**Universality Does Not Mean Access: A response to CHPI's "Who needs pharmacare?"**

As the debate about pharmacare in Canada heats up with the Implementation of the Advisory Council on Pharmacare, and the role this plays in the coming federal election in 2019, various pieces that misrepresent the case for pharmacare are appearing.

While consumers and healthcare advocates need to gain knowledge about the issues surrounding pharmacare, they also need to be cautious of inaccurate titles and claims, especially in cases where words like "studies and statistics" are used to give a sense of validity.

Recently, the Canadian Health Policy Institute (CHPI) released a report on a paper called "Prescription drug plan coverage 2016: how many Canadians were insured, under-insured or uninsured?"[1]

According to the study, 23.2 million of 36.3 million Canadians in 2016 had a private drug plan and 13.1 million had coverage under public drug plans.

The paper argues the following points:

- (1) "The problem isn't uninsured people, it's underinsured drug costs" because Canada already has:
- (a) "*Near* universal insurance coverage across the population for ordinary prescription drug costs." Here, the author refers to public and private insurance coverage, and as a combination, results to "near universal insurance coverage."

a. About CHPI and the Author, Brett J. Skinner

The paper was published in CHPI's peer-reviewed online journal, which is only accessible via a paid subscription.[2] It is written by CHPI's CEO, Brett J. Skinner. Evident from CHPI's website, Skinner has written many of the CHPI journal articles. He is also the Founder and CEO of CHPI, the journal's lead Editor, a member of the Advisory Board, and a member of the Editorial Advisors.

[1] CHPI, "Who needs pharmacare: Study shows that of 36.3 Million Canadians in 2016, 23.2 million had a private drug plan and 1.31 million had coverage under public drug plans," *CNW Newswire,* 19 June 2018, accessible at: https://www.newswire.ca/news-releases/who-needs-pharmacare-study-shows-that-of-363-million-canadians-in-2016-232-million-had-a-private-drug-plan-and-131-million-had-coverage-under-public-drug-plans-685910031.html.

[2] In order to purchase the article, it is $20CAD plus HST. As an individual, the cost for access to the CHPI journal is $240CAD plus HST. For patient groups and charities, the cost is $500CAD plus HST. The Canadian Cancer Survivor Network did not purchase the article.

Despite the barrier in cost and accessibility, the news release and research on previous pieces Skinner has published online reveals more than enough to capture the nature of his arguments against pharmacare.

## I. Universality Versus Accessibility: The Case for Pharmacare

The claim of universal insurance coverage is widely known. Both pharmacare advocates and the federal government have made this statement but it is crucial to understand that insurance coverage is not what the gap argument is about for pharmacare.

The gap does not lie in the quantity of insurance coverage in Canada but precisely in what kinds of drugs and treatments are listed under the formularies for these insurances, their accessibility and affordability. Canadians are finding themselves with out-of-pocket expenses in order to take their prescription medicines. Unfortunately, an increasing number of these drugs and treatments are costly to the point that Canadians are not taking their prescription drugs at all, skip their doses or reduce them. This phenomenon is termed as non-adherence.

According to Pharmacare 2020, "1 in 10 Canadians do not take their medicines as prescribed because of costs. This affects nearly 1 in 4 Canadian households."[3] To further put it in perspective, this rate of non-adherence results to "about 303,000 Canadians who had additional doctor visits, about 93,000 who sought care in the emergency department, and about 26,000 who were admitted to hospital at the population level. Many Canadians forewent basic needs such as food (about 730,000 people), heat (about 238,000) and other health expenses (about 239,000) because of drug costs. These outcomes were more common among females, younger adults, Aboriginal peoples, those with poorer health status, those lacking drug insurance and those with lower income."[4]

While there are people in Canada who have no insurance coverage – and it is a problem that pharmacare advocates understand – it is clear that underinsured coverage plans also significantly result in access issues. Perhaps the author misunderstood pharmacare advocates on this point.

First and foremost, universal coverage does not equal access to medically necessary therapies. Pharmacare patient advocates see that there is a gap in prescription drug coverage because it does not provide them timely, equitable, safe and effective access to medically necessary therapies. Patient advocates see that the path to pharmacare must not pursue universality that merely satisfies the lowest common denominator because this does not guarantee access. In

[3] Steven G. Morgan et. al, "Pharmacare 2020: The Future of Drug Coverage in Canada," *The Pharmaceutical Policy Research Collaboration,* University of British Columbia, 15 July 2015 at 7.
[4] Michael R. Law et. al, "The consequences of patient charges for prescription drugs in Canada: a cross-sectional survey," *CMAJ OPEN*, 6(1), 2018 at E63.

essence, the gaps in prescription drug coverage are a matter of accessible and affordable drug formularies that respond to the actual medical needs of patients. The problem is exacerbated for people with chronic illnesses or diseases, including cancer, and people with rare diseases because their treatments are often costly, unaffordable or unavailable.

## II. The Landscape of Prescription Drug Coverage in Canada

To give you an understanding of the state of prescription drug coverage and why Skinner claims that there is "near universal coverage,"" it is important to recognize that the federal government and provinces and territories (P/Ts) provide public coverage for a set list of prescription drugs. This list is known as a drug formulary.

The federal government provides coverage for specific populations. These are the First Nations and Inuit, members of the Canadian Armed Forces, veterans and the RCMP, federal inmates, certain classes of refugees and federal public servants. They make up about 3% of the total Canadian population.

Those who do not fall in these populations are eligible for public drug coverage plans provided by the P/Ts. However, these public plans are not available for everyone. Often, provincial drug plans cover seniors, those with disabilities, living on social assistance or, for low-income households. Depending on eligibility, children and adults may receive public drug coverage from some provinces.

These inconsistencies leave not only those that do not fall in the previously mentioned categories but also the age bracket starting from children to adults to people aged 64 years old, to not have any form of unconditional coverage. Their only means of insurance is either through their employer, if that is provided, or to purchase private drug plans. As a result, access to medically necessary drugs face the barrier of cost for this large population.

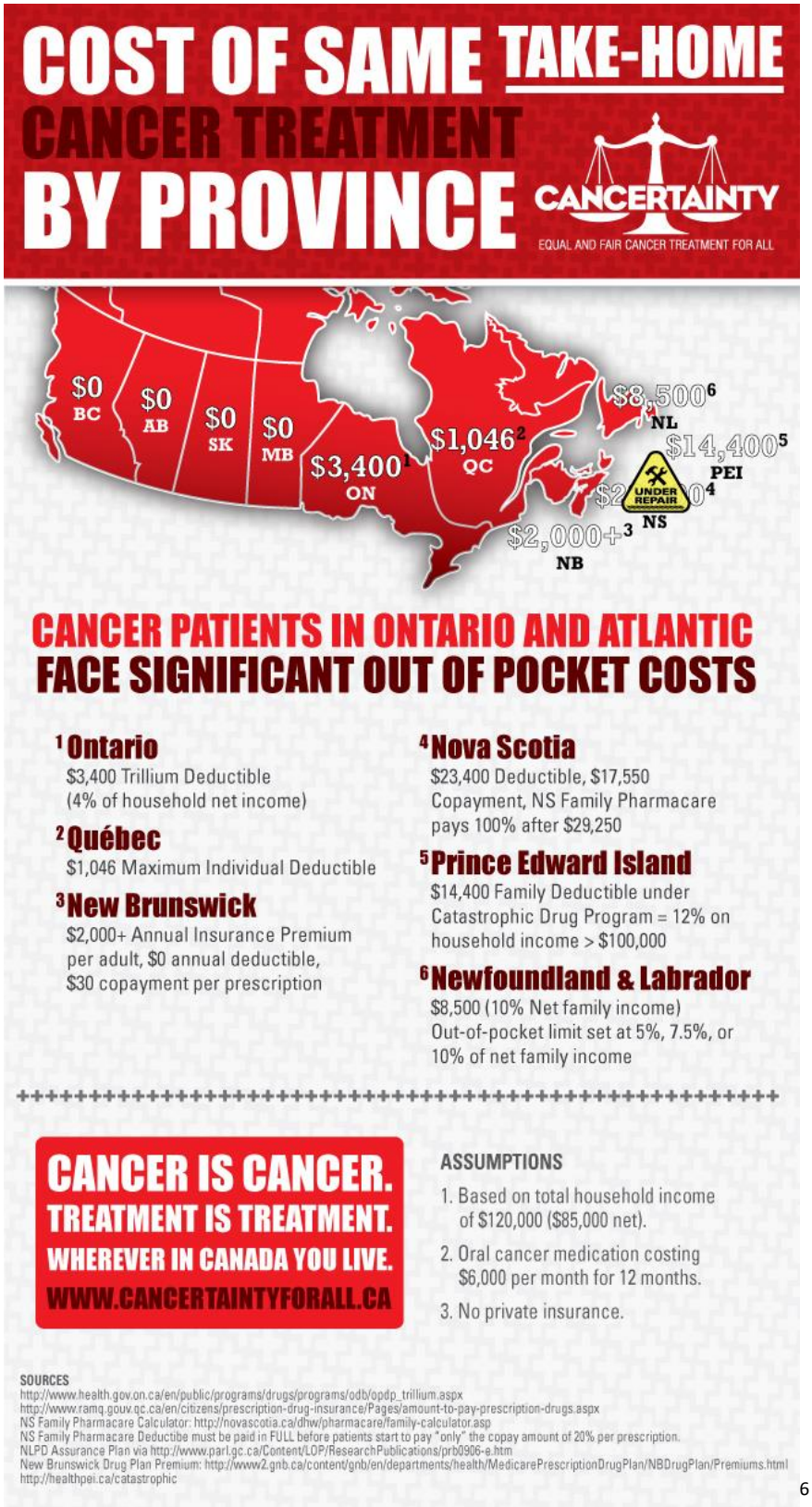
There are approximately 113,000 private drug coverage plans available in Canada and each has its own formularies. These private drug coverage plans are from 132 private health insurance providers across the country.[5] In total, drug formularies among prescription drug coverage plans differ between public and private plans, the P/Ts and in-hospital formularies. Furthermore, it depends on the formulary whether a prescription drug will be covered. Some insurance plans only cover generic drugs whereas some provide reimbursement for brand name drugs. Therefore, having a public and/or private insurance(s) alone does not guarantee coverage for medically necessary therapies because accessibility is determined by these formularies.

[5] Bill Casey, "Pharmacare Now: Prescription Medicine Coverage for All Canadians Report of the Standing Committee on Health," *House of Commons, 42nd Parliament, 1st Session,* April 2018, at 25.

As it can be seen and experienced, Canada has a deeply fragmented, inconsistent, costly and unsustainable landscape of healthcare that patients, caregivers, survivors and healthcare professionals have to navigate and finance.

## III. Case Example: Oral Medications

Oral medications for patients are a prime example to illustrate the issues in accessibility for prescription drug coverage. The graphic below illustrates the differences in cost of cancer take-home treatments across the provinces despite public insurance. Even if we consider the coverage private insurance may provide, it is dependent on whether private insurance has the specific take-home cancer treatment included in their formulary and what coverage plan a particular insurance allows. The consequence with these differences in coverage is that in some cases cancer patients move from one province to another simply to have access and coverage for their critically necessary drugs.

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[6] https://www.cancertaintyforall.ca/cost_infographic

## IV. Financing Pharmacare between Public and Private Insurance

Skinner then argues that the solution for a pharmacare plan is in "adjusting the cost sharing criteria for existing public drug plan benefits." With these points, he concludes that "advocates for pharmacare have the wrong understanding about gaps in prescription drug plan coverage" and the wrong solution for drug coverage in Canada.

Admittedly, Skinner is valid in his concerns over the barriers to access pharmacare may impose on faster coverage for new and innovative drugs that are coming down the pipeline. What is unclear, on the other hand, is how to achieve equitable and timely access to these drugs. While Skinner proposes that the problem is underinsured people, his results for addressing these costs is changing the expense thresholds for public programs. In Skinner's opinion piece called, "Canadians are being fooled into thinking we'll like pharmacare. We really, really won't," he argues that a way of addressing access to new drugs is to "expand existing public drug budgets to accommodate more and faster coverage for new drugs."[7] However, access is not guaranteed without explicit consideration of the out-of-pocket expenses that results from these cost sharing changes to public programs.

In CHPI's 2015 report "Pharmacare: what are the costs for patients and taxpayers?," Skinner and his organization propose that the solution to pharmacare is more geared towards private insurance. Much different than the approach Skinner advocates for in his opinion piece and research paper, the CHPI report calls on F/P/Ts to somehow assist Canadians in accessing "superior private insurance coverage" and to "improve coverage for new medicines across existing public drug plans" in order to match the coverage provided in this "superior private insurance."[8]

The report takes the position that a better alternative to government monopoly on pharmacare is mandatory universal private insurance.[9] In this approach, Canadians would be required to buy private health insurance which offers a standard package that insurers must provide. On top of that, if there are services not covered in the standard package Canadians have the option of purchasing more insurance to cover these.[10]

With this solution, Canadians would be able to access their medically necessary therapies by paying for more private insurance. But in reality, the costs of premiums are rising, maximums

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[7] Brett J. Skinner, "Canadians are being fooled into thinking we'll like pharmacare. We really, really won't," *Financial Post*, 15 February 2018, accessible at: http://business.financialpost.com/opinion/canadians-are-being-fooled-into-thinking-well-like-pharmacare-we-really-really-wont.

[8] Brett K. Skinner et. al, "Pharmacare: what are the costs for patients and taxpayers?," *Canadian Health Policy,* 24 September 2015, accessible at: https://www.canadianhealthpolicy.com/products/pharmacare--what-are-the-costs-for-patients-and-taxpayers-.html, at 4.

[9] *Ibid* at 27.

[10] *Ibid* at 30.

are decreasing, and formularies are becoming restrictive or unavailable especially when an employer discovers that its employee(s) have a chronic illness or rare disease. A factor in the increasing costs of drugs is due to the complexity of innovative medicines and the inability of healthcare systems to properly review these drugs on their value and price. However, Skinner does not believe that the cost of drugs is increasing in the first place.[11] As a result, he approaches the pharmacare debate with this assumption.

The author's push for private insurance and cost reassessment is based on his fears of a government-run monopoly on pharmacare. However, the Advisory Council on the Implementation of Pharmacare released a Discussion Paper and this document outlined several approaches to addressing pharmacare. These approaches propose solutions such as: a comprehensive universal coverage, a safety net approach, or an approach in which public investment is increased to address gaps in coverage.[12] Other than the first solution, the rest call for a pharmacare model that improves upon existing plans of coverage rather than the takeover of insurance.

## V. Conclusion

It is clear in his research that Skinner has done extensive work on scrutinizing the data pharmacare advocates have presented. He repeats these criticisms he and his organization, CHPI, have found and uses them as a crux for their position against pharmacare. However, it functions as a red herring to the ambiguous connections his arguments and conclusion makes with the gap of pharmacare.

Universal coverage, either in private or public drug coverage, does not mean access to all medically necessary therapies. Rather, pharmacare must address the barriers patients experience in accessing their prescribed medications in a timely, equitable, and safe and effective manner.

[11] Brett J. Skinner, "How Ottawa's using a fake drug crisis to force through damaging pharmaceutical policy," *Financial Post*, 16 January 2018, http://business.financialpost.com/opinion/how-ottawas-using-a-fake-drug-crisis-to-force-through-damaging-pharmaceutical-policy.

[12] Health Canada, "Towards the Implementation of National Pharmacare Discussion Paper," *Government of Canada,* 20 June 2018 at 9.