AUSTERITY and its
ALTERNATIVES

# The Pharmacare Alternative

## Reducing Labour Costs While Improving Health Outcomes

Marc-André Gagnon (Carleton University)

The Second AltAusterity Workshop – March 23-24, 2018
Embassy Hotel & Suites, Ottawa, Ontario, Canada

Carleton UNIVERSITY

**February 27 2018:**
**Budget confirms new advisory council on implementation of national pharmacare**

**February 28 2017:**
**One day after raising hope about pharmacare, Morneau talks partial drug coverage**

*"A new national pharmacare program will be 'fiscally responsible' and designed to fill in gaps, not provide prescription drugs for Canadians already covered by existing plans."*

# Working Argument

- The problem with drug coverage in Canada is that it is a patchwork; An inequitable inefficient and unsustainable patchwork with no coherence or purpose. Some people think we can solve the problem by adding more patches, but the core of the problem is that it is a patchwork.

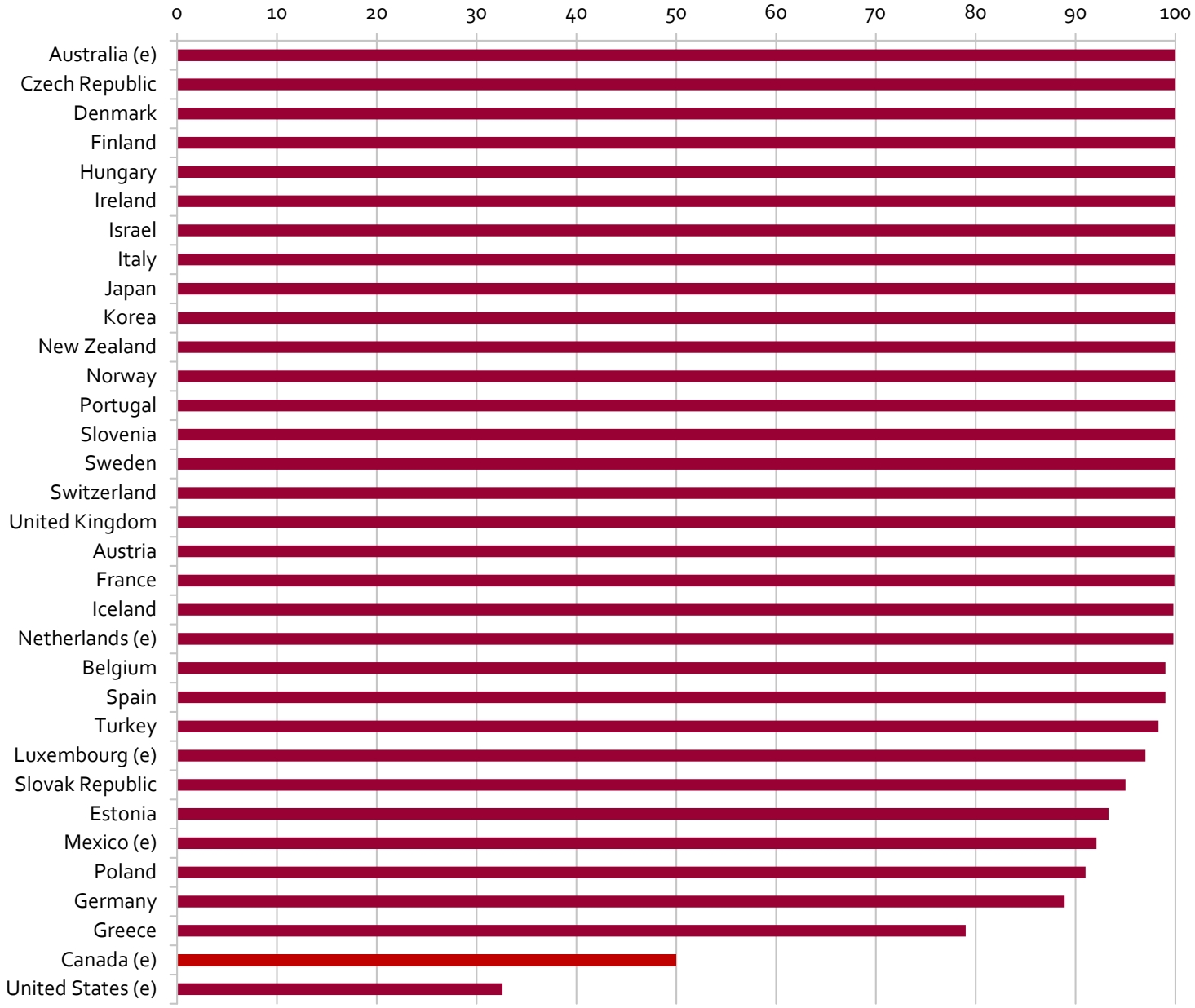
ALTAUSTERITY

# Current Drug Coverage in Canada

- Federal (2% of expenditures): Covers First Nations, RCMP, Military and Veterans (+Refugees).
- Provincial (42% of expenditures): Covers mostly the non-working population (seniors, social assistance beneficiaries). Quebec publicly covers workers without private coverage. "Catastrophic coverage" in many provinces.
- Private drug plans (36% of expenditures): Covers most of the working population, and their dependents (60% of population)
- Out-of-pocket expenditures (20% of expenditures): co-pays, deductibles, or people without coverage.

ALTAUSTERITY

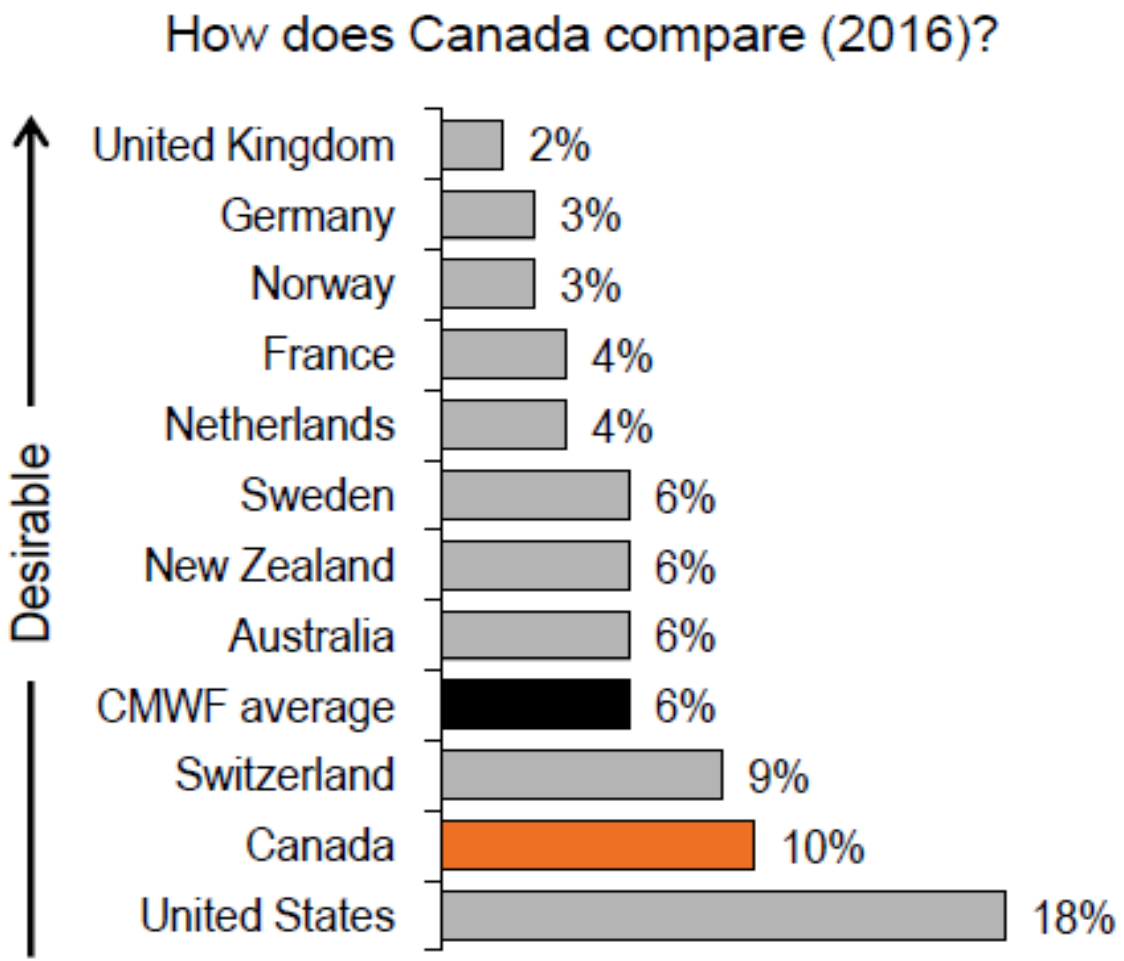
# Percentage of the population covered by a public drug insurance plan in all OECD countries (%), 2013



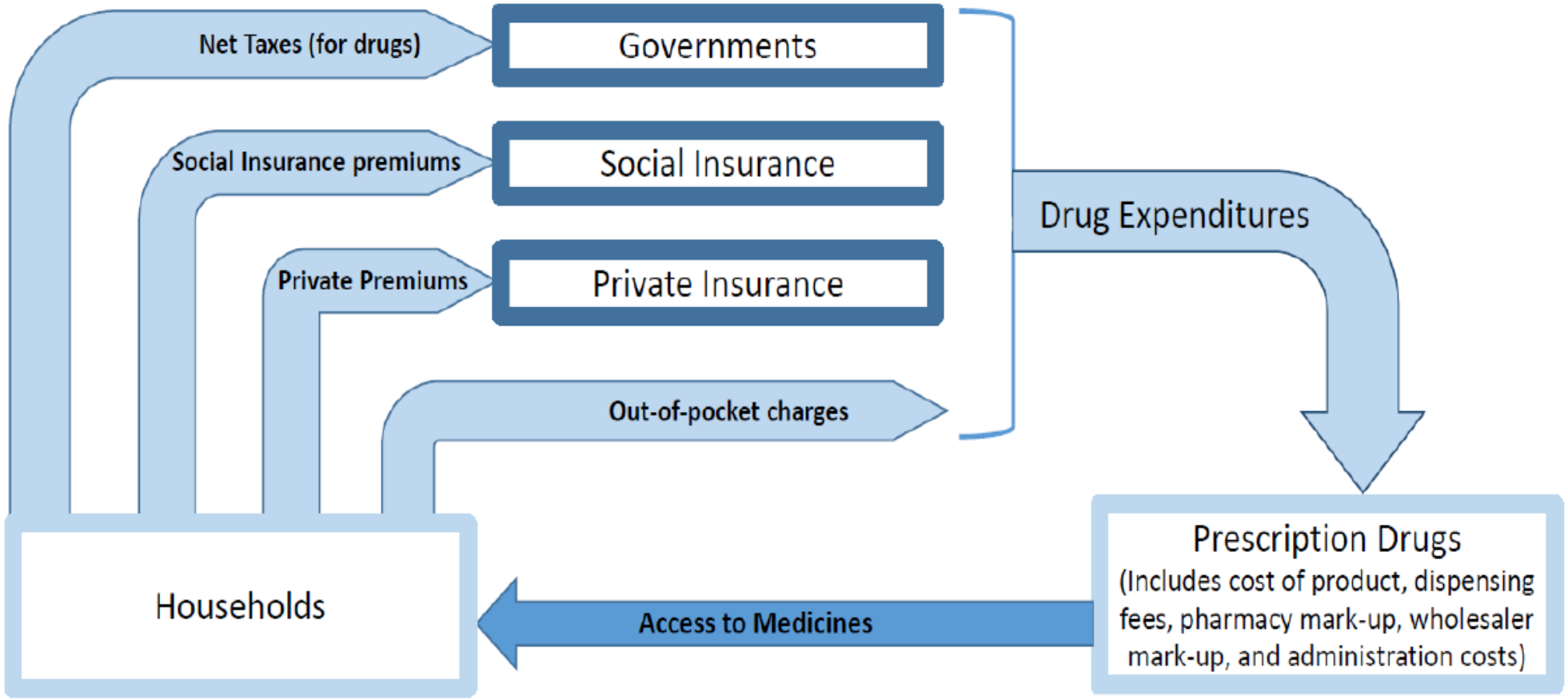

(e): estimate
Source: OECD Health Data: Social Protection
(Extracted from OECD iLibrary)

Within last year, did not fill prescription for medicine or skipped doses of medicine because of the cost

**Results From The Commonwealth Fund's 2016 International Health Policy Survey of Adults in 11 Countries**

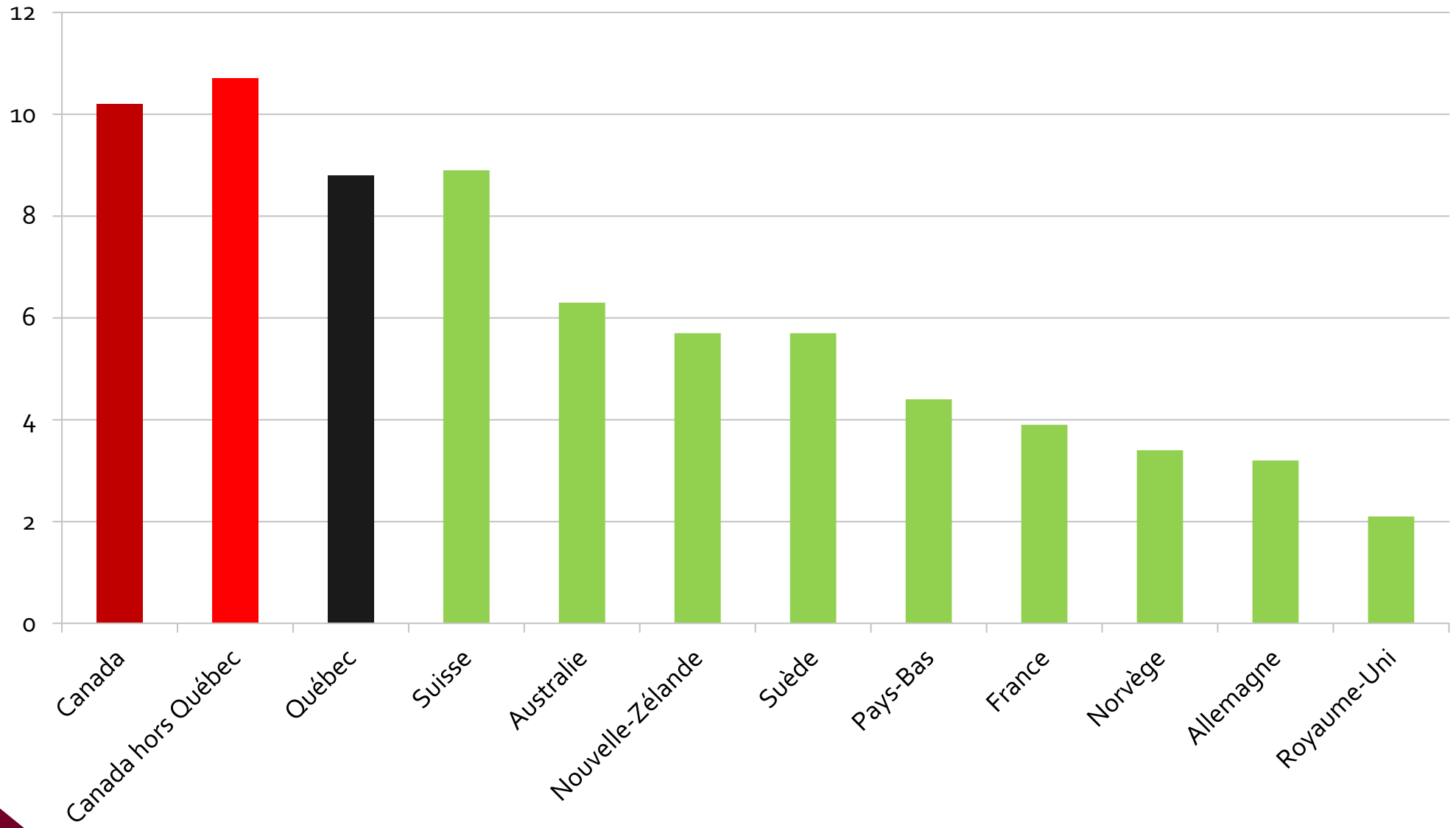


## Figure 1
## Drug financing approaches to access prescription drugs




Source: Adapted from Evans 2008

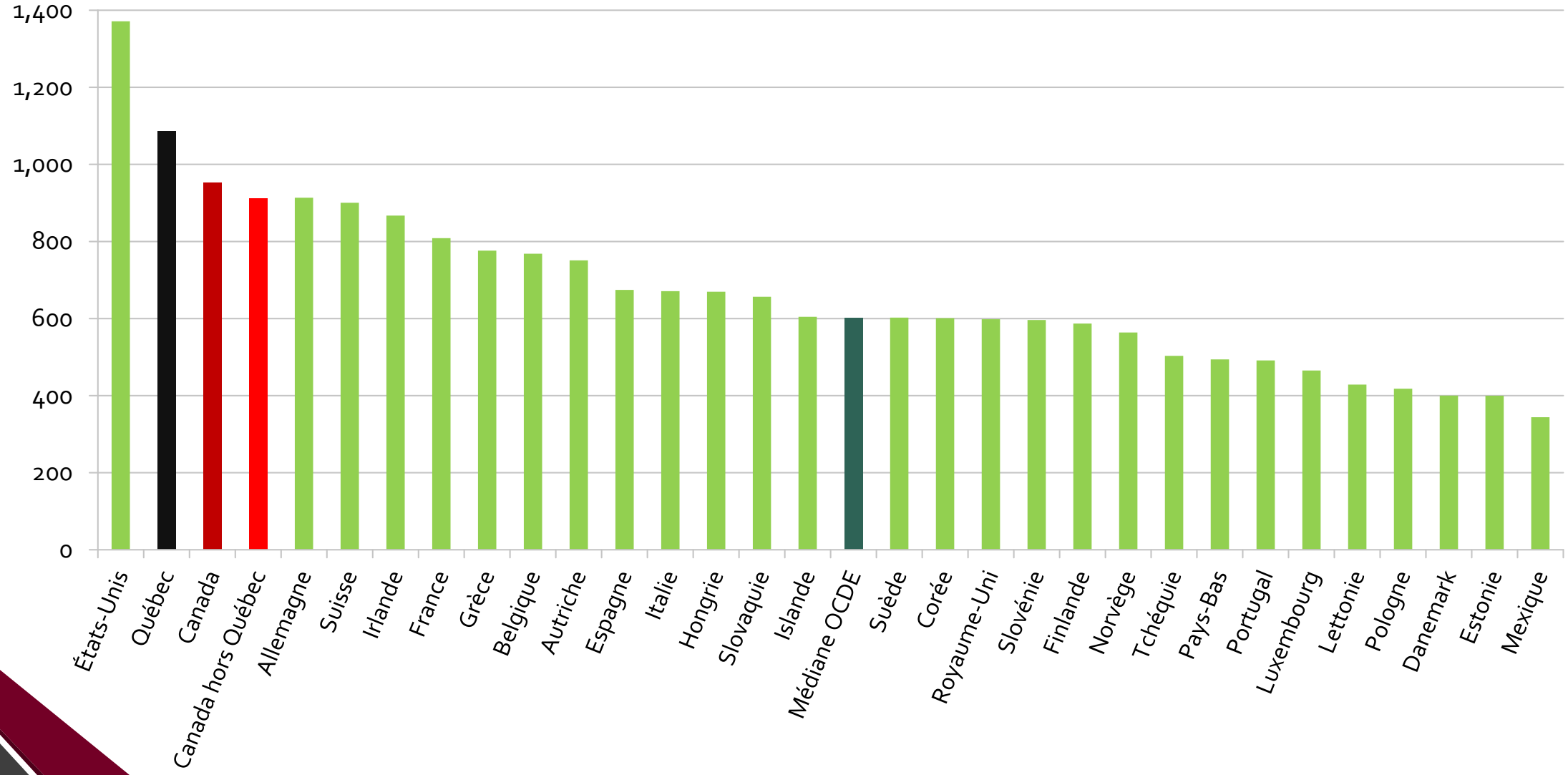
# Percentage of population (18+) that did not fill at least one prescription for financial reasons in 2016: Canada, Québec and comparable countries with universal drug coverage.



# Total expenditure per capita on medications, 2014 or nearest year. All OECD Declaring countries (+Quebec)

**CAN$, purchasing power parity**

**Source: CIHI, OECD Health Statistics 2014**



# Collective Cost of Private Insurance

- (Institutional) Skimming
- Waste ($5.1 bn)
- Tax subsidies ($1.2 bn)
- Administration costs ($1.3 bn)
- Private Coverage of Public Employees ($3 bn)

ALTAUSTERITY

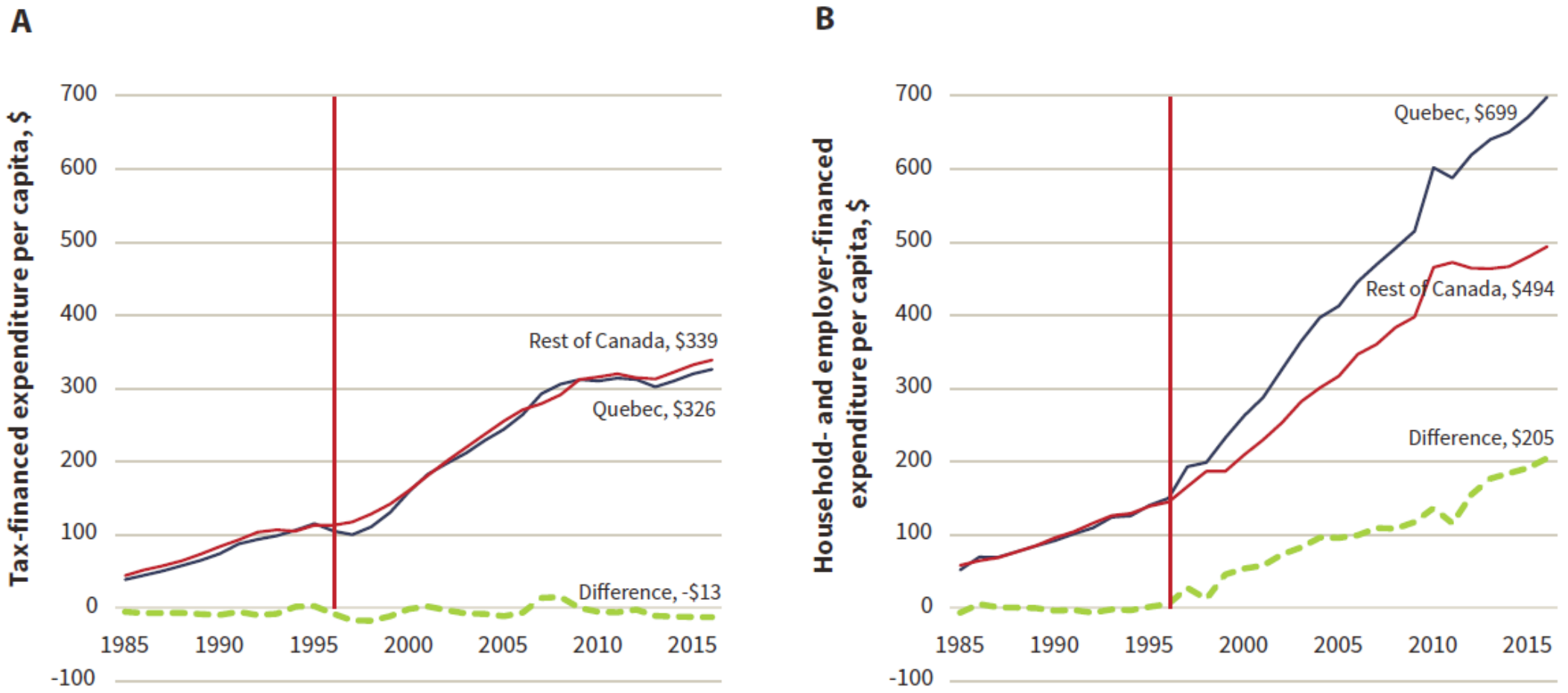
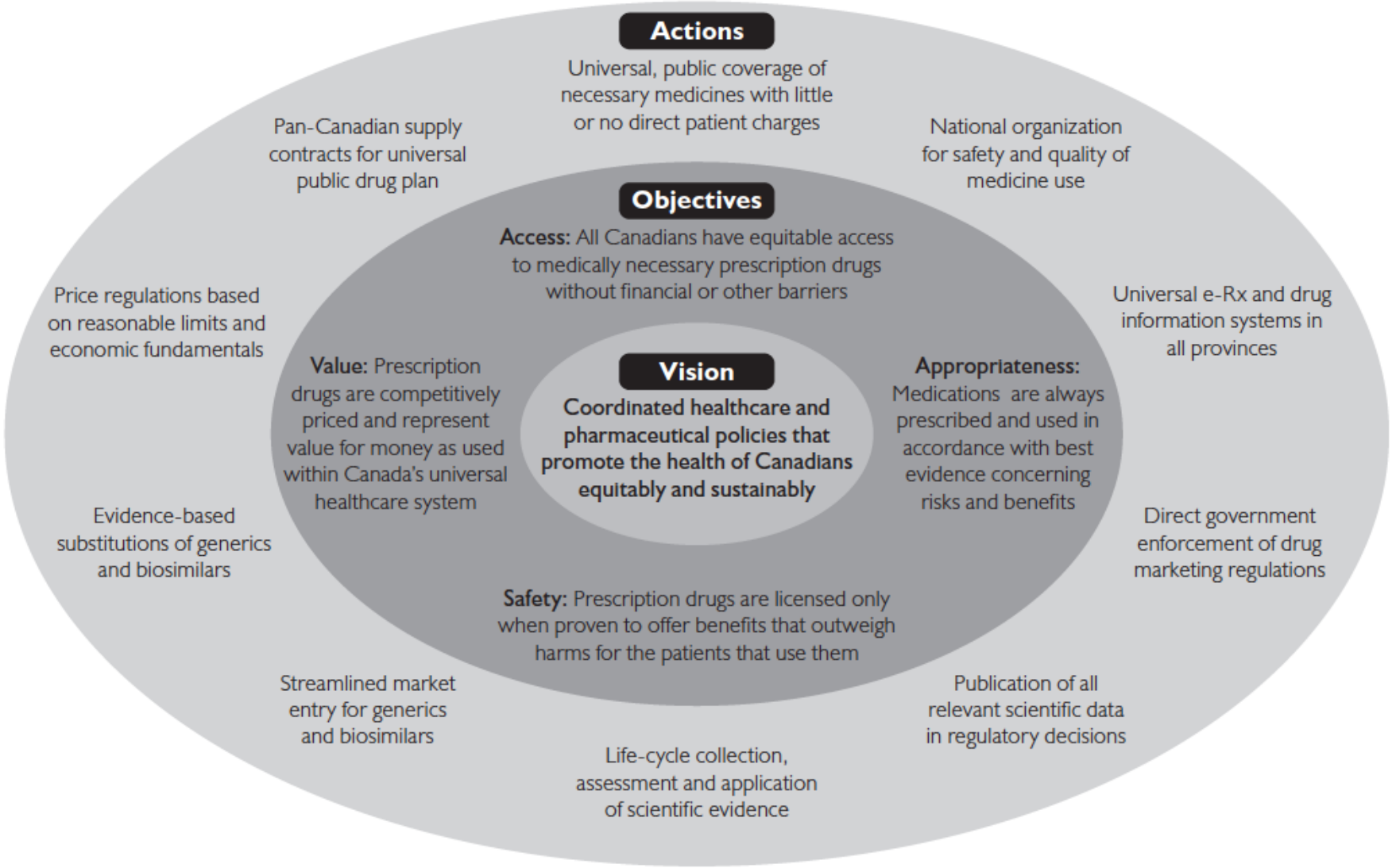



**Figure 1:** Expenditure per capita on prescription drugs from 1985 to 2016 in Quebec and the rest of Canada, (A) tax-financed versus (B) household- and employer-financed. Source: Authors' calculations-based data from Canadian Institute for Health Information National Health Expenditure Trends, 1975 to 2016.[23] Tax-financed expenditures are those paid through government general revenues; household- and employer-financed expenditures are those paid out of pocket or through premium contributions to mandatory private or public insurance plans. Quebec data for 2015 and 2016 projected based on five-year average growth rates.

**FIGURE 1.** A renewed strategy for pharmaceutical policy, guided by a clear and compelling vision with supporting policy objectives and actions



## Estimation of the costs and benefits generated by a Canadian universal pharmacare program, keeping the same industrial policies associated to drug costs, based on 2012-2013 figures

| | |
|---|---|
| 1. Prescription drug expenditures in 2012 | $27,734 million |
| **Distribution of prescription drug costs/benefits** | |
| 2. Growth in expenditures from increase in use | +10% of actual expenses |
| 3. Reduction in expenditures from decrease in dispensing fees | -2% of actual expenses |
| 4. Reduction in expenditures from drug assessment | -4.3% of actual expenses |
| 5. Elimination of the monthly deductible in Quebec | -$364 million |
| 6. Generic drugs tendering process | -$642 million |
| Total savings on prescription drugs | -$155 million |
| **Total prescription drug expenditures with a universal pharmacare plan** | **$27,579 million** |
| **Additional impacts other than for prescription drugs** | |
| 7. Elimination of extra administrative costs of private plans | -$1,349 million |
| 8. Elimination of tax subsidies | -$1,204 million |
| **Total of additional impacts** | **-$2,553 million** |
| **Total net savings** | **$2,708 million (10% of expenditures)** |

Source: Author's figures; Gagnon and Hébert, 2010

## Cost and savings estimations from implementation of a Canadian universal pharmacare program with repeal of industrial policies associated to drug costs based on 2012-2013 figures

| | |
|---|---|
| **1. Current expenses in prescription medication** | **$27,734 million** |
| **Allocation of costs/profits in prescribed medications** | |
| Savings per competitive pricing | -$9,920 million |
| 2. Expenses increase by consumption increase | +10% of expenditures |
| 3. Expenses decrease according to decrease in dispensing fees | -2% of expenditures |
| 5. Elimination of monthly deductible – Quebec | -$364 million |
| Total savings for prescription drugs | -$8,895 million |
| **Total expenses for prescription drugs within a universal pharmacare program** | **$18,839 million** |
| **Additional impacts (other than prescription drugs)** | |
| 7. Eliminating private plan administrative costs | -$1,349 million |
| 8. Eliminating tax subsidies | -$1,204 million |
| Total additional impacts | -$2,553 million |
| **Total balance of savings** | **$11,448 million (41% of expenditures)** |

Source: Author's figures; Gagnon and Hébert, 2010

# Estimated cost of universal public coverage of prescription drugs in Canada

Steven G. Morgan PhD, Michael Law PhD, Jamie R. Daw BHSc MSc, Liza Abraham BSc, Danielle Martin MD MPubPol

**Table 2:** Estimated total change in public and private retail spending on prescription drugs with universal public coverage, all provinces combined

| Spending | Actual retail spending 2012/13, $ millions | Change in spending, $ millions (% change) | | | | | |
|---|---|---|---|---|---|---|---|
| | | Base scenario | | All model parameters set to worst-case scenario values* | | All model parameters set to best-case scenario values* | |
| **Public** | | | | | | | |
| Direct public spending on public drug plans | 9 725 | 3 383 | (35) | 7 813 | (80) | –438 | (–5) |
| Indirect public spending on private drug plans | 2 425 | –2 425 | (–100) | –2 425 | (–100) | –2 425 | (–100) |
| Subtotal | 12 151 | 958 | (8) | 5 388 | (44) | –2 863 | (–24) |
| **Private** | | | | | | | |
| Private-sector spending on private drug plans | 5 659 | –5 659 | (–100) | –5 659 | (–100) | –5 659 | (–100) |
| Patient out-of-pocket spending | 4 534 | –2 556 | (–56) | –3 911 | (–86) | –896 | (–20) |
| Subtotal | 10 193 | –8 215 | (–81) | –9 569 | (–94) | –6 555 | (–64) |
| **Total** | 22 344 | –7 257 | (–32) | –4 181 | (–19) | –9 418 | (–42) |

*From the perspective of assessing the cost-impact to government.

# PBO report: Federal cost of a National Pharmacare Program (savings $4.2 bn)

Table 3-7

After appling all assumptions, a Pharmacare program with the parameters outlined by the Commons committee would cost 83 per cent of current total expenditure on prescription drugs, or $20.4 billion, if it had been implemented in 2015-16.

Total Pharmacare Expenditure

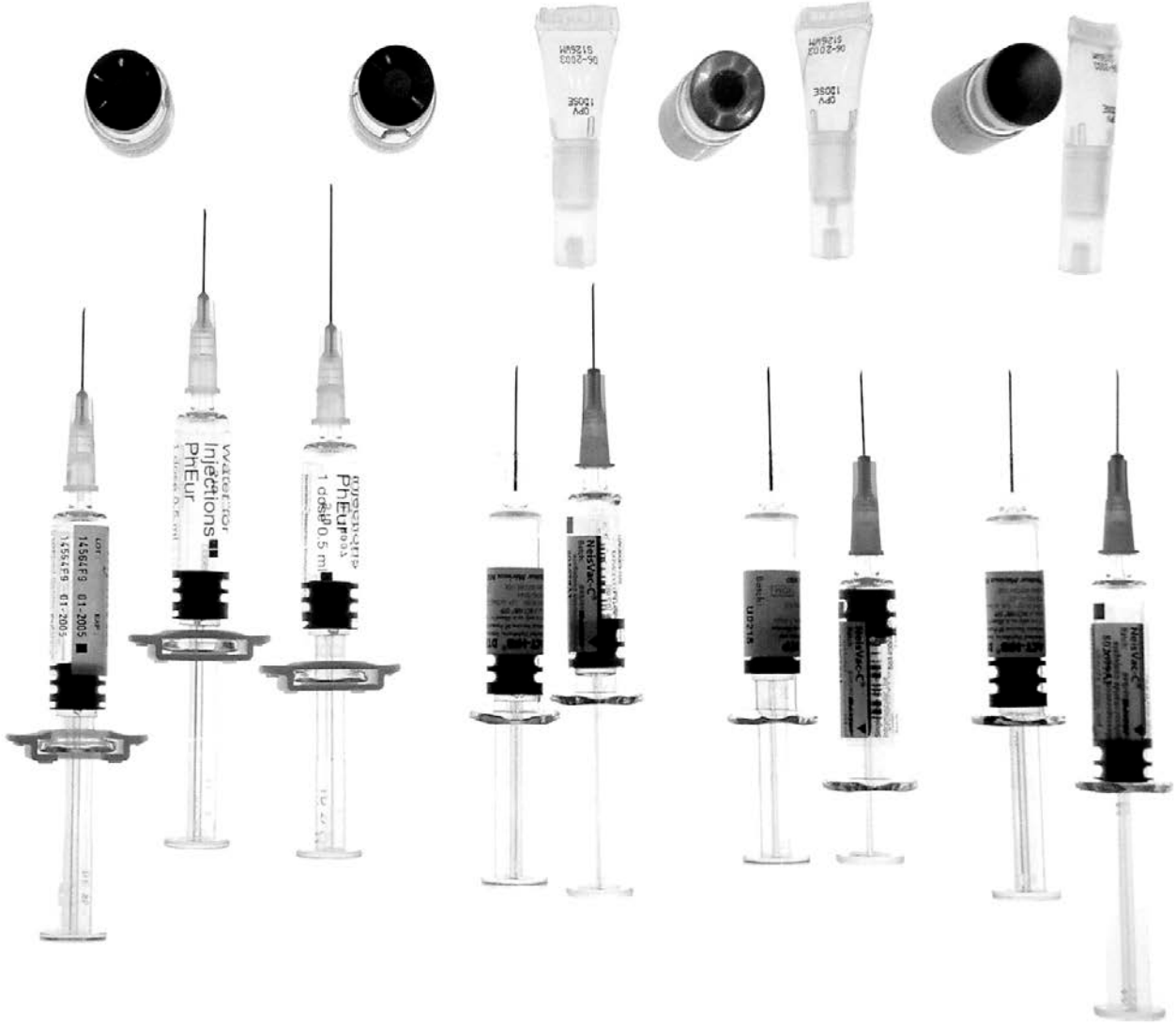
| | Current $RX | RAMQ | + Beh. effect | + Lowest ppu* | + Gen. Subst. | + 25% discount |
|---|---|---|---|---|---|---|
| AB | $2,723.3 | $2,311.1 | 107% | 101% | 99% | $1,873.5 |
| BC | $2,812.2 | $2,429.7 | 107% | 102% | 99% | $1,974.8 |
| MB | $820.2 | $724.2 | 107% | 100% | 98% | $590.1 |
| NB | $700.2 | $616.3 | 107% | 101% | 100% | $503.5 |
| NL | $465.5 | $403.1 | 108% | 101% | 99% | $333.2 |
| NS | $797.4 | $697.5 | 107% | 101% | 99% | $564.9 |
| ON | $11,306.3 | $9,349.5 | 107% | 100% | 98% | $7,431.6 |
| PE | $101.3 | $88.2 | 108% | 101% | 99% | $72.3 |
| QC | $8,053.8 | $7,246.7 | 108% | 107% | 105% | $6,436.0 |
| SK | $769.0 | $686.5 | 108% | 103% | 101% | $581.9 |
| **CDA** | **$28,549.1** | **$24,552.8** | **107%** | **103%** | **100%** | **$20,361.8** |

Source: PBO calculations of data from QuintilesIMS.

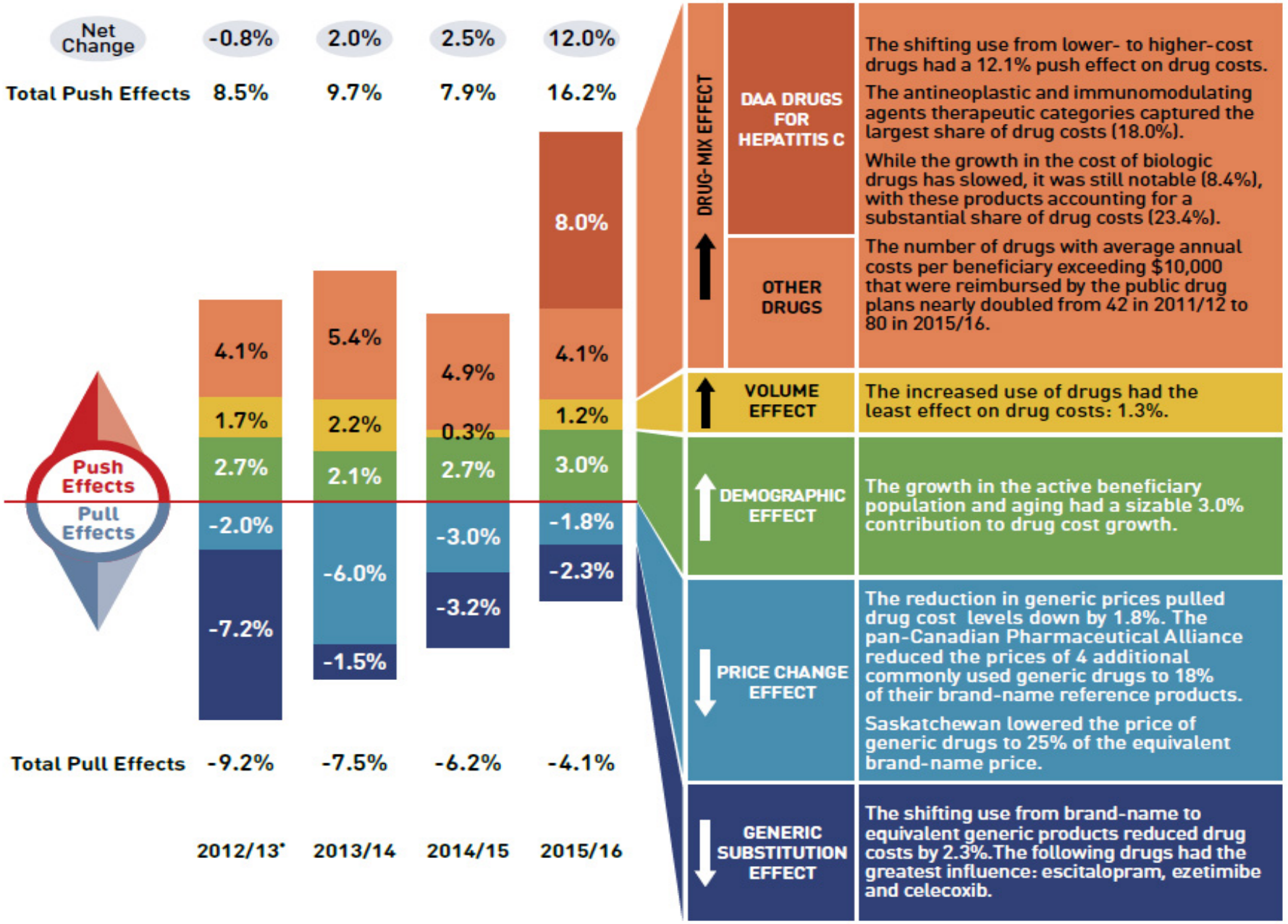
Notes: *ppu – price per unit

Percentages are calculated in reference to RAMQ values.

# Access to treatments



# Overview of Drug cost drivers




**Data source:** National Prescription Drug Utilization Information System Database, Canadian Institute for Health Information.

Manulife:
Drugwatch

Great West Life:
SMART

Sunlife:
Drug Risk
Management

FOCUS update
group benefits news
October 12, 2017

## Mass Contract Amendment – Drug Risk Management (DRM) - Reminder

As communicated in our August 31 Focus Update, we will be introducing an additional layer of review for new drugs and new usages for existing drugs. We will be implementing this change on **November 1 2017**, and will be amending your contract to reflect this.

### Drug Risk Management (DRM)

To better mitigate the risks associated with new high-cost drugs coming to market and to better align us with those of the industry, we have enhanced our drug review process.

Through our pharmacoeconomic assessment, Sun Life determines which drugs should be covered under our plans – and places the new medication in our group benefits plan, by determining if it should be:

- covered under the plan;
- covered under the plan but subject to the PA Program, if applicable; or
- excluded from the plan.

Review timelines will vary from an almost immediate decision to a couple of weeks/months for more complex drugs. Once the drug claims for this medication are deemed eligible, they can then be submitted at the pharmacy, reimbursed, and the patient may begin his treatment.

Our expert team of pharmacists leads this proactive governance and ensures members get access to the right drug, at the right time and for the right indication.

To help you better visualize our DRM process, we have prepared this flowchart.

**Reminder: Your contract will be amended effective November 1, 2017.**

**February 2015:**
**$5M hepatitis C strategy announced by P.E.I. government; P.E.I. is first province to offer newly-approved treatments with cure rates of 95% to 100%**

**March 2018**
**Ontario Expands Patient Access to Chronic Hepatitis C Therapies On Public Drug Plan, Regardless of the Severity of the Disease**

**March 2018:**
**B.C. expands drug coverage to anyone suffering from chronic hepatitis C**

**holkira™ pak**
ombitasvir/paritaprevir/ritonavir film-coated tablets
and dasabuvir film-coated tablets

# What do we want?

**Universal, Public, Evidence-based, Pan-Canadian, Comprehensive, Integrated Pharmacare Program with first dollar coverage for medically necessary cost-efficient drugs**

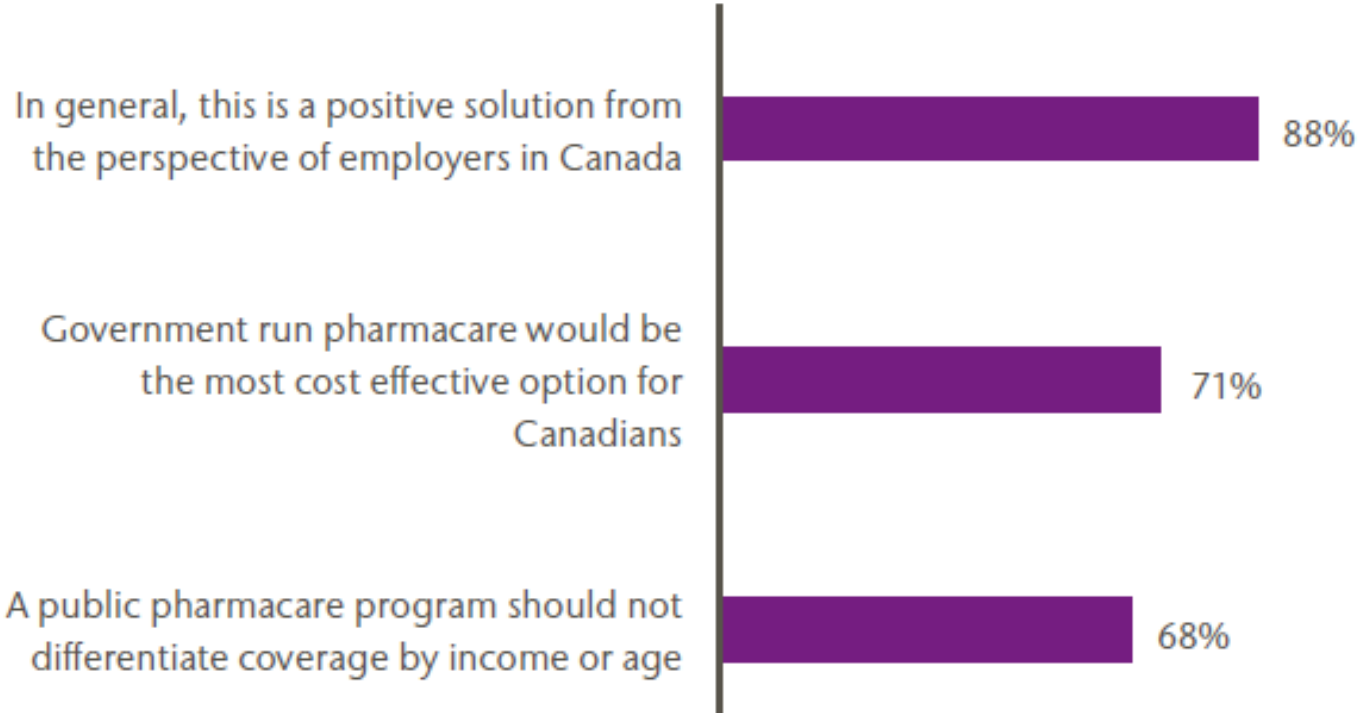
Who supports Universal Pharmacare ? Perspective of Employers

(Aon Hewitt 2016)

## Model 1: A pharmacare program that is mandated and administered by governments under principles similar to those of the Canada Health Act

In general, employers feel that a government administered program would be a positive solution; however, there appears to be some skepticism that good decisions would be made regarding coverage. Because of this, most still see a need for supplemental employer-paid coverage even if a government-run national pharmacare program existed.

*Percentage of employers that agree with statements regarding a scenario in which current medicare programs were expanded to include prescription drugs subject to national standards.*



# A universal pharmacare program is not a panacea. But, if implemented with the needed institutional capacities:

- Would improve access to medicines, appropriateness of prescribing, and health outcomes.
- Outside Quebec, would generate savings of 25% on prescription drugs (according to PBO).
- Would increase net disposable income for all Canadians.
- Would reduce labour costs for Canadian enterprises.
- Would allow Canada to stop being a model of waste and inefficiency when it comes to drug coverage.

ALTAUSTERITY

# Additional References


- Marc-André Gagnon. *Roadmap to a Rational Pharmacare Policy* (CFNU): https://nursesunions.ca/sites/default/files/pharmacare-report/index.html
- Marc-Andre Gagnon and Guillaume Hébert. *The Economic Case for Universal Pharmacare* (CCPA and IRIS) : www.pharmacarenow.ca
- Steve Morgan, Jamie Daw and Michael Law. *Rethinking Pharmacare in Canada* (C.D. Howe Institute): http://www.cdhowe.org/pdf/Commentary_384.pdf
- *Pour un Régime d'assurance-médicaments entièrement public* (Union des consommateurs): http://uniondesconsommateurs.ca/nos-comites/sante/rapports-et-memoires/pour-un-regime-dassurance-medicaments-entierement-public/
- Steve Morgan, Danielle Martin, Joel Lexchin, Marc-André Gagnon, Jamie Daw, Barbara Mintzes. *The Future of Drug Coverage in Canada.* Pharmacare 2020, July 2015: http://pharmacare2020.ca/
- Steve Morgan, Jamie Daw, Michael Law , Liza Abraham and Danielle Martin. "Estimated Cost of Universal Public coverage of prescription drugs in Canada". CMAJ. March 16 2015: http://www.cmaj.ca/site/press/cmaj.141564.pdf


ALTAUSTERITY

# Join the Conversation

Ma.gagnon@carleton.ca | @MA_Gagnon

Learn about our project and see more of our research and media:

http://altausterity.mcmaster.ca/

https://twitter.com/altausterity

*#altausterity*

ALTAUSTERITY