Marc-André Gagnon, PhD
Associate Professor, School of Public Policy and Administration

Carleton University
RB-5224
1125 Colonel By Drive
Ottawa, Ontario
K1S 5B6

FURTHER INFORMATION REGARDING THE IMPLEMENTATION OF A NATIONAL PHARMACARE PROGRAM

SUBMITTED TO THE HOUSE OF COMMONS
STANDING COMMITTEE ON HEALTH

APRIL 18, 2016

About the author: Marc-André Gagnon is Associate Professor of Public Policy at Carleton University. Gagnon is a researcher at the Pharmaceutical Policy Research Collaboration and the Rational Therapeutics and Medications Policy Research Group. He is also an expert advisor for EvidenceNetwork.ca. Gagnon holds a PhD in Political Science from York University and a Master of Advanced Study in Economics from the École Normale Supérieure de Fontenay/St-Cloud and the University of Paris-I Sorbonne. He completed post-doctoral studies at the Centre for Intellectual Property Policy at McGill University and the Edmond J. Safra Center for Ethics at Harvard University. Gagnon has published prolifically on pharmaceutical policy issues, in both academic journals and major media outlets. His latest report, *Pharmacare 2020* (http://pharmacare2020.ca/), which proposed a series of reforms to Canada's pharmaceutical policies, was endorsed by over 250 health academics.

Conflict of Interest Disclosure

I have no conflicts of interest to disclose. I regularly share my expertise with federal, provincial and foreign regulatory agencies; various federal, provincial and foreign political parties; various federal and provincial government departments; various health professional bodies; community groups; unions; and businesses in the pharmaceutical and insurance sectors. However, I accept no payments from these organizations.

In addition to my funding from the Canadian Institutes of Health Research for a research project on institutional corruption in the Canadian pharmaceutical sector, I have had three consulting contracts in the past five years (with Health Canada, the Canadian Federation of Nurses Unions and the Ordre des pharmaciens du Québec). In every case, I was not compensated for this work, as the funding was used only to pay research assistants involved in the project or to cover the costs of collecting data or publishing the findings.

In 2015, I received €750 to present at the annual "gold pill" gala hosted by the independent magazine *Prescrire* in Paris, France. I was also paid for a series of columns I wrote from 2010 to 2012 for the consumer protection magazine *Protégez-Vous*.

This short document summarizes some information from my academic research in order to shed light on the debate surrounding the implementation of a national pharmacare program.[1]

1. The Canadian system: An anomaly among OECD countries

The Canadian pharmaceutical insurance system could be considered an anomaly. Canada has a universal public health insurance system, but is the only country in the world to have excluded prescription drugs from that system, as if drugs were not an essential element of health care.

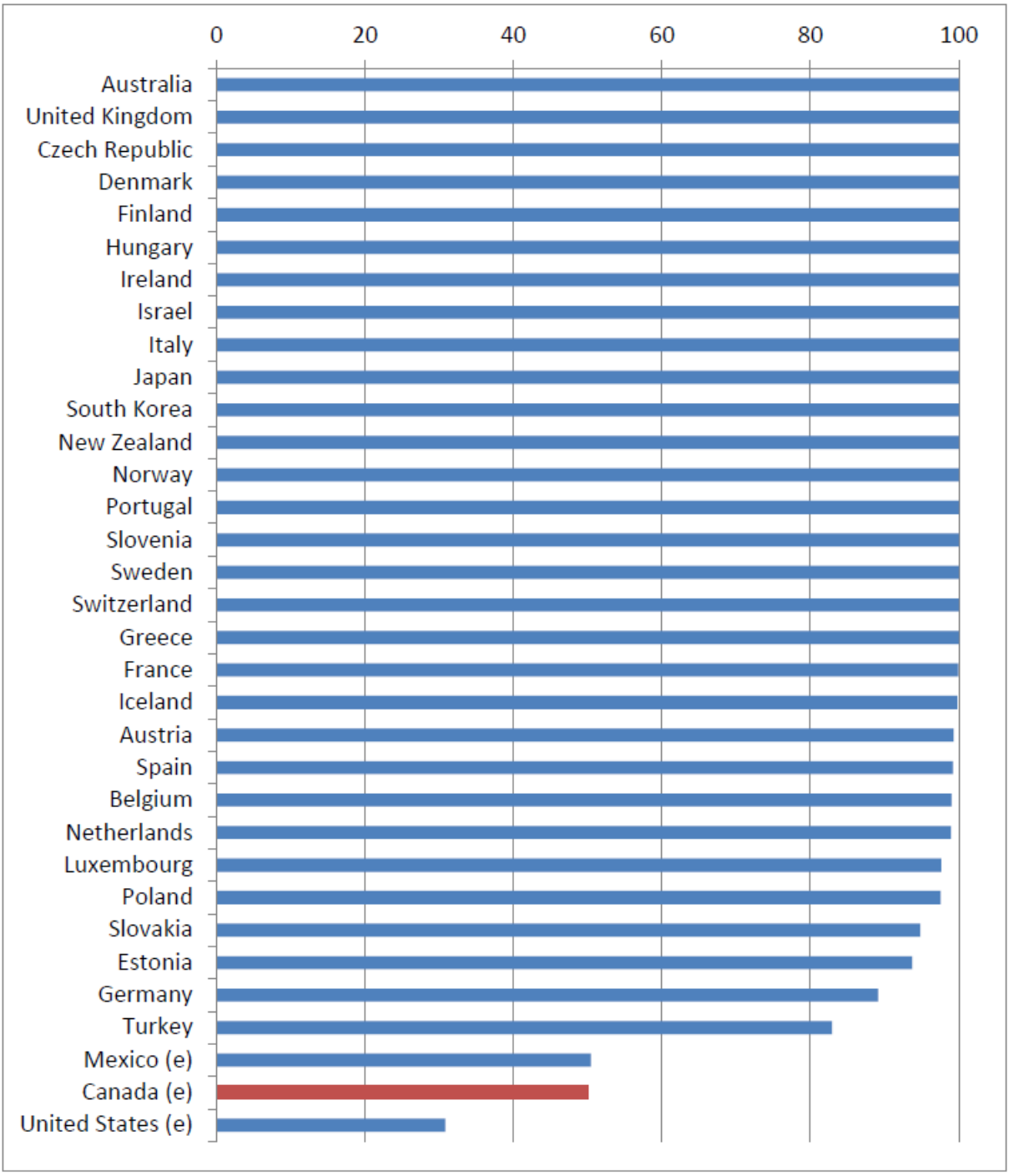
To obtain prescription drugs, Canadians in the labour force must buy private insurance or pay for them out of their own pocket. The provinces provide public coverage to two social groups who are unable to work: seniors and people on social assistance. Most provinces also provide "catastrophic" coverage for the entire population, which means that the provincial government will help patients who have to spend too much of their income on prescription drugs (Daw and Morgan 2012). Out-of-pocket deductibles and co-payments vary from one private plan to another and from one province to another. This means that Canadians have different degrees of coverage depending on where they live and work, but not necessarily according to their medical needs.

Provincial governments are not the only provider of public drug insurance plans, as the federal government offers public coverage to Aboriginal people, Inuit, members of the Canadian Armed Forces and Royal Canadian Mounted Police, federal prisoners, refugees and veterans (Gagnon 2012a).

Most OECD countries provide universal public coverage for prescription drugs. For example, nearly all European countries provide universal public coverage, funded either by taxes (income tax levies) or on a social insurance basis (pay deductions). Universal public drug insurance is not the exception but the rule among OECD nations.

[1] This report reprises and updates information presented in Gagnon 2014.

Figure 1
Percentage of Population Covered by a Public Drug Insurance Plan in All OECD Countries (%), 2010



(e): OECD estimate
Source: OECD Health Data: Social Protection

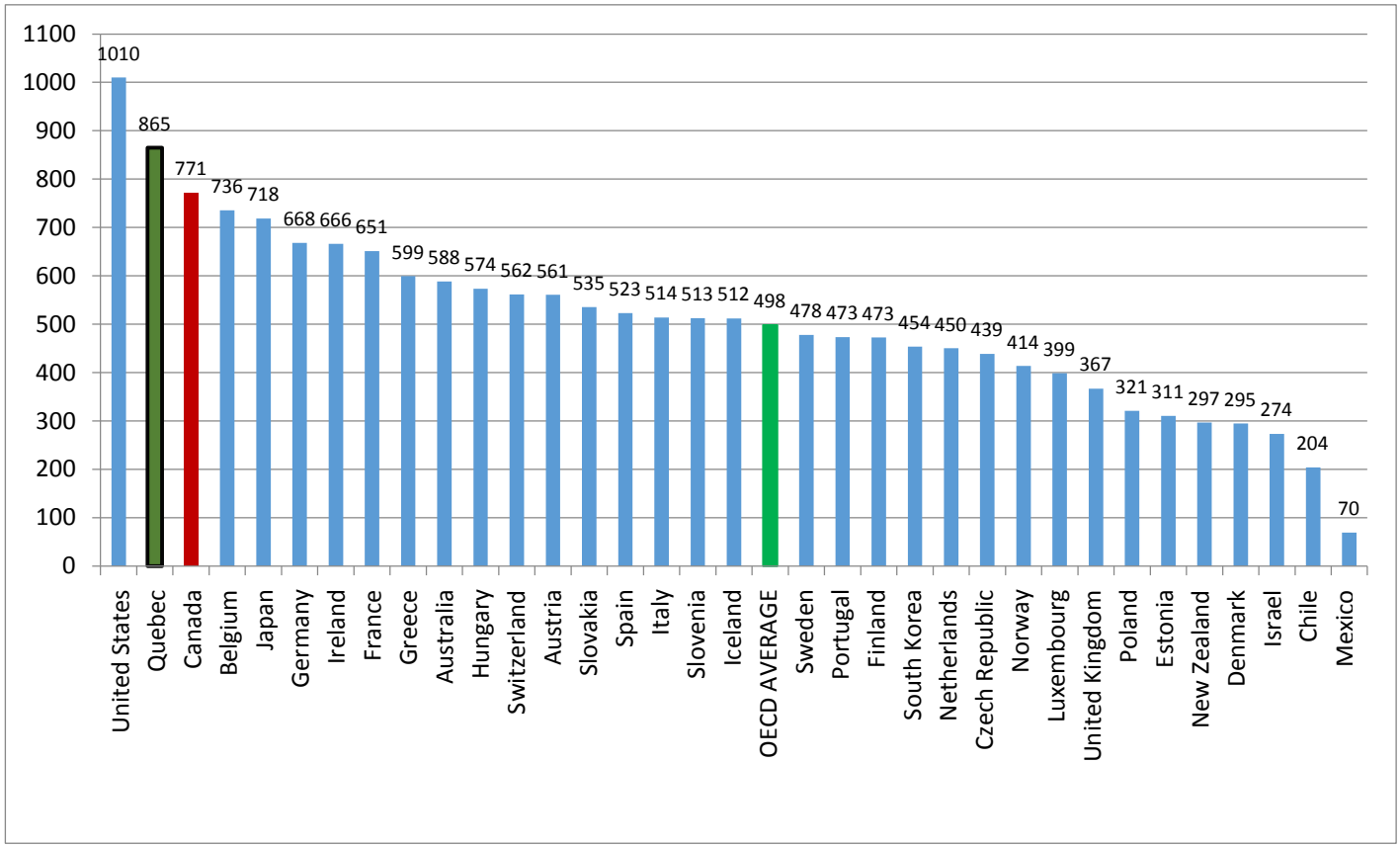
No more than half the population of North America has access to public prescription drug insurance. In theory, this lower level of coverage is not in itself a problem since the people not covered by public

insurance can buy private insurance. However, in reality private insurance does not cover everyone who does not have public insurance, and the result in Canada is particularly distressing: 1 in 10 Canadians admit they failed to fill at least one prescription in the past year for financial reasons (Law et al. 2012). This figure is much lower in European countries. Only 6% of Germans, 3% of the Dutch and 2% of the British report being in that situation in the previous 12 months (Morgan et al. 2013). When asked whether they could afford to fill their prescriptions over the past five years, 23% of Canadians said they could not on at least one occasion (EKOS 2013). Among OECD countries, only the United States (US) depends more on private insurance to cover prescription drug costs (OECD 2008). More than one in five Americans say that they did not fill at least one prescription in the past 12 months for financial reasons (Morgan and Kennedy 2010).

2. A costly system

The challenges to obtaining prescription drugs in Canada are significant. The main problem remains an inability to contain costs. Per capita prescription drug expenditures in Canada are higher than those in other OECD countries. Total spending depends on two factors: the price and quantity of drugs consumed.

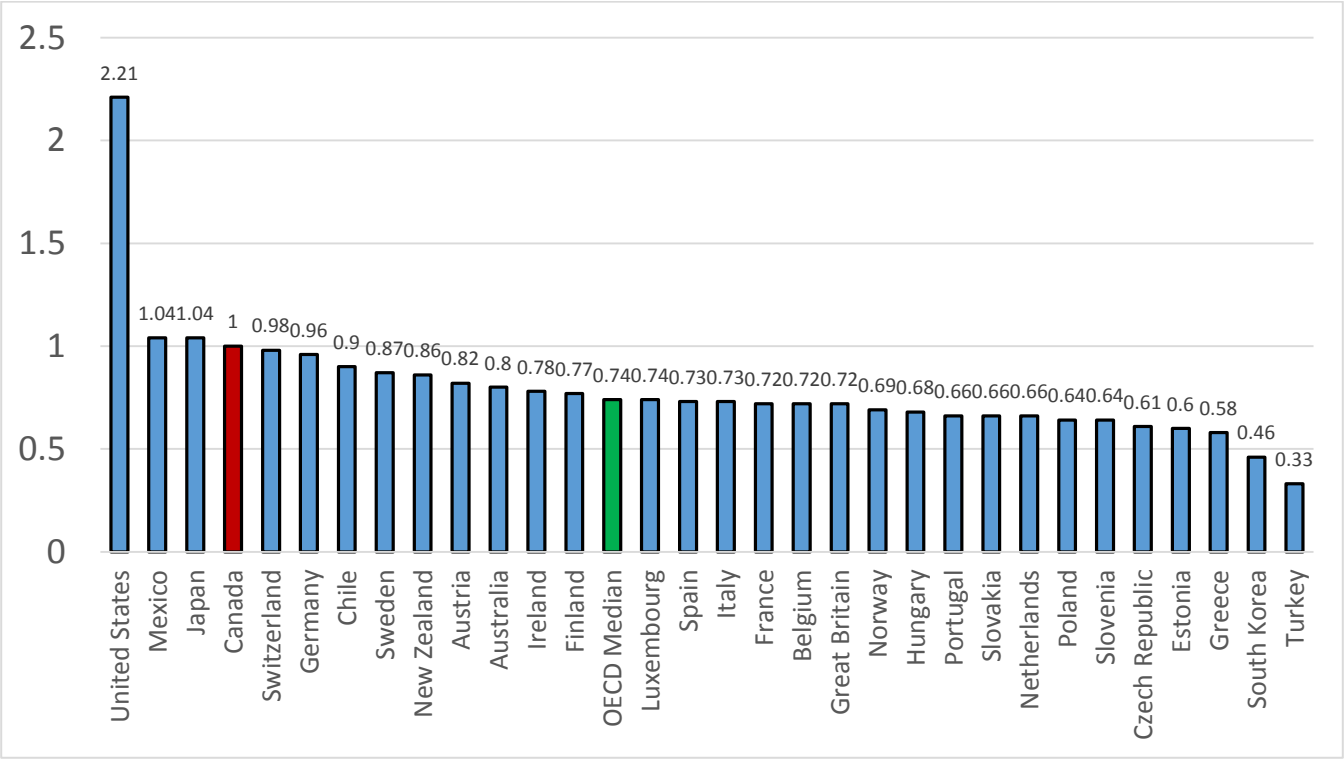
Figure 2
Total Per Capita Prescription Drug Expenditures, 2012 or Latest Year Available (US$, PPP)



Source: CIHI, OECD Health Data 2014

Some argue that a higher level of drug spending means that people are consuming more prescription drugs and therefore that they are covered better. But this argument does not explain everything. Canada is known for having significant drug access issues, while the US has even worse problems. Moreover, the US and Canada pay a lot for their prescription drugs. An analysis of the prices of patented drugs shows that Canada and the US rank in the top four most expensive countries for these drugs (see Figure 3). However, note that most countries use confidential agreements with drug manufacturers to obtain confidential rebates (Morgan, Daw and Thompson 2013). Yet the Council of the Federation reported that the rebates obtained in Canada in 2014 were worth $260 million, less than 2% of the total cost of patented drugs (Alberta Public Affairs Bureau 2014).

Figure 3
Ratio of Average Prices in OECD Countries to Prices in Canada
Bilateral Comparisons, 2014



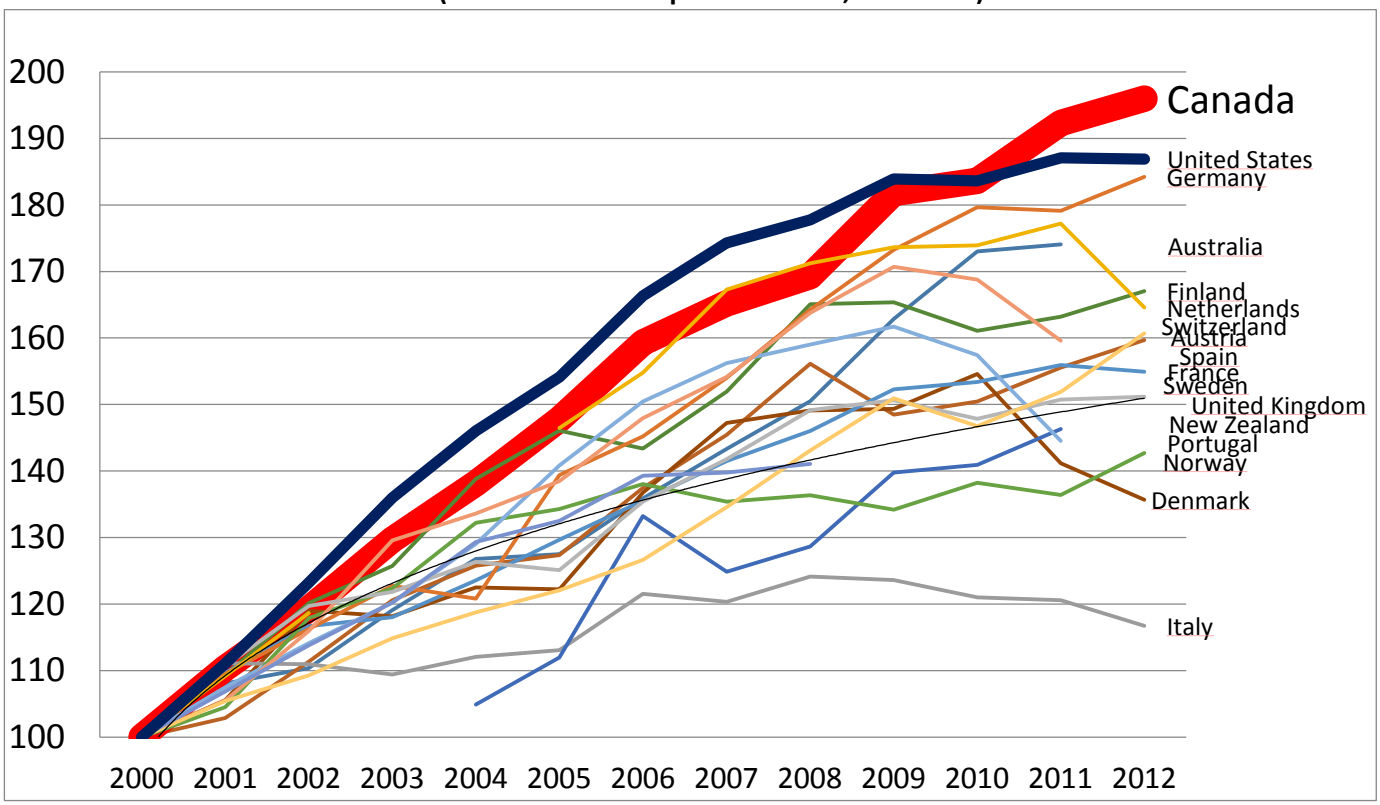
Source: IMS AG's MIDAS™ and PMPRB

Even taking into account the confidential rebates obtained by the pan-Canadian Pharmaceutical Alliance, Canada remains among the four most expensive countries in the world for patented drugs. Meanwhile, other countries benefit from confidential rebates on top of their lower disclosed official prices. If Canada paid the same official price for drugs as the OECD median, Canadians would save about 25% on patented drugs, equivalent to some $4.2 billion a year given that we spent $16.8 billion on patented drugs in 2014 (PMPRB 2015). Canada's fragmented drug insurance system (public and private, federal and provincial) is in large part responsible for our inability to benefit from better prices for patented drugs.

3. An unsustainable system

The fact that Canadians pay more for their prescription drugs is not necessarily a problem by itself. The policy of price inflation in Canada is the result of an innovation policy designed to attract pharmaceutical investment. While this policy has proved to be a complete failure and continues to cost taxpayers a great deal each year, paying higher prices would not be so bad if we were at least able to contain cost growth (Gagnon 2012b). But Canada performs very poorly in this regard. From 2000 to 2012, Canada experienced stronger annual growth in prescription drug costs than any other similarly developed nation. Measuring cost growth can be a complex task, as growth may vary because of demographic changes or differences relating to inflation. To avoid these pitfalls, Figure 4 shows annual growth in per capita costs in purchasing power parity terms, taking inflation into account.

Figure 4
Average Annual Real Growth in Per Capita Drug Costs, 2000 to 2012
(International Comparison in PPP, 2000=100)



Source: CIHI, OECD Health Data 2014

Canada experienced much higher cost growth than other similar countries. Note that, other than the US and Canada, where drug insurance coverage is provided mainly by private plans, all of these countries have some form of universal public drug insurance plan.

Both public and private drug insurance plans usually manage cost growth by raising the premiums of insured patients, increasing the co-payments or deductibles patients pay or restricting the treatments covered. As a result, out-of-pocket spending on prescription drugs by Canadian households increased by

an average of 33% (in constant dollars) between 1997 and 2009 (Sanmartin et al. 2014). Moreover, these costs grew far more for low-income households. Between 1997 and 2009, out-of-pocket spending on prescription drugs (in constant dollars) by the richest 20% increased by 21%; for the poorest 20%, this figure was 64% (Sanmartin et al. 2014).

In summary, Canadians pay more for their prescription drugs than similar countries with universal public systems. We suffer from poorer access to prescription drugs than people in those other countries do, and Canada's high annual cost growth makes our system unsustainable in the long run. Given the fragmented nature of the Canadian drug insurance system, the primary way of balancing plan budgets has been to shift costs to other parts of the system, particularly by increasing patients' out-of-pocket spending. It is time for Canada to draw on the best practices of other OECD countries so that we can enjoy better access to prescription drugs, at lower cost and prescribed in a more appropriate fashion.

In May 2013, a survey revealed that 78% of Canadians supported the idea of establishing a universal public prescription drug insurance program (EKOS 2013). This kind of system is not a panacea and will not resolve all the problems involved in buying prescription drugs. Countries that have this kind of system also face access and cost challenges. However, a universal public system would allow us to build the institutional capacity needed to improve access, reduce costs and make the system more efficient and therefore sustainable.

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