catastrophic drug costs (Health Council of Canada, 2009).

The provinces and the federal government arrived at the same consensus a decade ago, and yet today, we still feel the Canadian pharmaceutical policy has not moved an inch: we are still facing the same problems for the same reasons. Everyone is trying to balance their budgets but, since we cannot collectively contain costs, budgets are balanced by shifting the costs elsewhere in the system. Policy makers must not only recognize that there is a consensus about the inefficiency, inequity, wastefulness and unsustainability of the current Canadian drug coverage system, a hybrid (public-private) and fragmented system, but they must now take the necessary measures to address the issue and adopt a rational drug policy.

The reforms necessary to implement a rational drug policy must target three non-negotiable goals:

1. **Access to drugs for all Canadians based on their medical needs**
2. **Sustainability of the system**
3. **Rational use of medicines**

Since 2004, when the NPS was adopted, these have been the positions of federal and provincial governments. They are the same goals that the CLHIA (2013), regrouping private insurers, and the C.D. Howe Institute (Morgan, Daw and Law,

2013) claim to defend. To reach these goals, we recommend a reform of the actual drug insurance system, targeting four specific areas. In our view, these reforms are all necessary. They can be implemented successively but, we believe, the objectives of a rational drug policy will only be reached when they are all implemented together.

Reform #1: Improve access to drugs by including prescription drugs in the public health care system

Every Canadian should have adequate and equitable coverage for prescription drugs. A national pharmacare program must be offered to the entire Canadian population, whether such a drug plan is organized at the national level or on a provincial or regional basis. The most simple solution, as suggested by the C.D. Howe Institute (Morgan, Daw, and Law, 2013), is to include prescription drugs in the current health care system. However, if drug coverage is established by a province or region, all provinces must then collaborate to ensure the coverage will apply to all from coast to coast, and that the system does not allow a province to shift the costs to other provinces, which is what happens with confidential agreements (PLAs).

In order to diminish the impact of such a cost shift on public health insurance plans, we recommend exploring the impact of a fixed co-payment for a prescription, which would be progressively eliminated. We also suggest exploring the social insurance principle (through pay deductions) in order to partially fund the plan for people able to work. Finally, in order to be fair and equitable, the public plan must pool the risks among the whole population, and not exclude the "good risks" (the rich and healthy), allowing them to contribute to the funding of the plan. The whole population would then automatically participate in the plan and be covered. This would ensure the universality of the public drug plan. The federal government, the provinces and the territories must ensure public coverage for all and stop promoting private insurance by offering generous tax subsidies.

Reform #2: Ensure equitable access to drugs by establishing a national formulary

Currently, access to medications for Canadians depends greatly on their postal code. The difference in access to drugs in each province is explained, in part, by the province's health budget and its power to negotiate with pharmaceutical companies to get confidential rebates. Such a system is unfair. The coverage offered to the entire population must be based on a national formulary. Given the specific needs of certain

populations, such a formulary must remain relatively flexible. It still remains the common basis to ensure equitable drug access to all Canadians.

Reform #3: Control costs by systematically resorting to bulk purchasing for patented and generic drugs

In the last three years, the main innovation to contain prescription drug cost in Canada has been the creation of a bulk purchasing agency (the Pan-Canadian Pricing Alliance) for some patented and generic drugs. Bulk purchasing is more efficient than increasing PLAs because provinces are not pitted against one another through the "whipsawing" strategy adopted by pharmaceutical companies. Moreover, such an agency can play a role in reducing stock shortages if indemnity and contingency clauses are required for drugs more susceptible to shortages. Consequently, it helps ensure the safety of the supply.

Given the difficulties linked to coordination and collaboration between provinces, as well as the absence of a national formulary, this new alliance has not been able to fully realize its potential and remains, in many respects, inefficient. For example, generic drug prices are still negotiated in terms of a percentage of the patented drug price, and not enough medications are purchased through the alliance. The purchase of patented or generic drugs should systematically be done through a bulk purchasing agency.

With the current bulk pricing alliance, we have no guarantee the savings made by public plans will necessarily translate into savings for all Canadians because private plans and people with no insurance continue to pay their medications at an official price that is increasingly on the rise. Insured individuals who must pay a deductible or a co-payment, based on a percentage of the price of the drug, also find themselves paying too big a proportion of the price of the drug. Because it generates savings for public plans by indirectly taxing patients, the structure of the current bulk purchasing alliance remains problematic.

To ensure that a bulk purchasing agency benefits all Canadians, it should negotiate the official price of medications in a transparent way. However, since confidential agreements will likely remain the rule, rather than the exception, we must at least apply the same price to all in order to avoid shifting the cost to someone else. Moreover, to avoid indirectly taxing patients, we must eliminate deductibles

and co-payments for patients. If that is not possible, only a fixed co-payment for a prescription, not one based on the official price of the drug, would be acceptable.

Reform #4: Reform #4: Ensure appropriate use of medications by assessing the safety and efficacy of the medications

The security and safety of medications remains a major issue in Canada. Prescription drug deaths are high – in third place, after cardiovascular disease and cancer (Gøtzsche, 2013). While half of these drug deaths are due to medical errors (dosage errors or intake of medications in spite of contra-indications), the other 50% of deaths are due to adverse effects (Gøtzsche, 2013; Light, 2010). Pharmacovigilance, which aims to detect the adverse effects of a drug and to assess medical practices, is in bad shape.

The Canadian Senate recently examined the issue in order to highlight the scope of the problem (Standing Senate Committee on Social Affairs, Science and Technology, 2013). In its report, the Committee mentions the lack of available data as one of the main problems since, without a national formulary, data sources vary greatly for private and public plans. We have no database to analyze patients' drug usage or physicians' prescribing practices. When Health Canada sends out a warning to physicians about a medication more dangerous than initially determined, we cannot assess whether or not the prescribing practices are following evidence-based medical recommendations (or if they are simply driven by the marketing campaigns of pharmaceutical companies).

The recent creation of the Drug Safety and Effectiveness Network, by the Canadian Institutes of Health Research, is a step in the right direction, but it is not enough, particularly when we don't have strong data to enable us to analyze the security and safety of medications (Lexchin et al., 2013). To generate such data, a national formulary and a public and universal drug plan would be essential elements since they would permit the establishment of a complete database of drug usage in Canada. Such a system is already in place in British Columbia (BC Pharmanet), but the difference in drug usage within the public and private sectors remains problematic for any general analysis. BC Pharmanet is an important tool to improve drug usage and patients' health (Dormuth et al., 2012; Mamdani et al., 2006; Padwal

et al., 2007). It is inconceivable that such a tool is not already available across Canada, being used to improve the medical practices of all health professionals.

This series of four reforms is not a magical solution but clearly shows the direction policy makers should follow.

Let us repeat it once more: the current Canadian drug insurance plan is an institutional anomaly. It offers inadequate coverage to Canadians, it is inequitable because of its funding structure and it leads to a significant waste of money. In addition, Canada has one of the worst records among OECD countries when it comes to containing cost increases.

If there is, in fact, consensus among all stakeholders about the issues, the debate is still ongoing with respect to the solutions. Through an analysis of the current situation in the pharmaceutical sector, we showed that, more than ever, a universal pharmacare program could help us build the necessary institutional capacities to adapt to the challenges of the pharmaceutical world. The current fragmentation of plans, particularly having to resort to private plans, is the main obstacle in the way of Canada's progress toward a more efficient, equitable, and sustainable system.

Conclusion

Chapter 7

A universal pharmacare program is not a panacea. Even with a national formulary, a bulk purchasing agency and the institutional capacities to ensure better use of medicines, such a program would not solve all our current problems. Countries having such a system are also facing challenges in terms of access and costs. However, with a universal pharmacare program, we could build the institutional capacities needed to improve access, diminish costs, improve practices and ensure the longevity of a system now rendered more efficient.

The data in this report has shown how a universal pharmacare program would lead to equitable access to drugs while generating important savings for the Canadian population. Such a plan could be implemented with very few impacts on taxpayers, other than an increase in their disposable income.

Even if Canada offered first-dollar coverage, a universal pharmacare program would generate savings of 10% to 41% on prescription drugs, representing annual savings of $2.7 to $ 11.4 billion. Variations in savings depend on the strategies used

to revise and alter costly and inefficient industrial policies that artificially inflate prescription drug costs based on the illusion that it might attract more investments.

While Canada is risking its health system's survival, in the hopes of offering even greater industrial cost perks to attract elusive pharmaceutical firm investments, the latter have clearly left Canada by the wayside since the number of employees in the patented drug industry has dropped from 22,332 in 2003 (PriceWaterhouseCooper, 2005) to 14,990 in 2012. The offer of higher prices has not brought in more investments, as mentioned by the PMPRB. We can only hope that, in light of these facts, Canada responds to the industrial challenges in this sector by developing a rational industrial policy and stops draining health care budgets. Too often, we are under the impression that the main opposition to universal pharmacare comes from people who maintain a disguised regime of subsidies to the industry. In the meantime, all Canadians continue to pay for our policy makers' obstinacy in maintaining irrational and inefficient pharmaceutical policies.

In May 2013, economist Robert Evans (2013) reminded us that the expenses of some individuals are the revenues of others and that the main problem with a universal drug plan is not that it would be too expensive but rather that it would generate excessive savings. Accordingly, every saving is also a loss of revenue for others: corporate profits that hold a definite political influence. We can therefore expect that certain actors in this scenario will exert their power to pre-annihilate, and prevent, the creation of any type of public, universal, rational and efficient drug plan.

The need for a universal pharmacare program is one of the rare issues creating consensus among analysts from across the political spectrum. Finally, let us reiterate that 78% of Canadians support a universal pharmacare program, and 82% support bulk purchasing to reduce the costs of drugs (EKOS, 2013). After presenting a pragmatic roadmap for a national drug plan policy, along with the institutional capacities necessary to obtain and implement rational and appropriate pharmaceutical policies, we can only hope that the political will of our leaders will finally align with the public will.

Afterword

Mike McBane

I have patients saying, "I just can't afford this, I am going to have to live with my illness." Drugs for hepatitis C cost in the $80,000 range, beyond the reach of most who must pay for their own medicine. We desperately need a national pharmaceutical strategy.

Dr. Jeff Turnbull, Chief of Staff, Ottawa Hospital

Marc-André Gagnon's *Roadmap to a Rational Pharmacare Policy in Canada* will put an end to the suffering that health providers like Dr. Turnbull see every day in their practices by ensuring equitable access to drugs for all Canadians. Countering the conventional wisdom, the Roadmap shows how ensuring this access is entirely within reach, and would in fact control the cost of drugs through bulk purchasing and more appropriate use of medications.

It is hard to overestimate the importance of Professor Gagnon's work. He is providing solutions to one of health care's greatest challenges: how to ensure access for all Canadians to essential medicines and at the same time protect Canadians,

as well as their health care system, from excessively priced and inappropriately marketed prescription drugs.

I was fortunate to meet Marc-André just as he was completing his doctorate with Dr. Joel Lexchin. The Canadian Health Coalition was looking for a researcher to study the economic implications of universal pharmacare. We were referred to Marc-André, and so began what has been an exciting and fruitful relationship. His 2010 report, *The Economic Case for Universal Phamacare*, was a game changer. Before this report most people asked how we could ever afford universal pharmacare. Now the consensus is we cannot afford not to have pharmacare.

In the last four years a number of positive developments on the pharmacare front have taken place at the provincial and territorial levels through the Council of the Federation. There is also a growing policy consensus, as demonstrated by think tanks like the C.D. Howe Institute, endorsing the idea of a public universal drug plan. This shows the power of a great idea – ensuring value for money in pharmaceutical policy. We are grateful to the Canadian Federation of Nurses Unions for sponsoring this follow-up research report from Professor Gagnon.

As Gagnon's *Roadmap* makes clear, positive initiatives are underway at the provincial and territorial levels. They are headed in the right direction through the newly created Pan-Canadian Purchasing Alliance. But there are serious limitations, including a lack of national coordination. What's really needed now is federal leadership to coordinate a national approach to bulk purchasing, price negotiation, a national formulary, and the strengthening of institutional capacity. Fortunately, in the Canadian federation there is an institution which is designed to play this role. It is not called the Council of the Federation – it's called the Government of Canada.

One of the last things the Health Council of Canada said before it was closed due to a federal funding cut was that there can be no meaningful health care renewal without federal government leadership and a national pharmaceutical management plan. In 2006, upon assuming office, the Harper government walked away from a signed First Ministers' agreement to adopt Canada-wide solutions to access, affordability and safety of prescription drugs. Since then, the federal government's mantra is that pharmaceuticals – together with every other part of health care – are someone else's responsibility, be it the provinces, the regions, or the hospitals...

This abdication of federal leadership results in untold suffering for millions of Canadians who lack access to affordable medication. To make matters worse,

federal pharmaceutical policy fixes the introductory price of prescription drugs at approximately 30% above the OECD average. It is perverse for the federal government to encourage the excessive growth in prescription drug costs as well as abusive marketing behavior and illegal drug advertising, and to then pass onto others the cost and the damage.

As Professor Gagnon convincingly shows, public drug insurance is the solution to the current fragmented system that relies too much on expensive and inefficient private drug insurance. Private markets and commercial competition have made things worse, not better, for our health care system. Markets, as Professor Arnold Relman of Harvard University reminds us, are not designed to effectively deliver medical care, which is a social function to be addressed in the public sector.

The Roadmap shows us how we can strengthen our health care system to cover everyone, save money and save lives. It leads to what Tommy Douglas called the second stage of medicare, and what Alex Himelfarb calls medicare 2.0. They are referring to a health care system that focuses on prevention, health promotion and comprehensive, integrated services. A universal public drug plan, together with home and continuing care, are the strategic innovations we need to ensure medicare is affordable, equitable and efficient.

Mike McBane

National Coordinator, Canadian Health Coalition

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Annex 1

Per capita provincial variations sources for prescription drugs compared to average expenses per capita in the rest of Canada (ROC), April 2012-March 2013

	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Pharmacy dispensed prescribed drugs expenses (million $)	$2,364	$2,233	$616	$707	$8,532	$6,610	$610	$714	$95	$410
Provincial per capita expenses ($)	$511.4	$576.4	$570.8	$558.1	$631.8	$820.6	$807.3	$752.4	$651.4	$800.0
Per capita in the ROC ($)	$678.4	$666.3	$659.0	$660.0	$671.8	$607.0	$652.9	$653.6	$656.3	$654.1
ROC expenses variations per provincial capita	-24.6%	-13.5%	-13.4%	-15.4%	-6.0%	35.2%	23.6%	15.1%	-0.7%	22.3%
Variations based on population age	3.6%	-10.7%	-4.1%	-4.3%	-0.9%	4.3%	6.5%	6.8%	4.4%	7.0%
Variations expenses total per capita according to standardized age	-27.2%	-3.1%	-9.7%	-11.7%	-5.1%	29.6%	16.1%	7.8%	-4.9%	14.2%
Volume effect	-23.2%	-5.9%	-12.0%	-8.7%	-0.1%	23.5%	15.4%	11.5%	-1.1%	13.0%
Prescription volume	-40.4%	-30.6%	-12.0%	-19.9%	-23.5%	80.3%	-11.5%	-22.7%	-19.3%	-8.2%
Size of prescriptions	17.2%	24.7%	0.0%	11.2%	23.3%	-56.8%	27.0%	34.2%	18.2%	21.2%
Therapeutic choice effect	-4.7%	0.7%	-3.0%	-7.3%	1.7%	-1.6%	-1.4%	-2.4%	-4.8%	-5.9%
Therapeutic option	-3.6%	1.3%	1.5%	-2.8%	2.0%	-5.4%	0.7%	-0.5%	-0.7%	-2.5%
Medicine option	-1.1%	-0.6%	-4.4%	-4.5%	-0.3%	3.9%	-2.1%	-1.9%	-4.1%	-3.4%
Price effect	0.7%	2.1%	5.3%	4.4%	-6.7%	7.6%	2.0%	-1.3%	1.0%	7.1%
Prices paid	0.8%	3.0%	5.5%	5.4%	-5.9%	5.5%	3.3%	-0.4%	2.1%	8.1%
Use of generics	-0.1%	-0.9%	-0.2%	-1.1%	-0.7%	2.1%	-1.3%	-1.0%	-1.1%	-1.1%

Source: Morgan et al., 2013

Annex 2

Provincial Figures Details

Provincial synthesis of potential savings with the implementation of a universal pharmacare program comparing two scenarios, based on industrial policy cost modalities, using figures available for 2012-2013

		CANADA	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL
Scenario 1	Savings with a universal pharmacare program and cost/ industrial policies (million $)	2,708	105	248	42	6	1,041	828	32	57	4	11
	Savings with a universal pharmacare program and cost/ industrial policies (% of expenses in prescription drugs)	10%	4%	9%	5%	1%	10%	11%	5%	6%	4%	2%
Scenario 2	Savings with a universal pharmacare program and repeal of cost/ industrial policies (million $)	11,448	1,139	1,097	321	366	4,256	3,345	278	388	45	200
	Savings with a universal pharmacare program and repeal of cost/ industrial policies (% of expenses in prescription drugs) (million $)	41%	40%	40%	40%	40%	40%	45%	41%	40%	39%	40%

BRITISH COLUMBIA (scenario 1)

Estimation of the costs and benefits generated by a universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$2,831 million**
Allocation of costs/revenues in prescribed medication	
2. Increase in expenditures from increase in use	+10% of current expenditure
3. Reduction in expenditures from decrease in dispensing fees	-2% of current expenditure
4. Reduction in expenditures from drug assessment	-0% of current expenditure
5. Elimination of the monthly deductible in Quebec	$0 million
6. Tendering process for generic drugs	-$65 million
Total savings on prescription drugs	($156 million)
Total prescription drug expenditures with a universal pharmacare plan	**$2,987 million**
Additional impacts other than for prescription drugs	
7. Elimination of private plan extra administrative costs	-$138 million
8. Elimination of tax subsidies	-$123 million
Total – additional impacts	-$261 million
Total net savings	**$105 million (4%)**

Source: Author's figures; Gagnon & Hébert, 2010

BRITISH COLUMBIA (scenario 2)

Cost and savings estimations from implementation of a universal pharmacare program with repeal of industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$2,831 million**
Allocation of costs/revenues in prescribed medication	
Savings with competitive bidding	-$1,019 million
2. Increase in expenditures from increase in use	+10% of expenses
3. Reduction in expenditures from decrease in dispensing fees	-2% of expenses
4. Elimination of the monthly deductible in Quebec	$0 million
Total savings on prescription drugs	-$878 million
Total prescription drugs expenses with a universal pharmacare plan	**$1,953 million**
Additional impacts other than for prescription drugs	
5. Elimination of extra administrative costs by private plans	-$138 million
6. Elimination of tax subsidies	-$123 million
Total of additional impacts	-$261 million
Total net savings	**$1,139 million (40%)**

Source: Author's figures; Gagnon & Hébert, 2010

ALBERTA (scenario 1)

Estimation of the costs and benefits generated by a universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$2,755 million**
Allocation of costs/revenues in prescribed medication	
2. Increase in expenditures from increase in use	+10% of current expenditure
3. Reduction in expenditures from decrease in dispensing fees	-2% of current expenditure
4. Reduction in expenditures from drug assessment	-4.8% of current expenditure
5. Elimination of the monthly deductible in Quebec	$0 million
6.Tendering process for generic drugs	-$64 million
Total savings on prescription drugs	($5 million)
Total prescription drugs expenses with a universal pharmacare plan	**$2,760 million**
Additional impacts other than for prescription drugs	
7. Elimination of extra administrative costs by private plans	-$134 million
8. Elimination of tax subsidies	-$119 million
Total of additional impacts	-$253 million
Total net savings	**$248 million (9%)**

Source: Author's figures; Gagnon & Hébert, 2010

ALBERTA (scenario 2)

Cost and savings estimations from implementation of a universal pharmacare program with repeal of industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$2,755 million**
Allocation of costs/revenues in prescribed medication	
Savings with competitive bidding	-$982 million
2. Increase in expenditures from increase in use	+10% of expenses
3. Reduction in expenditures from decrease in dispensing fees	-2% of expenses
4. Elimination of the monthly deductible in Quebec	$0 million
Total savings on prescription drugs	-$844 million
Total prescription drugs expenses with a universal pharmacare plan	**$1,911 million**
Additional impacts other than for prescription drugs	
5. Elimination of extra administrative costs by private plans	-$134 million
6. Elimination of tax subsidies	-$119 million
Total of additional impacts	-$253 million
Total net savings	**$1,097 million (40%)**

Source: Author's figures; Gagnon & Hébert, 2010

SASKATCHEWAN (scenario 1)

Estimation of the costs and benefits generated by a universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$810 million**
Allocation of costs/revenues in prescribed medication	
2. Increase in expenditures from increase in use	+10% of current expenditure
3. Reduction in expenditures from decrease in dispensing fees	-2% of current expenditure
4. Reduction in expenditures from drug assessment	-1.4% of current expenditure
5. Elimination of the monthly deductible in Quebec	$0 million
6. Tendering process for generic drugs	-$19 million
Total savings on prescription drugs	($32 million)
Total prescription drugs expenses with a universal pharmacare plan	**$842 million**
Additional impacts other than for prescription drugs	
7. Elimination of extra administrative costs by private plans	-$39 million
8. Elimination of tax subsidies	-$35 million
Total of additional impacts	-$74 million
Total net savings	**$42 million (5%)**

Source: Author's figures; Gagnon & Hébert, 2010

SASKATCHEWAN (scenario 2)

Cost and savings estimations from implementation of a universal pharmacare program with repeal of industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$810 million**
Allocation of costs/revenues in prescribed medication	
Savings with competitive bidding	-$288 million
2. Increase in expenditures from increase in use	+10% of expenses
3. Reduction in expenditures from decrease in dispensing fees	-2% of expenses
4. Elimination of the monthly deductible in Quebec	$0 million
Total savings on prescription drugs	-$247 million
Total prescription drugs expenses with a universal pharmacare plan	**$563 million**
Additional impacts other than for prescription drugs	
5. Elimination of extra administrative costs by private plans	-$39 million
6. Elimination of tax subsidies	-$35 million
Total of additional impacts	-$74 million
Total net savings	**$321 million (40%)**

Source: Author's figures; Gagnon & Hébert, 2010

MANITOBA (scenario 1)

Estimation of the costs and benefits generated by a universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$918 million**
Allocation of costs/revenues in prescribed medication	
2. Increase in expenditures from increase in use	+10% of current expenditure
3. Reduction in expenditures from decrease in dispensing fees	-2% of current expenditure
4. Reduction in expenditures from drug assessment	(2.8 % of current expenditure)
5. Elimination of the monthly deductible in Quebec	$0 million
6. Tendering process for generic drugs	-$21 million
Total savings on prescription drugs	($79 million)
Total prescription drugs expenses with a universal pharmacare plan	**$997 million**
Additional impacts other than for prescription drugs	
7. Elimination of extra administrative costs by private plans	-$45 million
8. Elimination of tax subsidies	-$40 million
Total of additional impacts	-$85 million
Total net savings	**$6 million (1%)**

Source: Author's figures; Gagnon & Hébert, 2010

MANITOBA (scenario 2)

Cost and savings estimations from implementation of a universal pharmacare program with repeal of industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$918 million**
Allocation of costs/revenues in prescribed medication	
Savings with competitive bidding	-$327 million
2. Increase in expenditures from increase in use	+10% of expenses
3. Reduction in expenditures from decrease in dispensing fees	-2% of expenses
4. Elimination of the monthly deductible in Quebec	$0 million
Total savings on prescription drugs	-$281 million
Total prescription drugs expenses with a universal pharmacare plan	**$637 million**
Additional impacts other than for prescription drugs	
5. Elimination of extra administrative costs by private plans	-$45 million
6. Elimination of tax subsidies	-$40 million
Total of additional impacts	-$85 million
Total net savings	**$366 million (40%)**

Source: Author's figures; Gagnon & Hébert, 2010

ONTARIO (scenario 1)

Estimation of the costs and benefits generated by a universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$10,640 million**
Allocation of costs/revenues in prescribed medication	
2. Increase in expenditures from increase in use	+10% of current expenditure
3. Reduction in expenditures from decrease in dispensing fees	-2% of current expenditure
4. Reduction in expenditures from drug assessment	-5.5% of current expenditure
5. Elimination of the monthly deductible in Quebec	$0 million
6. Tendering process for generic drugs	-$247 million
Total savings on prescription drugs	-$61 million
Total prescription drugs expenses with a universal pharmacare plan	**$10 579 million**
Additional impacts other than for prescription drugs	
7. Elimination of extra administrative costs by private plans	-$518 million
8. Elimination of tax subsidies	-$462 million
Total of additional impacts	-$980 million
Total net savings	**$1,041 million (10%)**

Source: Author's figures; Gagnon & Hébert, 2010

ONTARIO (scenario 2)

Cost and savings estimations from implementation of a universal pharmacare program with repeal of industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$10,640 million**
Allocation of costs/revenues in prescribed medication	
Savings with competitive bidding	-$3,809 million
2. Increase in expenditures from increase in use	+10% of expenses
3. Reduction in expenditures from decrease in dispensing fees	-2% of expenses
4. Elimination of the monthly deductible in Quebec	$0 million
Total savings on prescription drugs	-$3,276 million
Total prescription drugs expenses with a universal pharmacare plan	**$7,364 million**
Additional impacts other than for prescription drugs	
5. Elimination of extra administrative costs by private plans	-$518 million
6. Elimination of tax subsidies	-$462 million
Total of additional impacts	-$980 million
Total net savings	**$4,256 million (40%)**

Source: Author's figures; Gagnon & Hébert, 2010

QUÉBEC (scenario 1)

Estimation of the costs and benefits generated by a universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$7,459 million**
Allocation of costs/revenues in prescribed medication	
2. Increase in expenditures from increase in use	+10% of current expenditure
3. Reduction in expenditures from decrease in dispensing fees	-2% of current expenditure
4. Reduction in expenditures from drug assessment	-3.1% of current expenditure
5. Elimination of the monthly deductible in Quebec	-$364 million
6. Tendering process for generic drugs	-$173 million
Total savings on prescription drugs	-$141 million
Total prescription drugs expenses with a universal pharmacare plan	**$7,318 million**
Additional impacts other than for prescription drugs	
7. Elimination of extra administrative costs by private plans	-$363 million
8. Elimination of tax subsidies	-$324 million
Total of additional impacts	-$687 million
Total net savings	**$828 million (11%)**

Source: Author's figures; Gagnon & Hébert, 2010

QUÉBEC (scenario 2)

Cost and savings estimations from implementation of a universal pharmacare program with repeal of industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$7,459 million**
Allocation of costs/revenues in prescribed medication	
Savings with competitive bidding	-$2,668 million
2. Increase in expenditures from increase in use	+10% of expenses
3. Reduction in expenditures from decrease in dispensing fees	-2% of expenses
4. Elimination of the monthly deductible in Quebec	-$364 million
Total savings on prescription drugs	-$2,658 million
Total prescription drugs expenses with a universal pharmacare plan	**$4 801 million**
Additional impacts other than for prescription drugs	
5. Elimination of extra administrative costs by private plans	-$363 million
6. Elimination of tax subsidies	-$324 million
Total of additional impacts	-$687 million
Total net savings	**$3,345 million (45%)**

Source: Author's figures; Gagnon & Hébert, 2010

NEW-BRUNSWICK (scenario 1)

Estimation of the costs and benefits generated by a universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$684 million**
Allocation of costs/revenues in prescribed medication	
2. Increase in expenditures from increase in use	+10% of current expenditure
3. Reduction in expenditures from decrease in dispensing fees	-2% of current expenditure
4. Reduction in expenditures from drug assessment	-2.9% of current expenditure
5. Elimination of the monthly deductible in Quebec	$0 million
6. Tendering process for generic drugs	-$16 million
Total savings on prescription drugs	($32 million)
Total prescription drugs expenses with a universal pharmacare plan	**$716 million**
Additional impacts other than for prescription drugs	
7. Elimination of extra administrative costs by private plans	-$34 million
8. Elimination of tax subsidies	-$30 million
Total of additional impacts	-$64 million
Total net savings	**$32 million (5%)**

Source: Author's figures; Gagnon & Hébert, 2010

NEW-BRUNSWICK (scenario 2)

Cost and savings estimations from implementation of a universal pharmacare program with repeal of industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$684 million**
Allocation of costs/revenues in prescribed medication	
Savings with competitive bidding	-$248 million
2. Increase in expenditures from increase in use	+10% of expenses
3. Reduction in expenditures from decrease in dispensing fees	-2% of expenses
4. Elimination of the monthly deductible in Quebec	$0 million
Total savings on prescription drugs	-$214 million
Total prescription drugs expenses with a universal pharmacare plan	**$470 million**
Additional impacts other than for prescription drugs	
5. Elimination of extra administrative costs by private plans	-$34 million
6. Elimination of tax subsidies	-$30 million
Total of additional impacts	-$64 million
Total net savings	**$278 million (43%)**

Source: Author's figures; Gagnon & Hébert, 2010

NOVA SCOTIA (scenario 1)

Estimation of the costs and benefits generated by a universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$964 million**
Allocation of costs/revenues in prescribed medication	
2. Increase in expenditures from increase in use	+10% of current expenditure
3. Reduction in expenditures from decrease in dispensing fees	-2% of current expenditure
4. Reduction in expenditures from drug assessment	-2% of current expenditure
5. Elimination of the monthly deductible in Quebec	$0 million
6. Tendering process for generic drugs	-$22 million
Total savings on prescription drugs	($32 million)
Total prescription drugs expenses with a universal pharmacare plan	**$996 million**
Additional impacts other than for prescription drugs	
7. Elimination of extra administrative costs by private plans	-$47 million
8. Elimination of tax subsidies	-$42 million
Total of additional impacts	-$89 million
Total net savings	**$57 million (6%)**

Source: Author's figures; Gagnon & Hébert, 2010

NOVA SCOTIA (scenario 2)

Cost and savings estimations from implementation of a universal pharmacare program with repeal of industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$964 million**
Allocation of costs/revenues in prescribed medication	
Savings with competitive bidding	-$347 million
2. Increase in expenditures from increase in use	+10% of expenses
3. Reduction in expenditures from decrease in dispensing fees	-2% of expenses
4. Elimination of the monthly deductible in Quebec	$0 million
Total savings on prescription drugs	-$299 million
Total prescription drugs expenses with a universal pharmacare plan	**$665 million**
Additional impacts other than for prescription drugs	
5. Elimination of extra administrative costs by private plans	-$47 million
6. Elimination of tax subsidies	-$42 million
Total of additional impacts	-$89 million
Total net savings	**$388 million (40%)**

Source: Author's figures; Gagnon & Hébert, 2010

PRINCE EDWARD ISLAND (scenario 1)

Estimation of the costs and benefits generated by a universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$114 million**
Allocation of costs/revenues in prescribed medication	
2. Increase in expenditures from increase in use	+10% of current expenditure
3. Reduction in expenditures from decrease in dispensing fees	-2% of current expenditure
4. Reduction in expenditures from drug assessment	(0.5% of current expenditure)
5. Elimination of the monthly deductible in Quebec	$0 million
6. Tendering process for generic drugs	-$3 million
Total savings on prescription drugs	($7 million)
Total prescription drugs expenses with a universal pharmacare plan	**$121 million**
Additional impacts other than for prescription drugs	
7. Elimination of extra administrative costs by private plans	-$6 million
8. Elimination of tax subsidies	-$5 million
Total of additional impacts	-$11 million
Total net savings	**$4 million (4%)**

Source: Author's figures; Gagnon & Hébert, 2010

PRINCE EDWARD ISLAND (scenario 2)

Cost and savings estimations from implementation of a universal pharmacare program with repeal of industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$114 million**
Allocation of costs/revenues in prescribed medication	
Savings with competitive bidding	-$40 million
2. Increase in expenditures from increase in use	+10% of expenses
3. Reduction in expenditures from decrease in dispensing fees	-2% of expenses
4. Elimination of the monthly deductible in Quebec	$0 million
Total savings on prescription drugs	-$34 million
Total prescription drugs expenses with a universal pharmacare plan	**$78 million**
Additional impacts other than for prescription drugs	
5. Elimination of extra administrative costs by private plans	-$6 million
6. Elimination of tax subsidies	-$5 million
Total of additional impacts	-$11 million
Total net savings	**$45 million (39%)**

Source: Author's figures; Gagnon & Hébert, 2010

NEWFOUNDLAND AND LABRADOR (scenario 1)

Estimation of the costs and benefits generated by a universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$495 million**
Allocation of costs/revenues in prescribed medication	
2. Increase in expenditures from increase in use	+10% of current expenditure
3. Reduction in expenditures from decrease in dispensing fees	-2% of current expenditure
4. Reduction in expenditures from drug assessment	(1.5% of current expenditure)
5. Elimination of the monthly deductible in Quebec	$0 million
6. Tendering process for generic drugs	-$12 million
Total savings on prescription drugs	($35 million)
Total prescription drugs expenses with a universal pharmacare plan	**$530 million**
Additional impacts other than for prescription drugs	
7. Elimination of extra administrative costs by private plans	-$24 million
8. Elimination of tax subsidies	-$22 million
Total of additional impacts	-$46 million
Total net savings	**$11 million (2%)**

Source: Author's figures; Gagnon & Hébert, 2010

NEWFOUNDLAND AND LABRADOR (scenario 2)

Cost and savings estimations from implementation of a universal pharmacare program with repeal of industrial policies associated to drug costs, based on 2012-2013 figures

1. 2012 prescription drugs expenditures	**$495 million**
Allocation of costs/revenues in prescribed medication	
Savings with competitive bidding	-$179 million
2. Increase in expenditures from increase in use	+10% of expenses
3. Decrease of expenses from dispensing fees reductions	-2% of expenses
4. Elimination of the monthly deductible in Quebec	$0 million
Total savings on prescription drugs	-$154 million
Total prescription drugs expenses with a universal pharmacare plan	**$341 million**
Additional impacts other than for prescription drugs	
5. Elimination of extra administrative costs by private plans	-$24 million
6. Elimination of tax subsidies	-$22 million
Total of additional impacts	-$46 million
Total net savings	**$200 million (40%)**

Source: Author's figures; Gagnon & Hébert, 2010

Appendix A
Message from the CFNU

Linda Silas
(French)

Depuis plus de deux décennies, la Fédération canadienne des syndicats d'infirmières et infirmiers (FCSII) préconise un régime national d'assurance-médicaments. En raison de l'augmentation continue du coût des médicaments sur ordonnance, et de la pression accrue sur un système de soins de santé déjà poussé à ses limites, la FCSII trouve maintenant de nouveaux alliés. Un nombre grandissant de personnes sont d'accord pour dire que les politiques relatives aux médicaments sur ordonnance doivent être réformées. Parmi les partisans de la réforme mentionnons l'Institut C.D. Howe (groupe de réflexion sur les politiques publiques), l'Association canadienne des compagnies d'assurances de personnes inc., les gouvernements provinciaux et territoriaux, ainsi que les défenseurs des patients, d'un océan à l'autre. Tout comme les premiers ministres, la FCSII est déterminée à freiner l'escalade des coûts des médicaments tout en assurant l'accès à des soins de qualité. L'échec à contenir les coûts des produits pharmaceutiques menace la capacité du Canada à offrir aux patients les soins qu'ils méritent. Si nous voulons offrir aux patients les médicaments dont ils ont besoin, un régime national d'assurance-médicaments devient une priorité pressante.

Vers une politique rationnelle d'assurance-médicaments au Canada demande aux gouvernements, assureurs, décideurs et compagnies pharmaceutiques de reconnaître

l'échec du système hybride actuel qui sert à financer l'achat des médicaments sur ordonnance. Le document de Marc-André Gagnon, Ph. D., illustre clairement comment le système actuel est injuste et inéquitable. De plus, il s'accompagne de gaspillage, notamment frais administratifs excessifs, subventions à caractère fiscal, et traitements coûteux et inutiles. Dans un tel contexte, une réforme n'est pas une mesure radicale mais plutôt un choix national responsable et impératif.

Lors de la réunion 2004 du Conseil de la fédération, les premiers ministres se sont engagés à créer un régime national d'assurance-médicaments. Les premiers ministres étaient d'accord mais le gouvernement fédéral n'a pas tenu ses promesses. À ce moment-là, la FCSII espérait que ses efforts allaient mener à un régime national d'assurance-médicaments. Malheureusement, malgré l'analyse raisonnée à l'appui, l'absence de volonté politique et l'importance accordée aux intérêts des entreprises demeurent encore les principaux obstacles. Depuis, aucune mesure pour créer un tel régime. Ottawa continue de transférer les coûts aux provinces qui voient alors leurs budgets s'étirer davantage. Or, une plus grande collaboration pour mettre en œuvre des mesures efficaces et économiques, par exemple, l'achat groupé de médicaments sur ordonnance serait une très bonne politique sur le plan public et fiscal.

Au cours des dernières années, nous avons observé quelques signes encourageants. Les premiers ministres provinciaux ont créé, dans le cadre du Conseil de la fédération, le Groupe de travail sur l'innovation en matière de santé, et forgé une alliance pour l'achat groupé de produits pharmaceutiques. Excellents premiers pas. Toutefois, sans réforme plus poussée, telle que détaillée dans le document, cette alliance n'arrive pas à réaliser son potentiel.

Des milliards de dollars d'économies sont à notre portée, et pourraient être réinvestis pour assurer la qualité et la sécurité des soins dispensés aux patients. Tout parti politique qui propose un régime national d'assurance-médicaments offrirait, en fait, de meilleurs soins de santé, et plus d'argent dans les poches des contribuables à la fin de la journée. Alors, pourquoi les politiciens ne sautent-ils pas sur cette occasion? Chaque année, des milliards de dollars sont gaspillés au sein du système parce qu'on ne concrétise pas ce régime promis depuis longtemps. Plus important encore, des millions de Canadiens et de Canadiennes n'ont pas accès aux médicaments dont ils ont besoin.

Un régime national d'assurance-médicaments est un concept qui a été mis à l'essai. Selon le rapport du professeur Marc-André Gagnon, le Canada est le seul pays de l'OCDE ayant un système universel de soins de santé qui ne s'accompagne pas d'un régime d'assurance-médicaments. Chaque pays développé ayant un régime universel de soins de santé, sauf le Canada, offre aussi une couverture universelle des

médicaments sur ordonnance, et tous offrent cette couverture universelle à un coût moindre que le Canada.

Le rapport de Marc-André Gagnon, offre une feuille de route pour l'élaboration d'une politique rationnelle en matière de médicaments, qui permettra au Canada d'entrer dans le 21e siècle, aux côtés des autres pays de l'OCDE. L'auteur suggère au gouvernement de saisir l'occasion et tirer avantage du consensus émergeant au sujet de la réforme. Il propose aussi des mesures pragmatiques et réalisables pouvant être prises maintenant afin que les politiques se traduisent en action. Gagnon reconnaît qu'un régime universel d'assurance-médicaments ne résoudra pas tous les problèmes du Canada, mais il permettra de bâtir la capacité institutionnelle nécessaire pour améliorer l'accès, diminuer les coûts, améliorer les pratiques, et assurer la viabilité de notre système de soins de santé. La FCSII encourage les principaux intervenants à lire attentivement ce document. Un régime national d'assurance-médicaments permettra aux gouvernements et aux patients d'économiser des milliards de dollars tout en améliorant les résultats en santé.

En s'appuyant sur les données présentées dans ce rapport, nous avons deux questions à poser à tous les gouvernements : 1) Quelle est l'alternative à ne rien faire? 2) Pouvons-nous vraiment nous permettre de ne pas considérer un régime national d'assurance-médicaments lorsque le coût des médicaments sur ordonnance demeure la deuxième composante la plus élevée des dépenses de santé, surpassant même le coût des médecins?

Le parcours a été long mais il est à souhaiter que les décideurs examinent attentivement les données : la prudence sur le plan fiscal et le consensus émergeant parmi les décideurs et le public suggèrent qu'il est maintenant temps d'agir. J'admets que la démarche est encore plus longue et ardue pour les patients et les familles qui ne peuvent pas se payer les médicaments permettant de sauver des vies, et qui doivent choisir entre nourrir leur famille et acheter les médicaments dont ils ont besoin pour soulager leur douleur. Dans un pays comme le Canada, où les soins de santé sont précieux aux yeux des Canadiens, aucune famille canadienne ne devrait pas être forcée de faire ce choix.

Toujours solidaire,

Linda

Appendix B Executive Summary

Marc-André Gagnon, PhD

(French)

Il y a une décennie, le gouvernement fédéral, les provinces et les territoires s'entendaient pour dire que la couverture des médicaments au Canada présentait des problèmes flagrants. Ils ont alors adopté la Stratégie nationale sur les produits pharmaceutiques. Malheureusement, au cours des dix dernières années, peu de progrès ont été faits. Les problèmes sont encore le manque d'accès aux médicaments sur ordonnance, l'échec à contenir le coût des médicaments, et le système fragmenté qui fait en sorte que des économies dans une partie du système se traduisent en augmentation des coûts ailleurs, et en gaspillage.

Un régime universel d'assurance-médicaments, financé par l'État, est la norme dans la plupart des pays de l'OCDE. Or, le fait que les médicaments ne soient pas couverts par notre système de soins de santé représente un anomalie. Les pays dont le système de soins de santé offre aussi la couverture des médicaments offrent un meilleur accès aux médicaments et une plus grande protection financière aux

personnes malades. Et ils le font à un coût significativement inférieur à celui de toute province canadienne. Toutefois, au Canada, la couverture des médicaments est offerte en fonction du lieu de travail et de résidence d'une personne, et non pas en fonction de ses besoins médicaux. Le Canada et les États-Unis sont marginaux par rapport à la couverture des médicaments car près de la moitié seulement de leurs populations ont accès à une assurance publique. De plus, l'ensemble de leurs dépenses sont plus élevées, et ils paient davantage pour les médicaments que les autres pays de l'OCDE.

Ce rapport démontre comment un tel système est inefficace, inéquitable, coûteux et insoutenable à long terme. Il est inefficace car il ne peut pas offrir une couverture adéquate à toute la population canadienne; il est inéquitable parce que plusieurs Canadiens et Canadiennes paient des sommes disproportionnées à leur revenu pour avoir accès aux médicaments; il est coûteux parce qu'ils paient trop, inutilement, pour les médicaments brevetés ou génériques; et il est insoutenable parce que les gouvernements n'arrivent pas à contenir l'augmentation des coûts.

Des données récentes nous démontrent comment l'absence d'un régime universel d'assurance-médicaments est un obstacle au progrès et à l'innovation. Au cours des dernières années, le coût des médicaments génériques, exprimé en pourcentage du prix des médicaments de marque, a diminué significativement dans toutes les provinces. Or, ces réductions des prix dans les régimes publics étaient souvent contrebalancées par une augmentation des prix dans les régimes privés. Depuis 2007, nous observons aussi une augmentation des ententes confidentielles (Product Listing Agreements ou PLA) entre les compagnies pharmaceutiques et les régimes publics provinciaux. Certes, ces ententes permettent à certains régimes publics de contenir le coût des médicaments, mais ces économies gonflent artificiellement les coûts pour les patients, les régimes privés et les provinces ayant peu de pouvoir quand vient le temps de négocier les prix. En 2010, le Conseil de la fédération a créé l'Alliance pancanadienne d'achat de médicaments (APAM) (comprenant toutes les provinces sauf le Québec). Premier pas important pour coordonner et simplifier les négociations. Toutefois, le processus de coordination au sein de l'Alliance demeure compliqué, particulièrement en l'absence d'un formulaire national. Par conséquent, cette nouvelle alliance n'a pas pu réaliser son potentiel. Peu de médicaments brevetés ont été achetés, et le prix négocié pour les médicaments génériques est en fonction du pourcentage du prix du médicament breveté plutôt que le prix le moins élevé obtenu en raison de la mise en concurrence. L'achat groupé ne permet pas d'assurer que les économies obtenues par les régimes publics deviennent

nécessairement des économies pour l'ensemble des Canadiens et des Canadiennes puisque les régimes privés et les personnes non-assurées continuent à payer leurs médicaments à un prix officiel qui continue d'augmenter, et sans bénéficier du pouvoir de négociation de l'Alliance. Les pénuries de médicaments se multiplient au Canada. On demande aux provinces et aux hôpitaux de trouver des solutions quand on sait combien ces ruptures de stock représentent un problème complexe exigeant un mécanisme d'approvisionnement assorti de clauses pour éviter les pénuries. Tous ces facteurs mettent en relief notre échec à assurer la viabilité de notre régime actuel d'assurance-médicaments, ainsi que le besoin urgent d'un régime national d'assurance-médicaments.

Le rôle des assurances privées fait souvent l'objet de débat dans le cadre des politiques en matière d'assurance-médicaments. Certains en prennent la défense en disant qu'elles permettent d'économiser des fonds publics, mais les données sont claires : les assurances privées sont une partie du problème et non la solution. Un régime hybride, public-privé, engendre une fragmentation du système, et la participation de plusieurs payeurs diminue leur pouvoir d'achat. Ces silos de financement empêchent les gestionnaires et les fournisseurs du secteur de la santé de considérer tous les avantages et de voir toutes les occasions d'économiser dans l'ensemble du système de soins de santé. Ce rapport examine les principaux problèmes liés aux régimes privés, notamment écrémage, i.e. accepter les « bons » risques (riche, en santé, jeune), et laisser les « mauvais » risques (incapable de travailler, faible revenu, personne âgée) à l'État; gaspillage (52 % en 2012) en raison du remboursement de médicaments plus dispendieux et n'offrant aucun avantage thérapeutique, ou payer des frais d'ordonnance inutiles; subventions à caractère fiscal offertes par le fédéral (environ 13 %); et frais administratifs excessifs.

Le rapport *Argumentaire économique pour un régime universel d'assurance-médicaments* (Gagnon et Hébert, 2010) démontrait qu'une couverture publique universelle d'assurance-médicaments, à partir du premier dollar dépensé, permettrait d'améliorer grandement l'accès aux médicaments, et permettrait aussi au Canada d'économiser de 12 à 42 % par rapport aux dépenses totales en médicaments sur ordonnance. Nous avons maintenant mis à jour certaines données de 2010, et ce nouveau rapport offre une analyse du contexte actuel étant donné l'évolution rapide des politiques pharmaceutiques canadiennes au cours des trois dernières années. Nous mettons en relief l'impact des politiques industrielles sur le prix des produits pharmaceutiques au Canada, et nous examinons le consensus grandissant par rapport au besoin de réformer l'assurance-médicaments et assurer la viabilité de notre système de plus en plus insoutenable. Ce travail explore comment mettre en

œuvre les réformes nécessaires en fournissant une feuille de route permettant de bâtir les capacités institutionnelles nécessaires pour améliorer l'accès, diminuer les coûts, améliorer les pratiques et assurer la longévité du système de soins de santé.

Il est nécessaire de réformer nos politiques relatives aux médicaments. L'Institut C.D. Howe, groupe de réflexion très connu, souscrit à un régime public et universel d'assurance-médicaments. L'Association canadienne des compagnies d'assurances de personnes inc. demande avec insistance des réformes à la couverture des médicaments afin d'offrir une meilleure couverture publique et privée. D'un océan à l'autre, les gouvernements provinciaux tentent désespérément de contenir les coûts tout en assurant l'accès. Et les organisations de santé observent l'impact direct du coût des médicaments sur la santé de leurs patients. On reconnaît le besoin urgent d'une réforme. Les quatre réformes suivantes ouvrent la voie aux décideurs :

Réforme 1: Améliorer l'accès aux médicaments en incluant les médicaments prescrits dans le régime public universel d'assurance-maladie

Tous les Canadiens et les Canadiennes devraient bénéficier d'une couverture adéquate et équitable des médicaments sur ordonnance. Un régime public d'assurance-médicaments doit être offert à l'ensemble de la population canadienne, que ce soit un régime national ou un régime organisé sur une base provinciale ou régionale. Parmi les mesures pour diminuer l'impact financier sur les régimes publics mentionnons : quote-part fixe (progressivement éliminée); le principe d'assurance sociale (par l'intermédiaire de déductions salariales); la mutualisation des risques; et mettre fin aux généreuses subventions à caractère fiscale offertes aux compagnies privés d'assurances.

Réforme 2: Assurer un accès équitable aux médicaments par la mise en place d'un formulaire national

Actuellement, l'accès aux médicaments pour les Canadiens et les Canadiennes dépend en grande partie de leur code postal. Le fait que l'accès aux médicaments varie d'une province à l'autre s'explique, en partie, par le budget en santé de la province et son pouvoir de négocier des rabais confidentiels avec les compagnies pharmaceutiques. Ce système est inéquitable. La couverture offerte à l'ensemble de la population doit reposer sur un formulaire national.

Réforme 3: Contrôler les coûts en recourant systématiquement à un pôle public d'achat groupé pour l'achat des médicaments brevetés et génériques

Au cours des trois dernières années, la principale innovation pour contenir les coûts des médicaments sur ordonnance au Canada a été la mise en place d'un pôle d'achat groupé pour certains médicaments brevetés ou génériques, notamment l'Alliance pancanadienne pour l'achat de médicaments. L'achat en masse est plus efficace que la multiplication des PLA (qui souvent dressent les provinces les unes contre les autres par la stratégie de « whipsawing »). De plus, une telle agence peut aider à assurer la sécurité des approvisionnements et réduire les pénuries de médicaments grâce à des clauses d'indemnisation et de réserve. Pour éviter de taxer indirectement les patients, il faut s'assurer que les franchises et les quotes-parts payées par les patients soient éliminées, ou si cela s'avère impossible, établir une quote-part fixe par prescription (plutôt qu'une quote-part basée sur le prix officiel du médicament).

Réforme 4: Assurer l'usage approprié des médicaments en évaluant l'innocuité et l'efficacité des médicaments

La sécurité et l'innocuité des médicaments demeurent un problème majeur au Canada. Le nombre de décès liés aux médicaments sur ordonnance est élevé : la moitié des décès liés aux médicaments sont dus à des erreurs médicales, l'autre moitié est liée aux effets indésirables. La création récente du Réseau sur l'innocuité et l'efficacité des médicaments par les Instituts de recherche en santé du Canada est un pas dans la bonne direction, mais c'est insuffisant. Actuellement, nous n'avons aucune donnée pour analyser l'innocuité et l'efficacité des médicaments. Pour générer de telles données, la mise en place d'un formulaire national et d'un régime public universel serait déterminante puisque ces deux mécanismes s'accompagneraient d'une base de données complète sur l'usage des médicaments au Canada.

Conclusion

Un régime universel d'assurance-médicaments permettrait au Canada de bâtir la capacité institutionnelle nécessaire pour améliorer l'accès, diminuer les coûts, améliorer les pratiques et assurer la longévité de notre système de soins de santé. Tel que démontré par les données, cela permettrait un accès équitable aux médicaments sur ordonnance tout en générant d'importantes économies pour la population

canadienne. Le seul impact sur les contribuables serait d'augmenter leur revenu disponible.

Si le Canada offrait une couverture universelle, à partir du premier dollar dépensé, des médicaments, cela se traduirait en économies de 10 à 41 % par rapport aux médicaments sur ordonnance, ce qui représente des économies pouvant aller jusqu'à 11,4 milliards de dollars par année.

La nécessité d'un régime public universel d'assurance-médicaments est l'un des rares sujets pouvant rallier les analystes provenant de l'ensemble du spectre politique. Enfin, rappelons que 78 % de la population canadienne appuie la mise en place d'un régime public universel d'assurance-médicaments, et que 82 % des Canadiens et des Canadiennes appuient le recours à un pôle d'achat public pour réduire le coût des médicaments.

Nous avons présenté une feuille de route pour la création d'un régime national d'assurance-médicaments, et nous avons parlé des capacités institutionnelles nécessaires pour élaborer et mettre en œuvre des politiques pertinentes en matière de produits pharmaceutiques. Les données sont claires. Il est temps pour le gouvernement de respecter la volonté du public et mettre en place des politiques rationnelles pour réformer le financement des médicaments sur ordonnance.

Un régime universel d'assurance-médicaments assurerait un meilleur accès aux médicaments sur ordonnance pour tous les Canadiens et les Canadiennes. De plus, il réduirait les écarts au sein du système de soins de santé tout en augmentant le revenu disponible des travailleurs. En bref, avec un peu de volonté politique, le Canada pourrait enfin entrer dans le 21e siècle.

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