

Submission to the Advisory Council on the Implementation of National Pharmacare

Much of the academic and “technical” discussion on national pharmacare has been about prescription drug prices and costs. This is a very important consideration, though the need for adequate universal coverage is equally compelling. A single payer model has dominated this discussion but is unlikely to quickly and significantly lower costs. It would be very disruptive and cumbersome to implement, which could quickly cool political and popular support. This is why we ought to carefully consider social insurance as a well-tested alternative to deliver national pharmacare.

Canada is High Cost... and then there's Quebec

In 2016, Canada had the fourth highest per capita drug costs among OECD countries, 44% higher than the OECD average, although those costs include value-added tax in some countries.¹ Our generic drug prices were seventh highest among OECD countries in 2016, 33% above the median price.² For comparison, Canada ranked 14th in GDP per capita among OECD countries that year.³

A single public payer drug plan under the Canada Health Act has been proposed to reduce prices and costs. Academic models suggest this will save billions in drug costs.⁴ The Parliamentary Budget Officer (PBO) used a single payer model to estimate national savings of \$4.2 billion every year.⁵ Relying on the PBO report, the House of Commons Standing Committee on Health's (HESA) report advocated a single payer drug plan under the Canada Health Act.⁶ Unfortunately HESA did not address funding or implementation, and it dismissed a ‘fill-the-gap’ alternative in less than a page.

Quebec uses a social insurance model to achieve universal drug insurance. The province struggled for years with per capita drug expenditures that were higher than all other provinces. This has recently improved; New Brunswick now has that unfortunate distinction.⁷ One study estimated a

¹ OECD Health Statistics 2018. Health expenditure (2016 data). Available at: <http://www.oecd.org/els/health-systems/health-data.htm>. Frequently requested data; Click Key indicators.

² Patented Medicine Prices Review Board, 2018. *Generic Drugs in Canada, 2016*. p.16.

³ OECD, 2018. OECD Data (2016 data). Available at: <https://data.oecd.org/gdp/gross-domestic-product-gdp.htm>.

⁴ Morgan SG, M Law, JR Daw, L Abraham, D Martin, 2015. Estimated cost of universal public coverage of prescription drugs in Canada. *Canadian Medical Association Journal*, 187(7): 491-97. See also Gagnon & Hébert, 2010, and Gagnon, 2014.

⁵ Office of the Parliamentary Budget Officer, 2017. *Federal Cost of a National Pharmacare Program*. Available at: http://www.pbo-dpb.gc.ca/web/default/files/Documents/Reports/2017/Pharmacare/Pharmacare_EN_2017_11_07.pdf.

⁶ Canada, 2018. *Pharmacare Now: Prescription medicine coverage for all Canadians*. Available at: <http://www.ourcommons.ca/DocumentViewer/en/42-1/HESA/report-14/>.

⁷ Canadian Institute for Health Information, 2017. *National Health Expenditure Trends 1975-2017*. Data Tables.

single payer model could save Quebec \$3.9 billion annually, 44% of 2017 spending.⁸ However, the authors did not consider savings possible from similar but better managed European models.

With such high costs and such big savings available, the single payer solution seems obvious. But to paraphrase Emile Chartier, nothing is more dangerous than an idea when you only have one.

There are two important questions:

1. Is a single payer model for national pharmacare the best way to reduce drug prices and costs?
2. Could a social insurance using mixed-funding achieve adequate and sustainable universal drug coverage?

Single Payer Models and Cost Control

Either model – single-payer or social insurance (SI) – could reduce costs over time,⁹ but each requires a well-planned and executed national prescription drug strategy to work effectively.

Considering a National Prescription Drug Strategy

A strategy should underpin the drug plan by identifying explicit goals aimed at health outcomes. It would include tactics such as monitoring and incenting appropriate prescribing, and establishing a national standard formulary and protection from catastrophic drug costs. A more modern and inclusive governance model should be created, similar to Germany's Federal Joint Commission which includes 13 non-governmental members providing advice to the Minister of Health. Patient needs and preferences need to be explicitly recognized. Cancer drugs and drugs for rare disorders need to be included. Pharmacy fees and mark-ups should be carefully assessed, since they represent about 27% of prescription costs (PBO 2017: 42). The strategy will require new and sustained federal funding to garner provincial support. Ideally, a comprehensive strategy should consider access to prescription drugs in the context of the entire health system, and beyond to embrace the social determinants of health.

Academic research has advocated for a single payer model based on economic models and assumptions that estimate dramatically lower costs. However, those assumptions create serious doubts as to whether savings are achievable in the real world. It's also important to step back to examine the fit between the proposed solution and the problem of high drug prices and costs.

Three recent research studies are commonly cited to justify using a single payer model to cut costs. One other report bears mention.

⁸ Morgan SG, M-A Gagnon, M Charbonneau, A Vadeboncoeur, 2017. Evaluating the effects of Quebec's private-public drug insurance system. *Canadian Medical Association Journal*, 189(40): E1259-63.

⁹ Gagnon MA, 2017. Financing the public provision of prescription drugs in Canada: Comparison and assessment of financing options. In: *How Ottawa Spends 2017-2018*. Ed: KAH Graham, AM Maslove. Available at: <https://carleton.ca/hos/>.

Consider:

1. Gagnon and Hébert¹⁰ (2010) contended a universal single payer drug plan with first-dollar coverage would produce savings estimated at between 10.7% and 42.7% under four scenarios. These estimates suggest poor public governance if such savings can be realized but are being willfully ignored. If that's true, Canadians may not trust governments with the stewardship of the entire drug budget. Beyond that, the report includes several factual errors, selectively uses outlier studies, makes unsubstantiated assumptions and ignores implementation. While the assumptions are clearly presented, the values shown cannot be validated because no formulas are provided.
2. Morgan et al. (2015)¹¹ published one of the most frequently cited estimates of savings from a single-payer drug plan. Buried in its appendices, it explains that in order to save \$7.3 billion annually, Canadian brand and generic drug prices must immediately fall by 11% and changing existing patient prescriptions would cut another 16%. Even in the appendices, no formulas are provided so it is impossible to understand or replicate the estimates based on the research document.
3. HESA required the PBO to use the Quebec drug formulary, the largest public formulary in Canada. This immediately "saved" \$3.9 billion in current private drug spending even though demand for those delisted drugs will not disappear overnight. The PBO also assumed a 25% "universal" (p.3) price discount, which immediately cut \$4.2 billion. If this was easy, the jurisdictions would already have achieved this through the pan-Canadian Pharmaceutical Alliance (pCPA). They have not – see below.

In addition to assuming prices would drop immediately, these studies all ignore the immense real-world disruption to prescriber decisions, patient preferences and drug tolerance, the drug supply chain (manufacturers, wholesalers and pharmacies), employer choices and of course directly to the business and employment impacts on insurers and pharmacy benefit managers. These are now extremely important considerations as we turn to implementation.

Finally, one report stands out for its exceptional estimate of savings through a single payer model. Canadian Doctors for Medicare argued "more than \$30 billion in public and private gross savings would be available (p.1)" by replacing the existing sources of funding with a universal single payer pharmacare plan.¹² In 2016, Canada's expenditures on prescription medicines totalled \$32.15 billion. It is not possible that savings from a single payer pharmacare plan could equal or exceed Canada's expenditures on prescription drugs.

¹⁰ Gagnon, MA, G Hébert, 2010. The economic case for universal pharmacare. Canadian Centre for Policy Alternatives and Institut de Recherche et d'Informations Socio-economique. Available at: <https://www.policyalternatives.ca/publications/reports/economic-case-universal-pharmacare>.

¹¹ Op cit, Morgan et al., 2015.

¹² Canadian Centre for Policy Alternatives and Canadian Doctors for Medicare, 2017. *Cost savings resulting from a national pharmacare program*. Available at: <https://www.policyalternatives.ca/publications/reports/cost-savings-resulting-national-pharmacare-program>. Two requests for clarification (July and September 2018) to CDFM remain unanswered.

We should not assume a single payer model is the best or only solution to high prices and costs. Under our single payer model, Canada also has some of the highest salaries for physicians and nurses¹³ suggesting national wealth and a plethora of policy decisions might also matter.

Fortunately, other institutions are more directly addressing drug price and cost challenges. After Health Canada approves a new drug, the Patented Medicine Prices Review Board determines ceiling prices for new patented drugs. The PMPRB has been considering important regulatory and guideline changes aimed at lowering new drug prices towards the OECD median. The Canadian Agency for Drugs and Technologies in Health is responsible for clinical and economic assessments of new drugs. Its recommendations equip the pCPA to negotiate lower patented drug prices for its public drug plan members. (The pCPA has also negotiated a framework with the generic drug industry to lower their prices.) These three bodies have far more important roles to play in managing prices and costs now and in the future than will be achieved by implementing a national pharmacare plan. In fact, on the assumption that national pharmacare will (and should) provide adequate coverage for Canadians presently without any or enough drug coverage, prescription drug costs will undoubtedly increase once a plan is introduced.¹⁴

The pCPA and Bulk Buying – Successful but Limited

As of March 31, 2017, the pCPA reported total annual savings of \$1.28 billion to its members' drug plans, an impressive sum, but equal only to about 4% of total prescription spending and 11% of provincial-territorial drug spending. No detail of these calculations is available, no independent validation has occurred and no updates have been provided. As of August 2018, 235 drug negotiations have closed, but that equals only about 3% of the 8,000 products on the Quebec formulary.¹⁵

Proponents of a single payer model believe that a single buyer, or more correctly a single agency for price negotiation, is required to negotiate lower drug prices and costs.¹⁶ The pCPA has indeed achieved lower prices for its beneficiaries but these prices are not available to patients who pay out-of-pocket or those who are privately insured. Indeed it is likely that patients paying privately subsidize the low prices paid by governments. The pCPA achievement does not explain why almost all countries have lower per capita drug costs than Canada and this fact does not appear to be associated with the model. For example, the Netherlands uses a social health insurance system to

¹³ Papanicolas I, LR Woskie, AK Jha, 2018. Health care spending in the United States and other high-income countries. *JAMA*, March 13. 319(10): 1024-39. In US dollars, Canada ranked third in compensation for general physicians, fourth for specialist physicians and fifth in nurses among 11 countries.

¹⁴ For example, the PBO report assumed utilization would increase by 12.5%. See Table 3-2, p. 37.

¹⁵ The pCPA began operations in 2010, though its activities have accelerated in recent years. pCPA savings and number of products as of March 31, 2017 available at: <http://www.canadaspremiers.ca/pan-canadian-pharmaceutical-alliance/>. The August 2018 figure is here: http://www.canadaspremiers.ca/wp-content/uploads/2018/09/PCPA_completed_negotiations_August31_2018.pdf. For the QC formulary drug count, see: <http://www.ramq.gouv.qc.ca/en/citizens/prescription-drug-insurance/Pages/prescription-drugs-covered.aspx>.

¹⁶ For example, Gagnon (2010) estimated \$1.49 billion by eliminating private drug insurance plans.

achieve per capita drug costs that are half of Canada's (US\$406 PPP, vs. \$833)¹⁷ despite having just half our population (17 million, vs. 36.7 million).

I am not aware of literature that estimates a point of diminishing return for drug price negotiations based on volume. In other words, how big is big enough, and at what point will global pharmaceutical manufacturers refuse to negotiate further discounts with Canada? It is likely that 'bulk buying' has inherent limitations. It is only one of several tactics within a national prescription drug strategy that allows other countries to outperform Canada.

Simpler solutions are possible. Discounts could apply to the entire market by including private payers in the pCPA.¹⁸ An easier approach would be for pCPA in its current form to negotiate patented drug prices for the entire market. After all, its work on generic prices applies to all beneficiaries. It is not equitable that some Canadians pay less than others, particularly when that disadvantage is greatest for those with no insurance.

In summary, assumptions about the model and the role of 'bulk buying' drive the headline claims of huge savings. Other tactics have already been successful, though they could be improved. A national strategy should be developed as an essential foundation. While academic models have helped start the pharmacare conversation, they have limited value in the real world. Other approaches should now be considered.

A social insurance solution

All European nations using SI have a broad drug formulary and all except Switzerland spend less per capita on drugs than Canada.¹⁹ SI countries cover more health services at the same or lower unit cost. Every country has adapted its model to suit its national goals, priorities, historical precedents and budget. This flexibility means we can learn from others and create a refreshingly coherent – and much less disruptive – pan-Canadian solution.

Another significant advantage to SI models is more choice through a complementary private insurance market. Private drug insurance will reduce the cost to public treasuries, making a mixed model more feasible for governments and taxpayers.²⁰ We do not know whether the general public would be willing to trade lower costs for greater choice and access to a private insurance 'safety net' allowing them access to drugs that budget-driven governments may refuse to list. As a next step, the Advisory Council could build discreet models with clear parameters, assumptions and trade-offs, and ask Canadians to rank these for overall desirability.

SI legally mandates health insurance with a third-party payer and requires separate (dedicated) contributions or premiums unrelated to risk. SI legislates or regulates insurers to operate in the

¹⁷ Op cit. OECD Health Statistics, 2018.

¹⁸ Pharmaceutical manufacturers are likely to offer a smaller percentage discount for the entire market than they currently offer to public plans, but the overall dollar cost reduction from including private payers may still be greater.

¹⁹ Op cit. OECD, 2018.

²⁰ Op cit. Gagnon, 2017.

public interest and typically establishes a minimum drug formulary. Subsidies exist for low-income patients and out-of-pocket expenses are uniformly capped. While our competitive insurance market increases choice and promotes technological innovation,²¹ these features likely increase costs over a single public funder. These are all features of Quebec's plan.

What happened in Quebec?

Critiques of Quebec's high costs tend to conflate its social insurance model with provincial policy and administrative decisions.²² Once separated, the model is sound but two key policies bear attention.

Beginning in 1994, the "BAP15" rule required brand drug companies to offer Quebec the best available prices in Canada in exchange for exclusive market access for 15 years. That rule effectively extended patent protection in Quebec, adding an estimated \$364 million (5.5%) in extra costs every year.²³ It was finally rescinded in 2013.

Second, Quebec does not encourage pharmacists to fill 90- or 100-day supplies of well-tolerated chronic use medications. As a result, the average quantity supplied per prescription is just 54% of the level in the other nine provinces. Quebec with 23% of the national population accounts for 43% of all prescriptions.²⁴ A US study found the average monthly cost for a three month prescription was 18% lower than for a one month supply of the same drug and dosage.²⁵ Practices in other provinces suggest they're unaware or unconvinced of any material benefit from perpetual 30-day supplies, but this practice does cost more.

The social insurance model does not mandate BAP15 or 30-day refills. These were simply Quebec's policy decisions, and should have been abandoned long ago. Since 2013, generic fill rates and per capita costs have improved relative to provincial peers.

Quebec's Advantages

Quebec residents eligible for public coverage pay premiums into a dedicated Drug Insurance Fund which makes drug costs more transparent. Subsidies and exemptions are an important policy, as in other provinces. The Fund provided drugs to 918,000 Quebecers – 26% of provincial beneficiaries – without any out-of-pocket cost, and about 500,000 low income recipients paid no premium.²⁶ The

²¹ For example, several private insurers offer phone apps that help plan members locate low cost pharmacies, and explore drug options. Access to substantive chronic disease management information is available through insurer websites. Customer service is accessible online or by telephone. Provincial plans do not offer these patient services.

²² Smolina K, S Morgan, 2014. The drivers of overspending on prescription drugs in Quebec. *Healthcare Policy* 10(2): 19-26.

²³ Gagnon M-A, 2014. Roadmap to a rational pharmacare policy in Canada. Ottawa: Report of the Canadian Federation of Nurses Unions.

²⁴ IQVIA, Canadian CompuScript. MAT September 2017. Personal communication, November 10, 2017.

²⁵ Rabbani A, GC Alexander, 2009. Cost savings associated with filling a 3-month supply of prescription medicines. *Applied Health Economics and Health Policy* 7(4): 255-64.

²⁶ RAMQ, June 26, 2017. See: <http://www.ramq.gouv.qc.ca/en/regie/press-room/news/2017/Pages/public-prescription-drug-insurance-plan-changes-financial-participation.aspx>. 2017.

rate of cost-related non-adherence remains the lowest in Canada.²⁷ Social insurance is designed to improve equity for low-income beneficiaries and Quebec's model meets that test.

Another major advantage learned in Quebec is that social insurance can focus on the minority of Canadians without any or enough drug coverage. It can therefore cause far less disruption to patients and the market. Consequently, SI would not require a massive shift of \$18 billion²⁸ in private drug spending to the government and commensurately higher taxes. Strong regulation would mean no one is excluded from coverage based on age or health status and competitive private insurers can encourage more innovation and patient-centred technology.

Conclusion

National pharmacare is crucially important but may not be the right solution to directly, quickly and effectively control drug prices and costs. Other federal and pan-Canadian agencies are already addressing those important objectives, although their work could be more effectively coordinated to reduce duplication and time-to-market for innovative drugs.

National pharmacare should instead focus on providing adequate universal drug insurance, using new national standards for formulary, plan design and out-of-pocket costs.

Since no health system is perfect we need more than one idea in our quest for universal drug insurance. Single payer could certainly work, but history indicates it's been too big and too complex to implement. A social insurance, mixed funding model is a more focused solution. It is financially and politically more feasible, and could therefore more quickly help all Canadians without any or enough drug insurance.

²⁷ Law MR, L Cheng, A Kolhatkar, et al., 2018. The consequences of patient charges for prescription drugs in Canada: a cross-sectional study. *CMAJ Open* 6(1): E63-E70.

²⁸ Op cit. CIHI, 2017. NHEX.