CANADIAN DOCTORS FOR MEDICARE | MÉDECINS CANADIENS POUR LE RÉGIME PUBLIC

Submission to the Standing Senate Committee on Social Affairs, Science and Technology

Bill C-64, An Act Respecting Pharmacare

Canadian Doctors for Medicare

September 2024

Who we are

Canadian Doctors for Medicare is a nationwide, evidence-based nonpartisan member organization composed of physicians and medical students dedicated to strengthening and preserving Canada's publicly funded health care system. Our vision is that a high-quality, equitable, and sustainable health system built on the best available evidence is the highest expression of Canadians caring for one another. We provide a voice for Canadian doctors who want to strengthen and improve Canada's universal publicly funded health care system. We advocate for innovations in treatment and prevention services that are evidence-based and improve access, quality, equity and sustainability.

As doctors working in hospitals and in the community, we have seen first-hand the health consequences when people cannot afford their medications. That is why **Canadian Doctors for Medicare is advocating for a universal, single-payer, publicly funded program that would provide first-dollar coverage for all essential medicines**, as chosen by an independent committee, to all people resident in Canada.

I. CDM's position on Bill C-64

CDM recognizes that the language in Bill C-64 is imperfect and imprecise in a number of respects.

- Bill C-64 does not explicitly commit to the universal, publicly funded, single-payer pharmacare program recommended in the Final Report of the Advisory Council on the Implementation of National Pharmacare and supported by the majority of Canadians;
- Comprehensiveness: Bill C-64 does not commit the federal government to expanding coverage beyond products for diabetes and contraception. Rather, it only "aims" to continue working toward implementation of a national formulary and national universal pharmacare;
- Universality: Bill C-64 does not define the term "universal" when it comes to who is covered, though presumably the intent is to mimic the criterion in the Canada Health Act;
- Public funding and administration: Bill C-64 does not explicitly commit to an expanded pharmacare program that is fully publicly funded first-dollar coverage and universal for all essential medicines;
- Accountability: Bill C-64 only commits the Minister to "considering" the Canada Health Act, not to abiding by the five principles enshrined in the Act;
- Conflicts of interest: Bill C-64 does not prohibit people with financial conflicts of interest from being appointed to the Committee of Experts that will make recommendations respecting options for the operation and financing of pharmacare.

Despite these limitations in Bill C-64, CDM strongly urges the Senate to pass the bill as quickly as possible. CDM takes this position because as doctors we have first-hand knowledge of the devastation that lack of access to essential medicines can cause and we recognize our inability to help people get the medicines that they need. We feel moral distress because we are "unable to take what [we] believe to be an ethically appropriate or right course of action, including avoiding

wrongdoing or harm, because of institutionalized obstacles."[1] In this case, the institutionalized obstacle is the lack of legislation mandating drug coverage for all Canadians. Moral distress can lead to physicians leaving practice or reducing their clinical hours, which contributes to lack of access to care for our patients.[2]

II. Why Pharmacare is necessary

Universal, publicly funded, formulary-based Pharmacare was envisaged in the 1964 Hall Royal Commission Report on Health Services[3] but not yet implemented. Over the ensuing decades pharmacare has also been recommended by various federal parliamentary committees, federal commissions and most recently by the Advisory Council on the Implementation of National Pharmacare led by Dr. Eric Hoskins (former Ontario MPP).[4] At this point, Canada remains the only country that offers universal publicly funded coverage for medically necessary physician and hospital services that does not also offer a universal publicly funded scheme for prescription medicines.

The current way that Canada covers the cost of prescription medicines is through a combination of privately funded insurance, publicly funded insurance and out-of-pocket payment. A 2022 Statistics Canada report[5] found that in the previous year, about one-fifth (21%) of Canadians reported not having insurance to cover any of the cost of prescription medications in the past 12 months. This problem was especially acute among immigrants (29%) compared to non-immigrants (17%) and among non-white persons (29%) compared to white and non-Indigenous persons (17%). Prescription medication use was lower among people who did not have prescription medication insurance (56%) compared to those who did (70%). One in 10 Canadians (9%) reported not adhering (e.g., skipping doses, delaying filling) to their prescription medication because of cost. The share of Canadians reporting cost-related non-adherence was more than double among people without prescription insurance (17%) compared to those with prescription insurance (7%).

Financing drug coverage through work-place benefits is a form of regressive taxation. The portion of an employee's health insurance that is paid by the employer is exempt from the employee's personal income tax. By subsidizing insurance coverage through the tax system, the subsidy an individual receives is based on his/her marginal income tax rate. Given the progressive nature of the Canadian tax system, this amounts to providing greater subsidies to higher income individuals.[6]

Current provincial drug plans are grossly inequitable. Figure 1 shows how much people would have to pay for three psychiatric medicines among those 65 and over and those under 65 with an annual net income of $55,600 depending on the province in which they live.[7] At the low end, a

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[1] Canadian Medical Association. Moral Injury: What Is It and How to Respond to It. September 9, 2021. https://www.cma.ca/physician-wellness-hub/content/moral-injury-what-it-and-how-respond-it

[2] Hostetter M et al. Responding to Burnout and Moral Injury Among Clinicians. The Commonwealth Fund, August 17, 2023. https://www.commonwealthfund.org/publications/2023/aug/responding-burnout-and-moral-injury-among-clinicians

[3] Emmett Hall. Royal Commission on Health Services. Ottawa: Government of Canada, 1964.

[4] Advisory Council on the Implementation of National Pharmacare. A Prescription for Canada: Achieving Pharmacare for All. Government of Canada, 2019.

[5] Cortes K, Smith L. Pharmaceutical Access and Use During the Pandemic. Statistics Canada, 2022.

[6] Stabile, M. (2002). Impacts of private insurance on utilization, *Paper prepared for the IRPP conference "Toward a National Strategy on Drug Insurance".* Toronto: University of Toronto.

[7] Clement F, Memedovich KA. Drug Coverage in Canada: Gaps and Opportunities. Journal of Psychiatry and Neuroscience 2018;43(3):148-150.

senior in Ontario would pay about $40 per year out-of-pocket compared to someone in New Brunswick who would pay almost $1600 out-of-pocket. While the disparities for people under 65 are not as great, they still exist.

Quarterly payments by government and patients depending on province of residence

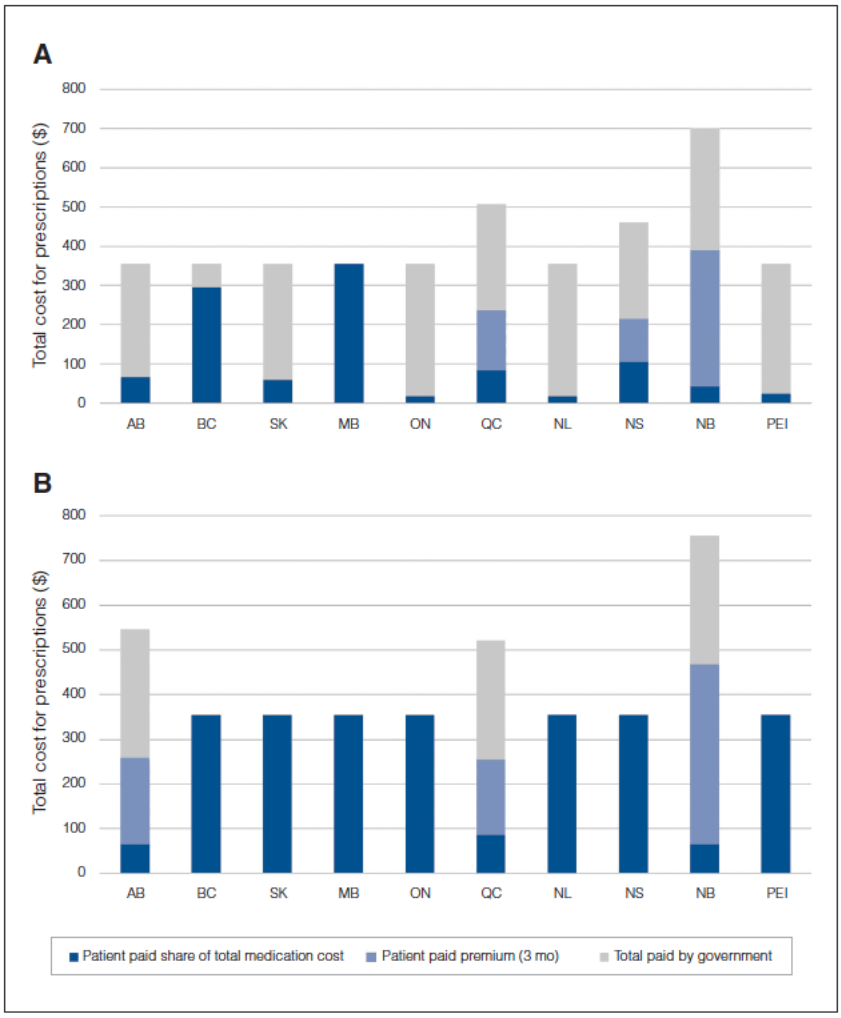

Fig. 1: (A) What the government and a patient older than 65 years (annual net income of about $55 600) pay for a 3-month dispensation of 20 mg/d of citalopram, 5 mg/d of aripiprazole and 7.5 mg/d of zopiclone. **(B)** What the government and a patient younger than 65 years (annual net income of about $55 600) pay for a 3-month dispensation of 20 mg/d of citalopram, 5 mg/d of aripiprazole and 7.5 mg/d of zopiclone.

Nor is the lack of coverage for prescription medicines just a problem for the poor. Cost-related non-adherence is greater than 6% among people **with insurance** who are in the medium-high income bracket.[8]

III. Who supports Pharmacare?

According to the most recent (July 2024) poll from Environics, support for Pharmacare is widespread across Canada. Nationally, 75% of Canadians strongly or somewhat support such a

[8] Law MR et al. The Effect of Cost on Adherence to Prescription Medications in Canada. CMAJ 2012;184(3):297-302.

program with support by province ranging from a low of 69% (Alberta) to a high of 82% (Newfoundland and Labrador).[9] 46% of Canadians would be less likely to vote for provincial premiers who reject Pharmacare versus 9% who would be more likely to vote for them.[10] Previous polls have found that regardless of which party people support, a majority are in favour of Pharmacare.[11]

IV. Who opposes Pharmacare

One of Canada's most respected health economists famously wrote, "Every dollar of expenditure is a dollar of someone's income."[12]The two primary groups that benefit economically from money spent on prescription drugs are the companies that make them and the private insurance industry that sells insurance plans to pay for them. Ever since the announcement that Pharmacare legislation was going to be introduced, both groups have intensified their lobbying of the federal government by 3.8- fold (pharmaceutical industry) and 8-fold (private insurance industry).[13]

The Canadian Life & Health Insurance Association (CLHIA) claims that Bill C-64 "risks disrupting workplace drug coverage for 27 million Canadians. It risks limiting choice in the specific medications people have access to. And it risks using scarce federal fiscal resources to replace existing coverage that people value, leaving millions uninsured or underinsured for the drugs they need."[14] The evidence that CDM has reviewed disagrees with this distorted assessment.

The Interim President of Innovative Medicines Canada (IMC), the lobby group representing the majority of the multinational pharmaceutical industry operating in Canada, said that "Canadians should be concerned about the impact of the proposed pharmacare model on their existing public and private drug coverage…Moving provinces towards a single-payer system, where drug coverage could be reduced to the lowest common denominator, would limit patient access to new treatments."[15] Again, the evidence that CDM has reviewed disagrees with this flawed analysis.

V. Myths about why Canada should not adopt Pharmacare

The comments from CLHIA and IMC are reflective of two of the most common arguments about why Canada does not need Pharmacare – cost and patient choice. A third objection that is often

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[9] Canadian Health Coalition. Attitudes Towards Health Care. Environics Research, July 2024. https://www.healthcoalition.ca/wp-content/uploads/2024/07/Environics-x-Canadian-Health-Coalition-Healthcare-Poll-Topline-Report-June-11-24-1.pdf

[10] Canadian Health Coalition. Attitudes Towards Health Care. Environics Research, July 2024. https://www.healthcoalition.ca/wp-content/uploads/2024/07/Environics-x-Canadian-Health-Coalition-Healthcare-Poll-Topline-Report-June-11-24-1.pdf

[11] Angus Reid Institute. Access For All: Near Universal Support for a Pharmacare Plan Covering Canadians' Prescription Drug Costs. October 29, 2020. https://angusreid.org/pharmacare-2020/.

[12] Evans R et al. APOCALYPSE NO: population aging and the future of health care systems. Canadian Journal on Aging 2001;20:160–191

[13] Council of Canadians. Liberal-NDP Confidence and Supply Agreement Led to Surge in Industry Lobbying, https://canadians.org/wp-content/uploads/lobbying-health-canada-080223.pdf

[14] CLHIA. Statement: CLHIA disappointed by the House of Commons' missed opportunity to clarify Pharmacare Act. June 4, 2024. https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/page/9E238144028031F785258B31004ABF5D!OpenDocument

[15] Innovative Medicines Canada. Innovative Medicines Canada statement on proposed pharmacare legislation. February 29, 2024. https://innovativemedicines.ca/newsroom/all-news/innovative-medicines-canada-statement-on-proposed-pharmacare-legislation/

raised is that some commentators argue that most of the provincial premiers are either indifferent or opposed to Pharmacare.[16] These arguments are all myths, easily debunked by evidence.

Myth 1: Provincial premiers are opposed

Opposition to new federal social programs is not new. Consider the attitudes of premiers in the mid-1960s towards a publicly funded universal first-dollar coverage for physician services. Outside of Saskatchewan, opposition to coverage for physician services was, in some way or another, almost universal.

- John Robarts (Ontario): Refused to dismantle private plans in favour of expanded OMSIP (Ontario Medical Services Insurance Plan) to meet federal requirements. "I reject the federal proposals as…tampering improperly with matters which are directly the responsibility of the province."
- Jean Lesage: Quebec would refuse to participate in any federal scheme in an area of primarily provincial jurisdiction.
- Ernest Manning: Legislation for income-based subsidization of private insurance coverage passed in 1963 "would give Canadians a program they could set alongside 'the socialistic type of program' in Saskatchewan."
- WAC Bennett (BC): So long as insurance was made available to all, it should be sufficient to meet the federal government's requirement for universality even if it was voluntary in nature. Bennett argued that "many people" might not wish to participate in a medical care insurance plan "for religious reasons."
- Duff Roblin: Manitoba would introduce a voluntary system of medicare if Ottawa contributes 50% of the cost.
- Louis J. Robichaud (NB): Supported medicare in principle but no serious planning for it until spring 1970. (Medicare not introduced until January 1, 1971.)

Yet, despite this opposition, by 1972 all the provinces had signed onto the Medical Care Act. British Columbia has already announced that it will sign a pharmacare agreement with the federal government.[17] Hopefully, this first step will soon be followed by other provincial and territorial governments.

Myth 2: A national program will not cover the "life-saving" medicines that people require

While CDM as a physician group recognizes the value of medicines in the Canadian health care system, we are also cognizant of the fact that only 1 in 8 -10 new medicines introduced annually provide a major therapeutic benefit beyond what is available from existing medicines. Another 1 in 5 new medicines offer a moderate benefit and the remaining 65-70% of new medicines are of marginal new benefit.

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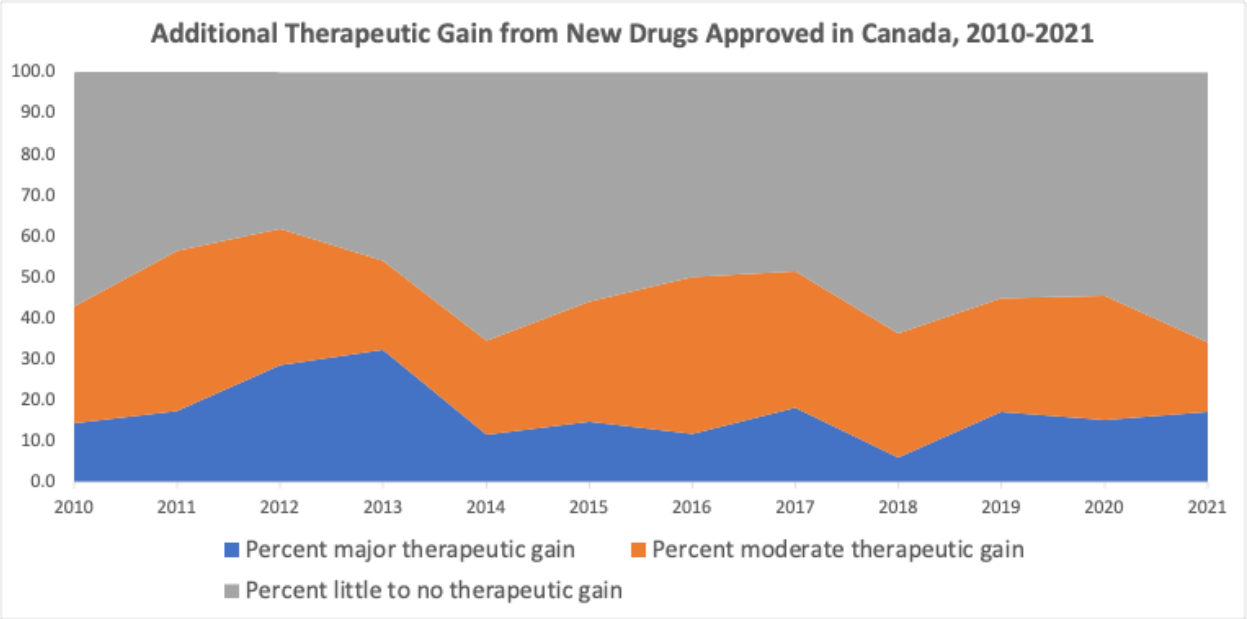
[16] Legree D. Where Every Province and Territory Stands on the Federal Pharmacare Bill. iPolitics. March 8, 2024. https://www.ipolitics.ca/news/where-every-province-and-territory-stands-on-the-federal-pharmacare-bill

[17] Canadian Press. B.C. Pharmacare Deal Will Cover Diabetes Meds, Hormone Therapy. CBC News, September 12, 2024. https://www.cbc.ca/news/canada/british-columbia/b-c-pharmacare-deal-will-cover-diabetes-meds-hormone-therapy-1.7322046#:~:text=British%20Columbia%20has%20become%20the,replacement%20therapy%20and%20diabetes%20expenses.



Health Canada approval of new medicines is no guarantee that they will be better than existing products as the above Figure shows. Private drug plans may cover all drugs approved by Health Canada, but that coverage does not translate into better health outcomes. In CDM's opinion as experts in the use of medications, it is virtually certain that a national formulary developed by a committee of experts (including patients) will provide coverage for all the medicines that are essential to promote and restore health for Canadians.

Myth 3: Pharmacare will cost too much.

Canada currently ranks fourth among 36 countries in the Organization for Economic Cooperation and Development in annual per capita expenditure on retail pharmaceuticals, spending US $200 more than the OECD average of US $614.[18] Morgan and colleagues investigated reasons for this disparity looking at ten high-income countries. They concluded that one of the main reasons why Canada was spending $2.3 billion more on six classes of primary care medicines than the average of the other nine countries was due to higher Canadian prices.[19] Higher prices are due to a number of factors but can be lowered through bulk purchasing. At present, the pan-Canadian Pharmaceutical Alliance only bargains with pharmaceutical companies for drug prices for public drug plans which account for 43% of the total of $41.1 billion cost of prescription drugs.[20] Bulk purchasing for all pharmaceutical spending could significantly lower drug prices. Although it is not the only reason why Australian prices for patented drugs are 30% lower than Canadian ones,[21] it is certainly one factor.

[18] OECD (2023), Health at a Glance 2023: OECD Indicators, OECD Publishing, Paris, https://doi.org/10.1787/7a7afb35-en
[19] Morgan SG et al. Drivers of Expenditure on Primary Care Prescription Drugs in 10 High-Income Countries with Universal Health Coverage. CMAJ 2017;189:e794-9.
[20] Canadian Institute for Health Information. National Health Expenditure Trends, 2023: Data Tables – Series G.
[21] Patented Medicine Prices Review Board. Annual Report 2022. Ottawa, 2024.

Another area where Pharmacare will lead to significant savings is lower administrative costs. Overhead costs for Canadian publicly funded medicare services are about 1% versus 14% in private health plans because of things such as advertising and profit margins.[22]

Arguments about cost are much more likely to be raised when it comes to new social programs than when it comes to other types of expenditures. Arguments were almost never raised that Canada could not afford $75 billion for new F-35 aircraft, $35 billion for the Trans Mountain Pipeline, and $28.2 billion for electric vehicle plants. It is time to recognize that the money spent on a pharmacare program will be more than made up for by the benefits to the health of Canadians.

Not only will there be direct economic savings from lower prices and administrative costs, there will also be indirect savings due to significant improvements in morbidity and mortality. A report prepared for the Canadian Federation of Nurses Unions[23] estimated that the lack of access to medically necessary medications led to annual deaths and increases in morbidity in the range of:

- 370 to 640 premature deaths due to ischemic heart disease;
- 270 to 420 premature deaths of working-age people due to diabetes;
- 550 to 670 premature deaths from all causes of people 55-64 years of age;
- 70,000 people 55+ suffering from deteriorating health status;
- 12,000 people with cardiovascular disease aged 40+ requiring overnight hospitalization.

CDM is in strong agreement with the statement in the report of the Advisory Council on the Implementation of National Pharmacare (Hoskins Report): “National pharmacare is not only good for Canadians, it’s good economic policy. It will reduce the economic inefficiencies that come with tens of thousands of private plans, which cost three times more to administer than public plans. It will replace multiple buyers with a single large, powerful purchaser, one that has the clout and authority to negotiate the best, lowest prices for prescription medications for Canadians.”[24]

[22] Morgan SG. When Will Canada Have National Pharmacare? BMJ 2024;385:q887.
[23] Lopert R et al. Body Count: The Human Cost of Financial Barriers to Prescription Medications. Canadian Federation of Nurses Unions, May 2018. https://www.cihi.ca/en/national-health-expenditure-trends
[24] Advisory Council on the Implementation of National Pharmacare. A Prescription for Canada: Achieving Pharmacare for All. Government of Canada, 2019.