Submission from the

Canadian Labour Congress

to the

Standing Committee on Health

Regarding the
Development of a National Pharmacare Program

October 31, 2016

INTRODUCTION

The Canadian Labour Congress (CLC) has been a long time and an avid supporter of a public National Pharmacare Program. On behalf of the 3.3 million members of the CLC, we want to thank the Standing Committee on Health for the opportunity to present our views in this submission regarding the development of a national Pharmacare Program.

The CLC brings together Canada's national and international unions along with the provincial and territorial Federations of Labour and 130 district Labour Councils whose members work in virtually all sectors of the Canadian economy, in all occupations, in all parts of Canada.

The prescription drug system in Canada involves several payers from the public sector, the private sector and individuals who have to pay out-of-pocket. The current multi-payer system has deficiencies with differential impacts on Canadians such as varying levels of prescription drug coverage, higher drug costs, uneven access to prescription drugs, different cost to Canadians for the same drugs, and differential out-of-pocket costs. These deficiencies are quickly growing due to the advent of newer pharmalogical developments, changing demographic needs, the pressures on public payers and individuals to contain costs and the private payers to continue to produce healthy profit margins.

The multi-payer system is fragmented. It is also not integrated with our Medicare system. Since the 1960s, there have been calls by key government initiatives studying the Canadian healthcare system for the establishment of a national prescription drug program or pharmacare: the Hall Commission (1964), the National Forum on Health (1997), and the Romanow Commission (2002). In fact, pharmacare has been characterized as the "unfinished business" of our universal public health system in Canada.

These national initiatives had studied the patchwork prescription drug system, and have repeatedly found it lacking – all resulting in calls for a national pharmacare system which will better serve Canadians, no matter where they reside in Canada.

Yet, today we are still advocating for a public National Pharmacare Program as little progress has been done on this front.

PRESCRIPTION DRUG COVERAGE

In 2014 Canadians spent approximately $33.9 billion on drugs of which $28.8 billion or 85% was spent on prescription drugs.[1] The breakdown of prescription drug spending in Canada with the multi-payer system is: public sector ($12.1 billion, 42.0%), private sector ($10.3 billion, 35.8%) and out-of-pocket of Canadian households ($6.4 billion, 22.2%).[2]

Public sector includes spending from the federal government, provincial/territorial government and workers' compensation boards. Private spending sector is from private enterprises – mostly drug insurance plans. Out-of-pocket spending means individual Canadians and families paying for all of the costs of prescription drugs or some of the costs in deductibles and co-payments. In total, 58% of drug spending comes from private sources – a combination of private sector and individual out-of-pocket spending.

There are 2.8 million self-employed Canadians with no employer-based health benefit coverage.[3] Of the 15 million Canadians[4] with paid employment (full-time and part-time), one in three (64%) do not have health benefits provided by their employer.[5] In other words, 5.4 million Canadians in paid employment do not have employer-provided health insurance. Altogether, 8.4 million working Canadians, those self-employed and in paid employment, do not have employer-based health benefits.

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[1] Canadian Institute for Health Information. Prescribed Drug Spending in Canada, 2013: A Focus on Public Drug Programs. https://secure.cihi.ca/free_products/Prescribed%20Drug%20Spending%20in%20Canada_2014_EN.pdf. Accessed September 23, 2016.

[2] Ibid.

[3] Statistics Canada. Table 282-0089 - Labour force survey estimates (LFS), employment by class of worker and sex, seasonally adjusted and unadjusted, monthly (persons), CANSIM (database). (accessed:) Accessed October 3, 2016.

[4] Statistics Canada. Employment by age, sex, type of work, class of worker and province (monthly) (Canada). http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/labr66a-eng.htm. Accessed October 3, 2016.

[5] Barnes, Steve and Laura Anderson. July, 2015. Low Earnings, Unfilled Prescriptions: Employer-Provided Health Benefit Coverage in Canada. Wellesley Institutes. http://www.wellesleyinstitute.com/wp-content/uploads/2015/07/Low-Earnings-Unfilled-Prescriptions-2015.pdf. Accessed September 23, 2016.

Fewer women than men have employer provided health benefits coverage. Only one in four workers 25 years and under have employer-provided health benefits coverage.[6]

Full-time workers had more health benefits coverage from their employer than part-time workers. Among full-time employees, 73% had health benefits coverage by their employer, compared to only 27% for part-time workers. This leaves three-quarters of all part-time workers without employer-provided health benefits.[7]

In 2015, there were 2.2 million women and 1.1 million men in part-time employment in Canada. Three in four part-time workers ages 25 to 54 were women in 2015. It is estimated that approximately 1.6 million women and 0.8 million men working part-time in Canada did not have employer-provided health benefits.

Young workers are also less likely to have health benefits coverage. Only one in four or 26% of workers between ages 15 to 24 years had health benefits coverage compared to 72% of workers between 25 to 64 years.[8]

COST OF DRUGS

In 2014, Canada spent $28.8 billion for all prescription drugs or an increase of 0.9% from the previous year. This increase is part of the trend of slower growth prescription drug spending in recent years as patents for commonly used prescription drugs expired and generic drug pricing policies were implemented.[9] However, according to the Canadian Institute for Health Information (CIHI), savings from generic drugs "were offset by increased spending on newer classes of biologic drugs." This was echoed by the OECD

[6] Barnes, Steve and Laura Anderson. July, 2015. Low Earnings, Unfilled Prescriptions: Employer-Provided Health Benefit Coverage in Canada. Wellesley Institutes. http://www.wellesleyinstitute.com/wp-content/uploads/2015/07/Low-Earnings-Unfilled-Prescriptions-2015.pdf. Accessed September 23, 2016.
[7] Ibid.
[8] Ibid.
[9] Prescribed Drug Spending in Canada, 2013: A Focus on Public Drug Programs. Canadian Institute for Health Information. https://secure.cihi.ca/free_products/Prescribed%20Drug%20Spending%20in%20Canada_2014_EN.pdf. Accessed September 23, 2016.

which warned of the impending increase in the growth of prescription drug spending as more and more expensive specialty drugs become available.[10]

In fact, a survey of 200 employers found that four out of five (83%) drug plan sponsors reported expensive new drugs coming to market are jeopardizing the sustainability of these plans.[11] Express Scripts Canada forecasts expensive specialty medicines will increase to 35% of spending in 2018, from 27% in 2014.[12]

Just looking at patented (name brand) drug prices alone, in 2015, Canadian prices were 28% higher than the median OECD price.[13] Canadian patented drug prices have steadily increased. In fact, we have the third highest compared to France, Germany, Italy, Sweden, Switzerland, the United Kingdom and the United States of America (USA) – only Germany and the USA have prices higher than ours. Since 2000, Canada's expenditures in patented drug expenditures has increased by 184% compared to all the countries in this group. Further, patented drug prices in Australia, Spain, Finland, Netherlands and New Zealand are 14% to 34% lower than Canadian prices.[14]

Canadians not only pay more for prescription drugs, but we also spend more per capita and more as a share of GDP than most OECD countries. According to the OECD, Canada's prescription drug spending accounts for 17.2% of total health spending.[15] Compared to other OECD countries, Canada spends more on total prescription drugs as a share of GDP than most countries.[16] (see Figure 1) Among the OECD countries, Canada has the second highest prescription drug spending per capita at $772.00 USD – while the USA was the highest.

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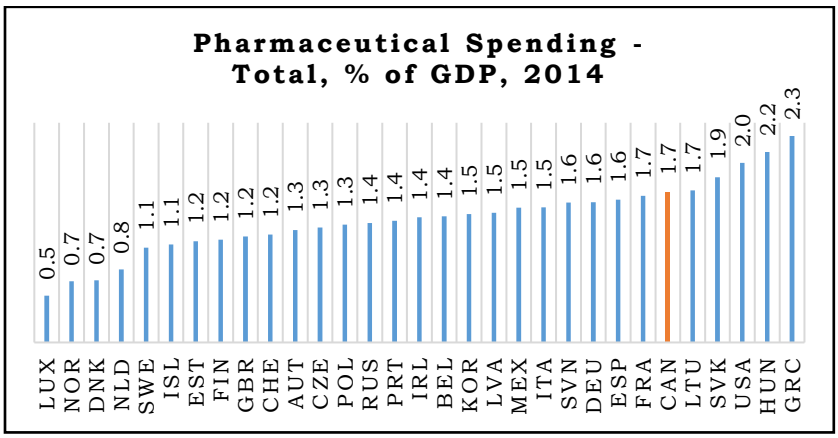
[10] OEDC. Health at a Glance 2015. http://www.oecd-ilibrary.org/docserver/download/8115071ec005.pdf?expires=1475086532&id=id&accname=guest&checksum=37FCCF7698FE6BA2449B0B30DAF4EA79 (Accessed: September 27,2016)
[11] Welds, Karen. March 2016. Beyond Specialty Drugs: Drug Plans Taking a Variety of to add. http://www.benefitscanada.com/wp-content/uploads/2016/03/BECA03_DrugPlanTrends_p028-033_lores.pdf. Accessed October 3, 2016.
[12] Ibid.
[13] Annual Report 2015. Patented Medicines Review Board. http://www.pmprb-cepmb.gc.ca/CMFiles/Publications/Annual%20Reports/2015/2015_Annual_Report_Final_EN.pdf. Accessed September 23, 2016.
[14] PMPRB Guidelines Modernization Discussion Paper, June 2016.
[15] OECD (2016), Pharmaceutical spending (indicator). doi: 10.1787/998febf6-en Accessed: September 27, 2016.
[16] OECD (2016), Pharmaceutical spending (indicator). doi: 10.1787/998febf6-en Accessed: September 27, 2016.

Figure 1



Source: OECD, 2016

Our multi-payer prescription drug system is expensive. Clearly stakeholders - pharmaceutical manufacturers, private insurance companies, and pharmacies - in the business of prescription drug supply are private for-profit players. The efforts by the federal, provincial and territorial governments, via the pan-Canadian Pharmaceutical Alliance (pCPA) to bulk-buy certain prescription drugs is laudable but overall, not very effective since the purchases are only for the public sector. These savings for governments are losses for pharmaceutical companies. Pharmaceutical companies recoup these losses through others in the system such as pharmacies, private insurance companies, employers, unions and individual Canadians who pay out-of-pocket.

At the same time, pharmacies have less ability to negotiate discounts or rebates from pharmaceutical companies. In addition, some provinces have started to implement drug pricing policies. These pressures have resulted in pharmacies recouping their losses by increasing dispensing fees.

In the meantime, private insurance companies' imperative to generate profits gives reason for them to delve into negotiating better drug pricing. Not surprisingly, a 2011 study in CMAJ showed that individuals and companies paid $6.8 billion more in premiums to for-profit insurers than they received in health-related benefits, compared to $1.2 billion in 1991.[17]

[17] Law, Michael, et al. 2014. The increasing inefficiency of private health insurance in Canada. Canadian Medical Association Journal. http://www.cmaj.ca/content/early/2014/03/24/cmaj.130913.full.pdfAccessed September 30, 2016.

Rising drug prices and administrative costs of private insurers are 10 times greater than those in the public sector,[18] making private health insurance very costly. Higher health insurance premiums pressure employers, who are plan sponsors, to look for new ways to contain their costs. This includes caps on the amount for prescription drugs, exclusion of certain drugs, annual or lifetime coverage limits or increases to out-of-pocket costs with higher co-payments and deductibles for insured members.

Unions are reporting that health and drug benefits are increasingly being negotiated at the bargaining table with employers. Employers and unions are unfairly put in the position of deciding the extent of availability of and access to prescriptions drugs for workers – a process based on affordability of the insurance plans rather than an evidence-based public system that is based on workers' medical needs.

The current multi-payer prescription drug system creates many disparities based on age, income, employment status, and even where one receives treatment. For example, a patient can receive "free" drugs if treated in a hospital but has to pay out-of-pocket or through their insurance if they get their treatment outside of a hospital. Other disparities from the multi-payer system include different pricing of the same prescription drug from province to province, and dispensing fees from pharmacy to pharmacy.

With the current multi-payer system, one in ten (3.5 million) Canadians are not taking their medicines as prescribed because of cost,[19] affecting one in four households.[20] A recent survey found British Columbia (29%) and Atlantic Canada (26%) have the highest levels of access problems for prescription drugs.[21]

Non-adherence to drug treatment, in particular, impacts low income Canadians, including low-wage workers; Canadians on low fixed-income; youth

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[18] Ibid.

[19] Law, Michael et al. 2012. The effect of cost on adherence to prescription medications in Canada. CMAJ January 16, 2012 cmaj.111270. http://www.cmaj.ca/lookup/doi/10.1503/cmaj.111270. Accessed October 3, 2016.

[20] Angus Reid. 2015. Prescription drug access and affordability an issue for nearly a quarter of all Canadian households. http://angusreid.org/prescription-drugs-canada/. Accessed September 27, 2016.

[21] Angus Reid. 2015. Prescription drug access and affordability an issue for nearly a quarter of all Canadian households. http://angusreid.org/prescription-drugs-canada/. Accessed September 27, 2016.

who have "aged out" of their parent's or guardian's health benefit plans; precarious workers who are part-time or work "gigs." However, even Canadians who have health benefit plans are paying more out-of-pocket costs for their drugs due to increasing and higher co-payments and deductibles.

Numerous studies have linked non-adherence due to the high costs of prescription drugs. For example, a recent study found that in 2012, for Canadians 40 years and over, with cardiovascular-related chronic conditions who spent 5% or more of their household income on prescription drugs were significantly older, often had household incomes of less than $30,000, and reported more co-morbidities. This study found these Canadians who spent 5% or more on their needed prescription drugs were almost three times as likely to report non-adherence due to the costs of their prescription drugs compared to those spending 5% or less than their household income.[22]

In Quebec, research found a high degree of non-adherence was associated with higher drug costs and among patients with higher co-payments. Additionally, the odds of non-adherence of people with free medication was reduced by 63% compared to those who had to pay a maximum level of co-payment.[23]

Additional research indicates Canadians suffering from poor health and chronic illnesses, with low household incomes and inadequate prescription drug coverage, were more likely to not adhere to their drug therapies due to the high cost of their medicines.[24] This is significant when 37% of Canadians have a chronic health condition.[25]

Low earnings have also been linked to low health benefit coverage (see Figure 5). This is most disturbing given today's increasing number and types of precarious work coupled with minimum wages which do not provide a living wage.

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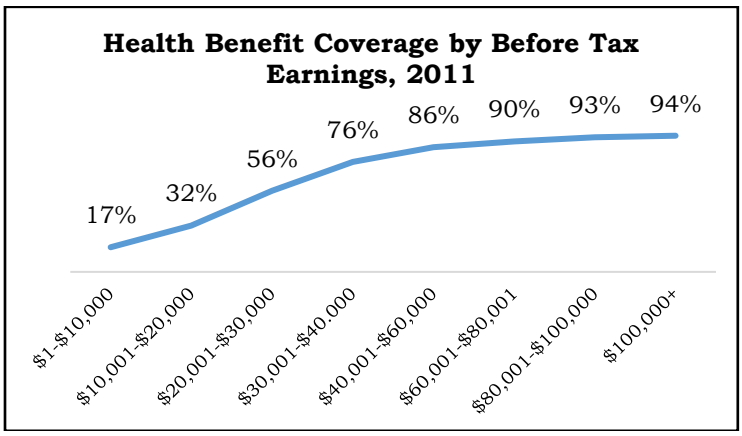
[22] Hennessy, Deirdre et al. June 15, 2016. Out-of-pocket spending on drugs and pharmaceutical products and cost-related prescription non-adherence among Canadians with chronic disease. http://www.statcan.gc.ca/pub/82-003-x/2016006/article/14634-eng.pdf. Accessed October 3, 2016.

[23] Ibid.

[24] Kennedy J, Morgan S. A cross-national study of prescription nonadherence due to cost: data from the Joint Canada-United States Survey of Health. *Clinical Therapeutics* 2006;28(8): 1217-24.

[25] 9000 Points of Care: Improving Access to Affordable Healthcare. http://9000pointsofcare.ca/wp-content/uploads/The-Plan.pdf. Accessed October 5, 2016.

Figure 2



Source: Wellesley Institute, 2015

The same study found people with no drug insurance are four times more likely to not adhere to their drug treatment regimen than those with health insurance. The predicted rate of non-adherence for low income households with no insurance was 10 times higher than high income households with no drug insurance.[26]

The consequences of non-adherence to prescription drugs are very serious, including increasing co-morbidities, severity of the health condition(s), emergency visits and hospital admissions. This is not only costly, but also results in escalating harm to the individual patients. It is estimated that one out of six hospital admissions is due to non-adherence to drugs.[27] Non-adherence to drugs for chronic care alone accounts for 5% of hospital admissions, 5% of physician visits, and contributes $4 billion to healthcare costs each year.[28]

Clearly, the current patchwork system is inequitable, costly, and inadequate and does not provide sufficient coverage, or even worse, no coverage at all to millions of Canadians.

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[26] Ibid.
[27] Samoy, L.J. et al. 2006. Drug-Related Hospitalizations in a Tertiary Care Internal Medicine Service of a Canadian Hospital: A Prospective Study. Accessed October 5, 2016.
[28] 9000 Points of Care: Improving Access to Affordable Healthcare. http://9000pointsofcare.ca/wp-content/uploads/The-Plan.pdf. Accessed October 5, 2016.

CANADA'S PHARMACARE AND TRADE DEALS

Canada is moving forward towards two trade agreements which will significantly increase the prices of prescription drugs for Canadians and limit Canada's ability to establish future national social programs, such as a National Pharmacare Program.

Both the Canada–EU Comprehensive Economic and Trade Agreement (CETA) and the Trans-Pacific Partnership (TPP) extend patent protection to drug companies, giving them an even greater monopoly than they currently have. As a result, it will take longer for Canadians to access cheaper, generic versions of drugs.

Canada already pays some of the highest prices in prescription drugs. The TPP's concessions to drug companies alone could see Canadians pay over $800 million annually in increased drug costs.

The investor-state dispute settlement (ISDS) in CETA and TPP allows massive corporations to directly sue democratically-elected governments to protect and expand their profits, outside of Canadian national courts.

For example, using the ISDS provision under the North American Free Trade Agreement (NAFTA), Canada is currently being sued by the giant drug company Eli Lilly for $500 million after our courts refused to extend patents on several of their drugs.

Both CETA and TPP will give large drug companies even more power to sue our governments if their patented drugs are excluded from government pharmacare plans. These trade agreements, if ratified, will lock Canada into its current level of privatization and commercialization, preventing public innovation, such as the introduction of a universal, national, public pharmacare program.

CONCLUSION

More and more Canadians are being left behind in our fragmented multi-payer system for prescription drugs. The current multi-payer prescription drug coverage depends on a number of factors not related to medical needs, including a person's age, income, employment status, workplace, their province of residence, and even where they are receiving their drug. This should not be

the case. In particular, cost-related non-adherence to prescription drug treatments affect vulnerable populations most. This patchwork system is resulting in poorer health outcomes and increasing co-morbidities among Canadians – ultimately costing individuals and the system more.

The deficiencies in the current patchwork prescription drug system already do not meet the changing needs of Canadians. Current disparities will only grow with time, if nothing is done. This already untenable situation will certainly be exacerbated if CETA and TPP are ratified. These trade agreements will impose even higher drug prices and threaten Canada's ability to establish national programs such as a National Pharmacare Program.

A healthy population is the backbone to development, growth and prosperity for any country. Yet Canada is the only country in the world that has a universal public health care system but not a universal public prescription drug program. While other developed countries offer their citizens this social protection, Canada leaves its citizens without such a safety net.

The only real solution is to establish a quality, universal, public, National Pharmacare Program which adheres to the principles of the *Canada Health Act*, and is integrated with our Medicare system. Such an integrated health care system would bring Canada so much closer to a universal, quality health care system that is equitable for all Canadians.

A number of independent studies, by highly respected health economists, have shown Canada can afford a single-payer National Pharmacare Program that is economical, safer and offers public accountability. These studies show a National Pharmacare Program would save Canadians between $4 billion and $11 billion a year.

This government can show leadership and stewardship for one of the most important and cherished program of this country – our health care system. There is a huge majority of Canadians (91%) that support a National Pharmacare Program.[29] And, a large number of Canadian health-related organizations, academics, health economists, and unions support a National Pharmacare Program. The time is now for a National Pharmacare Program.

[29] Angus Reid. 2015. Prescription drug access and affordability an issue for nearly a quarter of all Canadian households. http://angusreid.org/prescription-drugs-canada/. Accessed September 27, 2016.

RECOMMENDATIONS

1. Create a quality single-payer National Pharmacare Program which is publicly administered and publicly delivered with first dollar coverage that is consistent with the *Canada Health Act* (CHA) in terms of universality, accessibility, comprehensiveness, public administration and portability. The single-payer program will have the most optimal bulk purchasing power for prescription drugs that are most competitively priced. A single-payer program will also reduce the duplicity of administration found in the current multi-payer system, and will result in better administrative efficiency at a lower cost.

   First dollar coverage will ensure no Canadian is left without the medicines they need because out-of-pocket payments, such as co-payments and deductibles, will be eliminated.

   This National Pharmacare Program should be integrated with the Medicare system to ensure the highest quality, safest and best universal health care for Canadians.

2. Create a national formulary of medicines which is comprehensive, to ensure superior drug choice and access to a range of drugs. Formularies ensure safe and effective prescription drug use while containing costs and providing the best value. Oversight of the national formulary will be under taken by a publicly accountable national group of non-partisan stakeholders who are at arms-length from the government.

3. The federal government should not ratify the TPP, CETA or any other trade agreement that results in higher prescription drug prices and hinders or prevents, in any way, Canada's sovereign right to establish national public social programs in the future.

4. The federal government will share the cost of a National Pharmacare Program with the provinces and territories, contributing at a minimum 25% of total program costs.

All of which is respectfully submitted by the CLC.

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