AUSTERITY and its ALTERNATIVES

Getting More for Less

Universal Pharmacare as an Alternative to Austerity

Marc-André Gagnon
Carleton University, Canada

March, 2018

Carleton UNIVERSITY

ABOUT US

Austerity and its Alternatives is an international knowledge mobilization project committed to expanding discussions on alternatives to fiscal consolidation and complimentary policies among policy communities and the public. To learn more about our project, please visit www.altausterity.mcmaster.ca.

Austerity and its Alternatives is funded through the Partnership Development stream of the Social Sciences and Humanities Research Council (SSHRC).

About the Authors

Marc-André Gagnon (MarcAndreGagnon@cunet.carleton.ca)

Marc-André Gagnon is an associate professor in the School of Public Policy and Administration at Carleton University.

Report designed by the Centre for Communicating Knowledge at Ryerson University (excluding cover page).

Carleton UNIVERSITY

ALT AUSTERITY

Introduction

Canada is the only country with a universal health care system that does not include prescription drugs, as if prescription drugs were not an essential health care service. In Canada, access to prescription drugs for the working population is still organized first and foremost as a privilege offered by employers to employees. On average one out of ten Canadians admitted not filling a prescription or skipping doses in the last year due to financial reasons.

Countries with universal drug coverage not only provide better access to prescription drugs to their population, but also spend on average 30% less per capita on prescription drugs. For many years the debate has been raging in Canada about the necessity to scrap the current patchwork of public and private drug plans and introduce universal public drug coverage.

In its last budget in March 2018, the Federal Government announced the implementation of an Advisory Council for the Implementation of National Pharmacare. It seems that the debate about national pharmacare has switched from "should we have national pharmacare?" to "what type of national pharmacare should we implement?" Health policy experts are overwhelmingly supporting the idea of universal pharmacare (a public drug plan that would cover all Canadians in the same way). The Parliamentary Budget Officer showed that such a system would not only provide better access to prescription drugs for Canadians, but it would also reduce total spending by around 20%. Other studies using different assumptions showed that savings could be between 10 and 41%, or between 19 and 42%. After two years of consultation on this issue, the Standing Committee on Health at the House of Commons recommended in April 2018 the inclusion of prescription drugs in the existing Canadian Universal health care system.

Nevertheless, another option receives a lot of support. Some have been arguing for a national plan that would preserve current private plans and simply "fill the gaps" by providing coverage only to those who fell through the cracks of the current Canadian patchwork system. This second option would mimic the hybrid public-private system of mandatory drug coverage found in Quebec. The problem with this option is that, instead of achieving significant savings by eliminating the fragmentation in drug coverage, it would increase spending on prescription drugs without implementing any measure to contain costs and reduce drug prices. Quebecers spend around 20% more on prescription drugs than the rest of Canada, but does not a lot better than other provinces in terms of improved access to prescription drugs. More spending by some means more income for others. It is thus not a surprise that this second option is strongly supported by commercial interests like insurance companies, drug companies and pharmacy chains (which benefit from the current system by capturing higher margins on drug prices and charge higher dispensing fees to private drug plans).

The advocates of the "fill the gaps" approach use two main arguments: 1.Current patchwork coverage provides better therapeutic choice for patients with private coverage. 2.Filling the gaps would cost less public money than universal pharmacare. Let's analyze these two arguments one by one.

Greater Choice for Patients?

Public plans, which cover around 50% of the Canadian population, normally require value for money, which means that they assess the therapeutic value of a new drug before accepting its reimbursement. In comparison, for many years most private plans in Canada accepted to reimburse any new drugs at any price. Just imagine for a second that a customer at Tim Hortons enters the restaurant and says that he is willing to buy anything at any price. We can expect that the check will be expensive. Now imagine that year after year half the clients at Tim Hortons say that they will buy anything at any price. What do you think will be on the menu after 20 years? Healthier food at lower prices or junk food at very high prices?

To be approved by Health Canada, a new drug simply needs to show that it is better than a placebo, and not necessarily better than existing drugs. By accepting to pay for any drug at any price, there is no incentive for drug companies to produce real therapeutic innovation. Instead, drug companies can create commercial success out of huge marketing campaigns for expensive but therapeutically insignificant products. Year after year, annual reports of the Patented Medicines Price Review Board show that between 2010 and 2017, four out of five patented drugs that entered the Canadian market did not represent a significant therapeutic improvement as compared with existing products.

In this context, should we be surprised that the only Canadian "Big Pharma" company, Valeant, has developed a business model focused on mergers and acquisitions in which returns are obtained by increasing prices and closing down research labs? Valeant made this their operating principles in their annual report, in which they explain their bias towards products reimbursed by private insurance:

> "Over 75% of our product sales are also cash pay or reimbursed through private insurance, helping to protect us from government-driven price decreases that are becoming increasingly common around the world. We expect to continue our focus on durable products in less price-sensitive markets"

The more a reimbursement system provides incentives for drugs with insignificant therapeutic value, the less incentive it provides for innovative products with significant therapeutic value, the lesser is the therapeutic choice for patients.

Private Plans Now Less Generous

In the last 5 years, many new drugs arrived on the market with astronomical price tags, from orphan drugs (for rare diseases) to oncology treatments, including hep C drugs. The cost impact of these drugs has been a serious challenge to public and private insurers. Public plans reacted with strong price negotiations and treatment tiering (by paying first for the least expensive of clinically similar treatments), while private plans reacted by increasing the financial burden of patients; for example by increasing co-pays and deductibles, or by including annual or lifetime caps.

In fact, private health insurers no longer offer "more generous" drug coverage than public plans. In Canada, around two-thirds of private drug plans are managed by one of the big three insurance companies: Sunlife, Great West Life and Manulife. These companies normally offer fully insured plans to smaller employers and "administration services only" (ASO) plans to larger employers.

The fully insured plans offered by these companies were recently modified to mimic public plans. For example, in 2015 Manulife announced their DrugWatch program, which requires that new drugs receive approval by the Canadian Agency for Drugs and Technology of Health, before they can be considered for reimbursement. The Canadian agency analyzes cost-effectiveness for public drug plans. In 2017, Great West Life and Sunlife began similar default programs, namely SMART and Drug Risk Management that evaluate new expensive drugs before reimbursement. Private plans are thus reducing their coverage because of high cost drugs. Meanwhile, the fragmentation caused by private plans in Canadian coverage inhibits our collective capacity to reduce drug prices through cost-effectiveness and rational use of medicines.

Many ASO plans still cover anything at any cost. However, considering that many households have spousal plans, if fully insured plans refuse to pay for new expensive drugs when others agree to do so, one can expect massive cost-shifting towards ASO plans. One can easily predict most ASO plans will also need to reduce the level of drug benefits at one point or the other.

What About Very Expensive Drugs

A fully public and universal pharmacare can go a long way to achieve better access for expensive drugs. A non-fragmented universal public plan based on the active management of a national formulary could allow reducing drug prices through active negotiations, discriminating in favour of therapeutically significant

drugs, lowering co-pays for patients, and ensuring getting value for money. A good example is the new generation of treatments against hepatitis C. A wave of new hep C drugs arrived on the Canadian market in 2015 including Sovaldi by Gilead Science, Daklinza by Bristol Myers-Squibb and Holkira Pak by Abbvie. While hep C is not a rare disease, these new drugs that can now cure the disease, were priced at a very high level ($55,000 for a twelve weeks treatment with Sovaldi). The problem is that at this price, treating the 245,000 Canadians with hep C would mean spending more than $13 billions, which is more than half of what we spend on all prescription drugs every year. Note that willingly pricing the drug in a way that it is not affordable for everyone might not be the most charitable decision, but it is an excellent business decision to preserve a "disease pool" that will reproduce the market for hep C for the time the drug is patented.

Private and public plans reacted in different ways. Most private plans simply accepted to cover the drug for everyone at full price. One might think that this "generous" coverage offers patients a better access to the drugs they need; however this assumption is, again, wrong. Most people with private coverage normally have to pay a co-insurance rate: for example, a co-insurance rate of 20% means that the patient still has to pay $11,000 out-of-pocket, which remains unaffordable for many. Furthermore, the financial pressure of Hep C drugs on private plans is not foreign to the reasons why large insurers changed their default drug insurance plans to evaluate new drugs before approving reimbursement.

The outcome with public plans was completely different. First, public plans refused to reimburse the drug for everyone with hep C. Only people at a late stage of hep C were able to access the drug, which is far from an optimal solution. Prince Edward Island was the first province to find a more interesting solution by using the differential advantages offered by a public drug plan. Instead of reimbursing all drugs at full price, Prince Edward Island decided, instead, to bargain with drug companies. The province struck a deal with Abbvie and announced a $5 million program to cover the 400 people with hep C on the island, which means that they were able to obtain the treatment for Hep C at $12,500 per patient, allowing the province to provide the drug to all patients, not only those at late stages. Ontario and British Columbia then followed PEI's lead and announced similar deals in March 2018.

A good public drug plan refuses to pay for anything at any price and focus on getting value for money. As such, it can provide much better access to the drugs Canadians need, in a sustainable way.

The Public Cost for Filling the Gaps

The second argument for the "fill the gap" approach is that it reduces public spending as compared to universal pharmacare.

It is unclear if this would really be the case. 30% of the $10 billion spent in private drug coverage each year is for the private drug coverage of public employees. The Federal and Provincial Governments offer generous tax subsidies for health benefits by not taxing the employee's marginal income represented by the health benefits. These subsidies, which represent around 20% of the amount spent by private plans are very problematic because the higher your income, the higher your marginal income tax rate, and thus the larger the subsidy you receive. The "fill in the gaps" approach thus wants to preserve a system based on regressive subsidies benefiting the richer.

Finally, the advocates of the "fill in the gap" approach have also been lobbying public plans to allow coordination with public catastrophic drug coverage. For example, in Ontario, the Trillium public drug plan will provide almost complete coverage once you spent more than 4% of your annual income in prescription drugs. The coordination of plans means that private plans will pay for the equivalent of the first 4% of the annual income of the employee, and the latter will then be dumped on the public plan to pay for the rest of the coverage. We end up in a formidable dynamics of institutional skimming where employees representing "good risks" stay on private plans while "bad risks" are dumped in the public plans. Nothing is done to contain costs, but everything is done to shift catastrophic costs out of private plans as an institutionalized system of risk selection. Let it be clear, when "fill in the gaps" advocate demand public catastrophic coverage for all Canadians, what they are asking is that the public plans should be designed to serve the commercial needs of private plans instead of the health needs of the population.

Still, one could say that "filling the gaps" would save public money, even if it is more expensive overall for Canadian households, and this is a good thing because people want lower taxes. However, the reason why people want lower taxes is that they want higher net disposable income. Universal pharmacare is not about increasing taxes, it is about increasing net disposable income for Canadian households while reducing labour costs for Canadian enterprises and improve their competitiveness.

Current drug coverage in Canada is an inequitable, inefficient and unsustainable patchwork with no coherence or purpose. We pay more and get less than comparable countries with universal pharmacare. Some would like you to think that we can solve the problem by adding more patches, but the core of the problem is that it is a patchwork.