

**Policy Options: Towards Making a Universal Prescription Drug Policy for
Canada**

by

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Abstract

A universal prescription drug coverage policy remains an unfinished business of Canadian healthcare system with over sixty year long historical roots. Since national medicare doesn't provide prescription drugs outside of hospitals, provinces and territories have independently developed public drug insurance programs (primarily for seniors and the poorest on social assistance) under various eligibility and patient cost-sharing arrangements. The absence of universal public coverage inevitably created a large role for private financing of prescription drugs by means of a variety of costly private insurance plans and out-of-pocket payments that many Canadians cannot afford. This situation has by now driven the system to a crisis point where the phenomenon of fast-rising costs of medically necessary drugs has added further adverse effects on public health, in terms of reduced equity of access and lost socio-economic wellbeing. It costs the health system billions of dollars downstream by requiring additional visits to physicians and resulting hospitalizations as patient health conditions deteriorate due to cost-related non-adherence to prescriptions. In the past a number of attempts towards making a national pharmacare failed and the status quo with a confusing patchwork prevailed. Of late, the federal government has taken a sincere initiative to implement a universal drug coverage plan inclusive of some measure of user-charge. This study evaluates the likely impact of different types of patient charges in a public system of prescription drug coverage for Canada. Employing qualitative and quantitative methods of analysis, it examines both primary and secondary data to evaluate the three policy options considered in this study. Taking all aspects into account, reasonable policy recommendations are made to make an affordable and efficient prescription drug coverage for all Canadians with the aim of reducing cost-related non-adherence to prescriptions, providing improved access to medications and, in the end, to achieve better health outcomes.

Keywords: pharmacare; medicare; regressive impact; moral hazard; deductible; premium; coinsurance; copayment; cap; ceiling; generics, formulary

Dedicated to
my father
Professor Amanullah Khan
and
my mother
Mrs. Noor Mahal Khan

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CHAPTER 1

Introduction

As of now, prescription drug coverage in Canada relies on a patchwork system of 113 public plans and more than 100,000 private plans.¹ This vast number of drug insurance plans, however, offers no ground for comfort. The Final Report of the Advisory Council on the Implementation of National Pharmacare, published in June 2019, discovered that despite numerous public and private plans “One in five Canadians [i.e., about 20% or 7.5 million] struggle to pay for their prescription medicines. Three million don’t fill their prescriptions because they can’t afford to. One million Canadians cut spending on food and heat to be able to afford their medicine. Many take out loans, even mortgage their homes. Sadly, far too many Canadians die prematurely or endure terrible suffering, illness or poor quality of life because modern medicines are out of reach for them.”²

The provincial drug plans have different criteria for reimbursement. Premiums, deductibles, copayments, co-insurance and maximum annual beneficiary contributions vary across the provinces and influence the magnitude of annual costs incurred by Canadian patients. A close review of four representative provincial models illustrates the complex patchwork character of pharmaceutical insurance and cost-sharing: (i) British Columbia’s family-income-based voluntary plan, (ii) Alberta’s premium-based voluntary plan (iii) Ontario’s age-based and income-tested voluntary plan, and (iv) Quebec’s premium-based employer-centered mandatory plans. Details of each provincial plan are shown in Appendix 1.

¹ Morgan, S. *Evaluating National Pharmacare Options: Existing Policies Across Canada (a report prepared for the Advisory Council on the Implementation of National Pharmacare)*; cited in Health Canada, *A Prescription for Canada: Achieving Pharmacare for All* (Final Report of the Advisory Council on the Implementation of National Pharmacare (Ottawa: Health Canada, June 2019), Annex 4: pp. 134-5.

² Health Canada, *A Prescription for Canada: Achieving Pharmacare for All*, *ibid.*, p. 7; explanatory words inside the brackets added.

Despite implementation by each province of a prescription drug coverage the latest national survey in October 2020 finds that the share of Canadians not filling or renewing their prescriptions due to cost concerns is rapidly rising.³ Whereas in 2019, one-in-five or 20% were not filling their prescriptions, in 2020 this figure rose to almost 25% or a quarter of all Canadians. In addition, more than two-in-five (44%) of Canadians are concerned about their ability to afford prescription drugs in 10 years. Only one-quarter (24%) felt very confident about being able to afford their prescription drugs.⁴

The idea of universal drug coverage, as a part of universal healthcare has long been debated in Canada. **The Commission on the Future of Health Care in Canada** (2002), chaired by Roy J. Romanow recommended federal and provincial (and territorial) governments work together to cover prescription drugs within Medicare and adopt a long-term strategy of a "comprehensive drug coverage". As a first step toward that goal, the Commission recommended, federal government make Catastrophic Drug Transfer (additional funds) to offset the cost of provincial and territorial drug plans to protect people from high drug-costs. It also recommended creating a national drug agency, a formulary, a new medication management program, and reviewing certain aspects of Canadian patent law.⁵

The Romanow Commission argued that, when Medicare was first introduced in the 1960s, prescription drugs played a limited role in the healthcare system and in the day-to-day lives of the vast majority of Canadians. But the situation was different by 2002 as prescription drugs played a greater role. In the Commission's view, given the expanding role of prescription drugs in Canada's

³ Angus Reid, 'Access for all: Near Universal Support for a Pharmacare Plan Covering Canadian's Prescription Drug Costs'. October 29, 2020; <https://angusreid.org/pharmacare-2020/>

⁴ Angus Reid, *ibid.*

⁵ Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Commissioner: Roy J. Romanow), 2002, pp. xxxii-xxxiii

healthcare system, **prescription drugs can be considered as medically necessary as hospital or physician services.**⁶

The **Standing Senate Committee on Social Affairs, Science and Technology Report on the State of the Health Care System in Canada** (2001-02), chaired by Senator Michael J.L. Kirby, looked at the federal role in healthcare, with special reference to the supply side, human resources and the need for greater competition, etc. On issues relating to prescription drug coverage, the Kirby Committee said that no Canadian should suffer undue financial hardship because of the cost of prescription drugs. It opined that the federal government should cover 90% of the cost. It also called for the federal government to work closely with provinces and territories to establish a single national formulary.⁷

The Committee argued that the *Canada Health Act* does not preclude private insurers from supplementing provincial health care insurance plans.⁸ It proposed four possible options for a national pharmacare initiative – (i) a comprehensive public program (fully public), (ii) a comprehensive public/private initiative (partnership effort among the federal government, provincial governments and the private sector for providing coverage for all drug expenses), (iii) public/private initiative to protect against high drug expenses (shared effort among the federal government, provincial governments and the private sector only against high drug costs) and (iv) tax initiative to protect against high drug expenses (Canadians receive a tax credit for ‘medically necessary’ prescription drug expenses above a threshold, e.g., above a certain percentage of income).⁹ However, in the sixth and final volume of the report it states that the Committee supports the five principles of the *Canada Health Act* and declares that none of its recommendations require any change to the *Canada Health Act*.¹⁰

⁶ Ibid., pp.189-190.

⁷ Health Canada, *A Prescription for Canada: Achieving Pharmacare for All*, *ibid.*, p.31.

⁸ Standing Senate Committee on Social Affairs, Science and Technology, *Interim Report on the State of Health Care System in Canada* (Chair Michael J. L. Kirby), vol.1, 2001, p.98.

⁹ *Ibid.*, vol. 4, pp.77-80.

¹⁰ *Ibid.*, vol. 6, p.4.

Interestingly, of late, an encouraging level of consensus has emerged. In June 2019, the Advisory Council on the Implementation of national pharmacare recommended that “everyone in Canada should have access to prescription drugs based on their need and not their ability to pay, and delivered in a manner that is fair and sustainable.”¹¹ This recommendation, especially the commitment to delivering public pharmacare in a “fair and sustainable” manner, underscores the urgency of the call for an affordable national prescription drug plan for Canadians. I have thereby formulated the research question as follows: *Should the federal government include a cost-sharing component in the proposed universal prescription drug coverage for Canada?*

The research undertaken for this thesis essentially explores alternative theories and impacts of cost-sharing on prescription drug utilization. It analyzes both qualitative and quantitative data which help inform policy options aimed at implementing a universal public pharmacare and evaluate them on the basis of a set of criteria and measures. In the end, in light of the final analysis, recommendations are made with the goal of providing affordable prescription drugs for all Canadians.

¹¹ Health Canada, *A Prescription for Canada: Achieving Pharmacare for All*, *ibid.*, p. 1.

CHAPTER 2

Methodology of the Study

This section states, in brief, the mixed methods employed in this research project. It provides a detailed review of the complex cost-sharing options in present prescription drug programs across Canada. It includes in-depth interviews with healthcare professionals and policy experts conducted between July 2020 and November 2020. The analysis of the interviews identifies major themes to address before formulating workable policy options on prescription drug insurance for Canada. It also includes a quantitative survey using SurveyMonkey conducted from October to December 2020. Though the number of participants in the survey is modest, it represents a cross section of participants aware of the co-payment issues. It focused on some components of the prospective universal prescription drug policy and on the overall importance of such a policy compared to other public policy issues in Canada.

I have used a semi-structured questionnaire providing necessary probes for each question asked in the qualitative interviews. The interviews have been conducted, of necessity, via email. I have conducted a thematic analysis using a data matrix for the qualitative study, in addition to subjecting the quantitative data to applicable analysis using Excel. I have maintained a codebook for thematic analysis and a qualitative conceptual framework.

In doing the literature review, I used the SFU library database, Google Scholar, JSTOR (a scholarly journal storage), Canadian Institute for Health Information (CIHI), Statistics Canada, Health Canada, and all provincial and territorial websites for health and drug coverage details, as well as the websites of numerous think-tanks (e.g., Fraser Institute, C. D. Howe Institute, Institute for Research on Public Policy). In reviewing the literature, I used critical discourse analysis (CDA) as an analytical framework for studying connections between socio-political structures or nodes of power and ideologies expressed in the relevant literature. This required me to critically examine these reports within their historical, political, and socio-economic context. It has also been indispensable to evaluate the sensitivity of stakeholders (i.e., what it takes to move them) in

adopting and welcoming or, for that matter, resisting and blocking legislation and/or implementation of a particular public policy measure like the proposed universal pharmacare.

The steps I have followed in the literature review process can be outlined as follows:

- All relevant papers collected are listed using a spread sheet.
- A general summary of each document has been written in a Word file.
- A thorough analysis (taking all aspects of a particular paper into account) has been done.
- Notes have been re-examined to signify the dominant discourses of those papers.

CHAPTER 3

Theories of Cost Sharing and their Effect on Public Health

The national drug plan proposed by the Advisory Council has recommended a modest cost sharing formula for prescription drugs. The Council has recommended, “out of pocket costs for all products listed on the national formulary not exceed \$5 per prescription, with a copayment of \$2 for essential medicines and an annual maximum of \$100 per household per year.”¹² In recommending this, the Council has taken into account, implicitly, various often conflicting rationales for and against cost-sharing. The difference of opinion arises from disagreement over the nature of pharmacare:

- (i) Financing healthcare costs resembles private insurance plans where the liability is shared between the insurer and the insured;
- (ii) Healthcare is a public service and should be paid entirely out of general tax revenue.

The Advisory Council’s recommendation attempts a reconciliation between these two outlooks. This chapter assesses arguments for and against introducing direct patient cost sharing for accessing prescription drugs, and the theories on which they are founded.

3.1 Alternative theories of patient cost sharing

Different methods of cost-sharing (co-payments, deductibles, co-insurance and premiums) are intended either (a) to prevent ‘unnecessary’ (i.e. non-essential) utilization of necessary medication or (b) to reduce third-party payer expenditures by shifting part of the financial burden from insurers to patients. The inclusion of the rationale ‘unnecessary’ is based on two dimensions of information asymmetry: moral hazard and adverse selection. Information asymmetry arises when one party to

¹² Health Canada, *A Prescription for Canada: Achieving Pharmacare for All. Final Report of the Advisory Council on the Implementation of National Pharmacare* (Ottawa: Health Canada, June 2019), p. 63.

a transaction has relevant information that he or she could readily communicate to the other, but does not do so.

- (i) **Moral Hazard:** Moral hazard in the context of pharmaceutical insurance arises from the absence of any fiscal incentive on physicians or patients to be prudent. If the cost of a prescription drug is zero, a patient may pressure a physician to prescribe a clinically unnecessary drug. Neither the patient, nor the physician (nor even the pharmacist, for that matter) has any incentive to resist prescribing, or resist dispensing an expensive brand-name drug over its generic equivalent.
- (ii) **Adverse Selection:** Adverse selection in the context of pharmaceutical insurance arises when a physician's practice becomes dominated by patients prone to request unnecessary prescriptions.

Some policy analysts argue that patient cost-sharing reduces the risk of ‘moral hazard’ by introducing out-of-pocket expenditures. The Advisory Council endorsed the ‘moral hazard’ argument, in the belief that cost-sharing can “encourage the proper use of drugs.”¹³ However, the Council found very little evidence that ‘free’ prescription medicines lead to overuse, abuse, or wastage. The Council’s report cites a Scottish study, which found that, as co-payments were gradually reduced, use of prescription medications went up : “This increase slowed considerably over the course of four years, suggesting that the initial uptick in use was because some people had not been getting the drugs they needed, rather than a surge in wasteful consumption.”¹⁴ Moreover, cost-sharing, however modest, adds to the cost of administration, and creates a barrier at the point of care.

Moral hazard may arise from inappropriate prescribing practices. According to much expert testimony, quality prescribing is difficult and complex because of proliferation of drugs (over 13,000 drugs on the Canadian market alone) and also because seniors with multiple chronic diseases may need 10 or more medications simultaneously. Dr. Anne Holbrook, an expert witness, told the House Standing Committee that many physicians lack necessary skills due to inadequate

¹³ Heath Canada, *ibid.*, p. 61.

¹⁴ Health Canada, *ibid.*, p. 61.

training. They receive altogether some 9 to 50 hours in medical school time in ‘Clinical Pharmacology,’ and are necessarily left vulnerable to influence of pharmaceutical companies. In Dr. Holbrook’s opinion, inappropriate prescribing practices result in 300,000 Canadians suffering serious, disabling, or fatal medication-related harm annually and 20% of Canadian medical malpractice cases relate to prescribing of medications.¹⁵ The House Standing Committee report on pharmacare records evidence tendered by many other expert witnesses to the same effect.

Curbing over-prescribing behaviour by physicians and other medical professionals may significantly reduce prescription drug spending and thus have indirect effects on cost-sharing by patients in at least two ways: (i) it will help reduce overall spending on drugs and save money for the federal government; (ii) savings from fewer prescriptions make patient cost-sharing burden lighter. An international meta-study from Germany, however, forcefully contradicts the logic of adverse selection in prescription drugs policy. It analyses the extensive theoretical and empirical literature on patient cost-sharing published during the last forty years, showing that persuasive evidence for demand-side adverse selection among patients is lacking. According to this study, the commonly presented empirical evidence that, in absence of co-payments, patients might overuse or misuse or abuse the health system is not found. The meta-study concludes that health insurance beneficiaries are not aiming to abuse the health system. In fact, introducing cost-sharing seems to endanger proper healthcare since it deters the sick from claiming the benefits.¹⁶

It appears that the information asymmetry problem stems more from influence on physicians by pharmaceutical companies than from hypochondriac patients. Extensive advertising by pharmaceutical firms induces physicians to prescribe their brand products. A recent study in the US has found 23% of out-patient prescriptions inappropriate, with an additional 35% deemed

¹⁵ Dr. Anne Holbrook, in *Pharmacare Now: Prescription Medicine Coverage for all Canadians: Report of the Standing Committee on Health, [Chair: Bill Casey]* (Ottawa: House of Commons), April 2018, p. 57; <https://www.ourcommons.ca/DocumentViewer/en/42-1/HESA/report-14>

¹⁶ Holst, J., *Patient Cost Sharing-Reforms without Evidence. Theoretical Considerations and Empirical Findings from Industrialized Countries: Theoretical Considerations and Empirical Findings from Industrialized Countries* (Berlin: Wissenschaftszentrum Berlin für Sozialforschung, 2010), p. [iv]; www.wzb.eu <https://www.researchgate.net/publication/235663499>

potentially inappropriate.¹⁷ Another US study found similar evidence, estimating 40% of antibiotics filled by older adults potentially inappropriate.¹⁸ An Ontario study indicated that 46% of seniors with a non-bacterial infection were prescribed antibiotics.¹⁹

Responsibility for antibiotic prescribing falls mostly on physicians in community settings such as family clinics. While some antibiotics are prescribed in hospital settings, most are not; 92% of prescriptions are dispensed in the community, and family physicians are responsible for 65% of all prescriptions in Canada (PHAC, 2018). National CARSS (Canadian Antimicrobial Resistance Surveillance System) data indicates that overall prescription rate for antibiotics in Canada remained steady over the last several years, at roughly 20 defined daily doses (DDDs) per 1,000 inhabitant-days. This equates to roughly 2% of the Canadian population receiving an anti-microbial on a typical day with an estimated annual expenditure of approximately \$822 million (PHAC, 2018). If an estimated 20%-40% of antibiotics are prescribed inappropriately, that would equate to roughly \$165-\$330 million of expenditures for unnecessary anti-microbials.²⁰

¹⁷ Chua, K., Fischer, M., & Linder, J. (2019). Appropriateness of outpatient antibiotic prescribing among privately insured US patients: ICD-10-CM based cross sectional study. *BMJ* 364: k5092. Doi: <https://doi.org/10.1136/bmj.k5092>

¹⁸ Olesen, S., Barnett, M., MacFadden, D., Lipsitch, M., & Grad, Y. (2018). Trends in outpatient antibiotic use and prescribing practice among US older adults, 2011- 15: observational study. *BMJ* 362: k3155. Doi: [10.1136/bmj.k3155](https://doi.org/10.1136/bmj.k3155)

¹⁹ Mercer, C. (2019). Education needed--for doctors and patients--to reduce inappropriate prescriptions. *CMAJ*, 191(18), E514-E515. DOI: <https://doi.org/10.1503/cmaj.109-5742>; Silverman, M., Povitz, M., Sontrop, J., Li, L., Richard, L., Cejic, S., & Shariff, S. (2017). Antibiotic prescribing for nonbacterial acute upper respiratory infections in elderly persons. *Ann Intern Med*, 166, 765-774. DOI:[10.7326/M16-1131](https://doi.org/10.7326/M16-1131)

²⁰ Bowbrick, C. *War on Drug Resistance: Policy Interventions to Tackle Antibiotic Misuse in Canada*, unpublished MPP capstone thesis, School of Public Policy, SFU (Vancouver, B.C.: Spring 2020).

As the data show, over-prescribing or inappropriate prescribing is significant. Many Canadians who can well afford their prescription drugs are being over-medicated, whereas millions of Canadians cannot access the medication they need. Drug companies lobby both prescribers and patients. However, prescribers are professionals with primary responsibility for prescribing. Since prescriptions are created by doctors, it is the doctors who should be addressed first to reduce inappropriate prescribing practices. Other steps against inappropriate lobbying of pharmaceutical companies should also be taken in order to break this vicious cycle.

Imposing a limited cost-sharing by patients might have a small role in curbing over-prescribing practices but it will not likely affect higher income groups in society who are the most over-medicated. It is more likely to affect lower-income groups who are under-medicated under the present system. In order to address the problem of over-prescribing in its entirety a sound strategy of public policy is required. This will require education campaigns targeting professional care providers and the general public and limits on the ability of pharmaceutical companies to lobby.

3.2 Effects of patient co-payments

The objective of this research project being an assessment as to whether a cost-sharing element should be incorporated in a national pharmaceutical insurance plan, I reviewed the relevant literature on the topic.

There is concern in this literature that any kind of cost-sharing carries the risk of reducing the probability of patients completely following a pharmaceutical-based plan of treatment.²¹ Furthermore, failure to regularly follow a plan of treatment may shift the cost-burden to other more expensive healthcare services down the line. There is legitimate concern about over-prescribing, which may be exacerbated with a national insurance program without cost-sharing. A peer-reviewed survey of recent research on various cost-sharing schemes (including caps and co-payments) finds that increasing what people pay for medicines has a two-fold impact: first, a reduction in the insurers' expenditures on drugs and, secondly, a reduction in the patients' drug

²¹ Luiza, V.L. et al., 'Pharmaceutical policies: effects of cap and co-payment on rational use of medicines (Review),' *Cochrane Database of Systematic Reviews* 2015, 5: CD007017. [DOI: 10.1002/14651858.CD007017.pub2](https://doi.org/10.1002/14651858.CD007017.pub2); pp. 1-142.

utilization. Such reductions may not be limited to ‘unnecessary’ or marginal medications alone. Cost-sharing may include “reductions in the use of life-sustaining medicines as well as medicines that are important in treating chronic conditions and medicines for asymptomatic conditions.”²²

The impact of cost-sharing on utilization of healthcare services is, however, quite ambivalent. According to the meta-survey cited above, cost-sharing leads either to small or no decreases in utilization of healthcare services; the effects remain uncertain. Modest cost sharing is less likely to reduce the use of essential medicines or to increase the use of other healthcare services.²³ As the Advisory Council noted:

Cost-sharing, while common, is criticized by health policy experts because it can prevent people from taking the medicines they need to stay healthy. Research shows even small charges to patients when they pick up prescriptions can be a barrier to getting needed medication, which can hurt their health and often cost the health system more down the road. User-fees are typically regressive, which means they impose a greater financial burden on low- than high- income households. User-fees can be particularly hard on patients (i.e., counter-productive) with chronic conditions, because they have to use prescribed pharmaceuticals year after year.²⁴

All user-fees have negative equity implications. “Even modest user-fees, while not a serious deterrent for middle-income and high-income earners,” G.P. Marchildon pointed out, “can prevent low-income individuals from seeking needed care.”²⁵ Shifting costs from the insurer to the consumer in low-income (and vulnerable) populations may lead to discontinuation of necessary

²² Luiza, V.L. et al., p. 4.

²³ Luiza, V. L., et al., *ibid.*

²⁴ Health Canada, *ibid.*, pp. 60-61.

²⁵ Marchildon, G.P., ‘Private Finance and Canadian Medicare: Learning from History,’ in Flood, C.M. and Thomas, B., eds., *Is Two-Tier Health Care the Future?* (Ottawa: University of Ottawa Press, 2020), p. 35.

medicines, which may cause deterioration of health and increased healthcare utilization and expenditures for patients and for insurers.²⁶

Out-of-pocket charges for drugs are associated with forgoing prescription drugs and other necessities and substituting additional healthcare services. A cross-sectional study in 2016 surveyed 28,091 Canadians regarding prescription drug affordability, consequent use of health care services and trade-offs with other expenditures. It found that 5.5% reported being unable to afford one or more drugs in the prior year, representing 8.2% of those with at least one prescription. Drugs for mental health conditions were most commonly reported for cost-related non-adherence. About 303,000 had additional doctor visits, about 93,000 sought care in an emergency department, and about 26,000 were admitted to hospitals. Many forwent basic needs like foodstuff (about 730,000), heat (about 238,000) and other health care expenses (about 239,000) because of drug costs. These outcomes were more common among females, younger adults, Aboriginal peoples, those with poorer health status, those lacking drug insurance and those with lower income.²⁷

Many participants in a 2016 Community Health Survey said they could not afford one or more prescriptions, although about 38% had private insurance and 21% had public coverage. Despite having insurance, they could not pay because most drug plans require members to pay co-payment or coinsurance.²⁸ Several studies of the impact of out-of-pocket charges on seniors and people dependent on social assistance found that more were admitted to hospitals and nursing homes after co-payments were introduced; death rates among them also increased. According to another Community Health Survey, also in 2016, 43% who skipped prescriptions (because they couldn't afford them) said their health worsened.²⁹

²⁶ Luiza, V.L. et al., *ibid.*, p.17.

²⁷ Law, M.R. et al., 'The Consequences of patient charges for prescription drugs in Canada: a cross-sectional survey,' *CMAJ OPEN*, (2018), 6(1): E63-E70; cited, Health Canada, *ibid.*, p.47.

²⁸ Macdonald, D. and Sanger, T., 'A Prescription for Savings: Federal Revenue Options for Pharmacare and their Distributional Impacts on Houses, Businesses and Governments,' Canadian Centre for Policy Alternatives, 2018; cited, Health Canada, *ibid.*, p.45.

²⁹ Statistics Canada, *Canadian Community Health Survey* (Ottawa: Statistics Canada, 2016); cited, Health Canada, *ibid.*, p.47.

Other empirical studies are not as clear cut as the above study. A US study, published in 2008, found that, after co-payment implementation, utilization of prescription drugs declined significantly by 17.2% ($P < 0.0001$). This pattern was observed at varying degrees for all drug classes investigated. Patients with diabetes, respiratory disease, and schizophrenia immediately reduced their use of non-indicated drugs significantly more than drugs indicated for their condition. Among Medicaid recipients, nominal co-payments are associated with significant reductions in use of clinically important drug classes. However, patients with other chronic disease exhibited a differential response depending on the disease indication of the drug class.³⁰ A recent European review of various empirical studies (from 1990 to 2011) across a wide range of countries assessed the distributional consequences of co-payments. The study indicates that co-payments encouraged those with low income and, in particular, those in need of care to reduce their use more than the remaining population. It is clear that cost sharing involves some important economic and political trade-offs.³¹

Introduction of direct patient charges in Quebec which shifted drug benefits from \$0 or \$2 per prescription to a 25 percent coinsurance charge (setting annual caps, depending on income, at \$200, \$500 or \$750), decreased drug use by 9% per day in the elderly and 14% among people on social assistance.³² Another analogous policy change in Nova Scotia, which modified seniors' coverage from no copayment to \$3 per prescription (up to an annual maximum of \$150), resulted in reduction of drug use in the concerned patient group significantly. It was found that among those

³⁰ Hartung, Daniel M., et al., 'Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-Service Medicaid Population,' *Medical Care*, 46(6), June 2008, pp.565-72.

³¹ Kiil, A. and K. Houlberg, 'How does copayment for health care services affect demand, health and redistribution? A systematic review of the empirical evidence from 1990 to 2011,' *European Journal of Health Economics*, 15(8), November 2014, pp.813-28.

³² Tamblyn, R., Laprise, R., Hanley, J., Abrahamowicz, M., Scott, S., Mayo, N., Hurley, J., Grad, R., Latimer, E., Perreault, R., McLeod, P., Huang, A., Larochelle, P. & Mallet, L. (2001). Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons. *Journal of the American Medical Association*; 285(4):421–429.

who were even unlikely to reach their annual maximum, the use of drugs for peptic ulcers and reflux disease dropped by 5% and the number of users of one type of diabetes drug also decreased by 5%.³³

Defenders of the status quo, nevertheless, continue to argue that the existing provincial drug plans (which entail substantial cost-sharing by patients) are workable and fair because they entail only limited cost-sharing for lower-income Canadians.³⁴ For these defenders, prescription medicines with co-payments and other forms of cost sharing are affordable for all Canadians, except for a small segment of the population best taken care of by existing provincial plans.³⁵

However, the most compelling evidence of harms caused by the current system came from front-line healthcare workers who witness them daily. For instance, as Dr. Danyal Raza testifies before the House Standing Committee on Health, “People certainly die from complication of their medical conditions that often are untreated because they don’t have access to pharmaceuticals.” Dr. Raza estimated that between 5.4 percent and 6.5 percent of hospital admissions are the result of non-adherence to recommended drug treatments, resulting in annual costs to the tune of \$1.6 billion.³⁶

It is evident that there are positive and negative consequences from implementation of cost sharing as a source of the healthcare financing. On one hand, the burden of cost sharing increases awareness of costs for treatment and may limit unnecessary use of healthcare services. On the other hand, it prevents some patients from accessing needed care. Some recent studies reviewed

³³ Kephart, G., Skedgel, C., Sketris, I., Grootendorst, P., & Hoar, J. (2007). Effect of Copayments on Drug Use in the Presence of Annual Payment Limits. *American Journal of Managed Care*; 13(6 Pt 2): pp.328-34.

³⁴ Barua, B. et al., ‘Provincial Drug Coverage for Vulnerable Canadians’ (Vancouver, B.C.: Fraser Institute, 2018); <https://www.jstor.org/stable/resrep23988.3>

³⁵ Barua, B. et al. *ibid*.

³⁶ See, as quoted in *Pharmacare Now: Prescription Medicine Coverage for all Canadians, Report of the Standing Committee on Health*, Chair: Bill Casey, April 2018, p.122; see, also: <https://www.ourcommons.ca/DocumentViewer/en/42-1/HESA/meeting-74/evidence>

by Kolasa and Kowalczyk find that, in the majority of cases, the health policy impact of out-of-pocket payments on health outcome is insignificant. Reduction of the out-of-pocket burden, these authors conclude, cannot be achieved successfully without adequate extension of healthcare coverage or engagement of other sources of healthcare financing. When formal fees are being introduced, protection against catastrophic healthcare payments is needed for the most vulnerable groups.³⁷

One meta-analysis shows an 11% increase in odds of non-adherence to medicines in publicly insured populations where copayments for medicines are necessary.³⁸ This meta-analysis included 199,996 people overall, 74,236 people in the copayment group and 125,760 people in the non-copayment group. Average age was 71.75 years. In the copayment group versus the non-copayment group, the odds ratio for non-adherence was 1.11 (95% CI 1.09–1.14; P = <0.00001). Another meta-study concluded that imposing patient charges is relatively less effective in reducing prescribing than influencing prescribing doctors and regulating the pharmaceutical industry itself: “It may be that the undesirable consequences of policies influencing patients, particularly user charges, outweigh the benefits,” and that, “it is more appropriate to influence prescribing and although interventions to improve prescribing practice have been developed, they often achieve relatively modest benefits and sometimes at high cost”.³⁹

This leads us to agree with Sinnott et al. that policy makers should be wary of “potential negative clinical outcomes resulting from non-adherence, and also possible knock-on economic repercussions.”⁴⁰

³⁷ Kolasa, K. and M. Kowalczyk, ‘Does cost sharing do more harm or more good? a systematic literature review,’ *BMC Public Health* 16: 992 (2016); [DOI 10.1186/s12889-016-3624-6](https://doi.org/10.1186/s12889-016-3624-6)

³⁸ Sinnott, S.-J. et al., ‘The Effect of Copayments for Prescriptions on Adherence to Prescription Medicines in Publicly Insured Populations; A Systematic Review and Meta-Analysis,’ *PLOS ONE*, 8(5), May 2013; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3665806/pdf/pone.0064914.pdf>

³⁹ Lee, I.-H. et al., ‘International experience in controlling pharmaceutical expenditure: influencing patients and providers and regulating industry – a systematic review,’ *Journal of Health Services Research & Policy*, 20(1), January 2015, pp. 52-53; <https://www.jstor.org/stable/26751340>

⁴⁰ Sinnott, S.-J. et al., *ibid.*

CHAPTER 4

Expert Testimonies on Effects of Copayment given to the House Standing Committee on a National Pharmaceutical Policy

In this chapter I attempt to compile some key evidence offered by expert witnesses appearing before the House Standing Committee on Health touching on the effect of copayments and on various measures suggested to finance the cost of a universal national pharmacare program for Canada. The balance of opinion favours imposing no or very low-cost sharing.

Dr. Steven Morgan, Dr. Danielle Martin and Dr. Marc-André Gagnon, in their witness testimony before the House Committee, severally suggested that a universal prescription drug coverage program is the best way to ensure equal access to prescription drugs for all Canadians and to ensure that the drugs covered by such a program are worth the money they would cost. They recommended that the federal government, subject to the agreement of provinces and territories, implement a public drug plan that provides universal coverage to all Canadians with little or no direct cost to patients. Dr. Danielle Martin explained that extremely low or zero cost sharing is necessary because of the strong evidence that even very small payments can prevent individuals with relatively low incomes from filling their prescriptions.⁴¹

These experts are of the opinion that to make the pharmacare program sustainable and effective, it should provide coverage only for drugs listed on a single Canadian formulary, to be developed on the basis of best evidence on the risks and benefits of each drug. In their view the program should be managed by a publicly accountable management agency, which would establish the formulary and conduct price negotiations.⁴²

⁴¹ *Pharmacare Now: prescription medicine coverage for all Canadians: Report of the Standing Committee on Health* (Chair: Bill Casey), April 2018, 2nd Parliament, 1st Session, p.65.

⁴² *Pharmacare Now*, *ibid.*, p. 66

Dr. Marc-André Gagnon explained to the Committee that the management agency could be modelled on the Canadian Blood Services (CBS), an independent agency funded and governed by provincial and territorial governments, responsible for bulk purchasing and managing a national formulary of plasma protein products developed in collaboration with the Canadian Agency for Drugs and Technologies in Health (CADTH). He recommended that a similar independent agency could manage the pharmacare program by merging the CADTH and the Pan-Canadian Pharmaceutical Alliance (pCPA).⁴³

Steve Morgan estimated savings of approximately \$7 billion a year through reduced administrative costs, savings from joint price negotiations and drug purchasing, and reduced spending on drugs offering limited therapeutic benefit. A universal public drug coverage program would shift approximately \$10 billion in costs from the private sector to the public sector. The federal government could raise funds for its portion of the agency's budget using a variety of mechanisms, such as corporate taxes, income taxes, GST and/or premiums. The new program would replace existing private drug coverage plans but private insurance companies could continue to play a role in administering claims for the program and/or providing additional coverage for drugs not listed on the formulary.

Greg Marchildon outlined two possible approaches regarding how a national universal public pharmacare program could be implemented in Canada. First, the national pharmacare program could be modelled on Medicare in Canada, which would involve expanding the *Canada Health Act* to include medically necessary prescription drugs dispensed outside of a hospital setting with federal financing provided through the Canada Health Transfer. Provinces and territories would run their own single-payer pharmacare plans and would remain legally responsible for their respective formularies. However, it would be possible for the federal, provincial and territorial governments to undertake negotiations to establish a single national drug formulary.

He outlined another option in which the federal government would be entirely responsible for both managing and financing the national universal program, under which prescription drug coverage would be provided to all Canadians by the federal government, replacing private and

⁴³ *Pharmacare Now*, *ibid.*, p. 66

public coverage plans currently in place, with a single universal plan.⁴⁴ Under this option there would be a federal formulary solely legislated and regulated by the federal government. A federal agency would be responsible for determining the national formulary and undertake price negotiations with drug manufacturers. According to Marchildon, this approach would offer the greatest potential to keep costs down, maintain clear lines of accountability, and eliminate individual and regional differences in coverage and access to prescription drugs.

Ake Blomqvist held that the federal government should focus on developing a strategy within its present jurisdiction and support reforms already underway at the provincial level. He suggests addressing gaps in prescription drug coverage to ensure that every citizen has access to a default plan with an upper limit on the percentage of income that a family spends on drugs. Ottawa should offer partial financial support to provinces to meet that standard. The federal government could take the lead role in the pCPA and make arrangements to support the inclusion of private insurers in the pCPA. Patented drug prices, he thought, could also be reduced substantially through regulatory changes to the Patented Medicine Prices Review Board (PMPRB).⁴⁵

The Canadian Medical Association favors the federal government providing additional funding to the provinces and territories to allow them to expand the coverage offered through their existing programs. The federal government could provide funding to the provinces and territories to enable them to establish an annual upper limit for out-of-pocket drug costs of \$1,500 or 3% of income. The Association estimated that the cost to the federal government of covering the entire amount above the \$1,500 threshold would be \$1.6 billion in 2016.⁴⁶

⁴⁴ *Pharmacare Now*, *ibid.*, pp. 67-8.

⁴⁵ *Pharmacare Now*, *ibid.*, p. 70.

⁴⁶ *Pharmacare Now*, *ibid.*, p. 70.

CHAPTER 5

Evidence from Select Comparator Countries

Many high-income countries have incorporated cost-sharing provisions into their universal prescription drug programs. For instance, in the OECD (Organization of Economic Co-operation and Development) Australia, New Zealand and the UK are significant comparator countries for Canada.

Australia instituted the Pharmaceutical Benefits Scheme (PBS), a national universal program, to subsidize medications for all Australians and the government negotiates the price of medicines with manufacturers, to keep prices low for consumers.⁴⁷ From January 1, 2020 individuals with concession cards pay AUS \$6.60 for most PBS medicines. However, for individuals without a concession card the maximum co-payment for the highest cost medicines may go up to AUS \$41.30. The government pays the cost above the cap. Another provision of cost-sharing under PBS is that since January 1, 2016, pharmacists may choose to discount the patient co-payment up to AUS \$1.00. The overall amount of co-payment is adjusted every year in line with the Consumer Price Index (CPI).⁴⁸ The formulary has no budgetary cap, meaning that as demand and medication availability grows, so do allocated funds. The bottom line being that no class of medication for a patient in effect remains unsubsidized.⁴⁹

New Zealand provides universal prescription drugs coverage for everyone living in the country with subsidized drugs through the Pharmaceutical Management Agency (PHARMAC, a Crown entity) that decides which drugs should be subsidized and by how much. Doctors generally

⁴⁷ Australian Government, Department of Health. 2021. “The Pharmaceutical Benefits Scheme (PBS)”. <https://www.pbs.gov.au/pbs/home> ; “Medicare” (Australia). Wikipedia. 2021. [https://en.wikipedia.org/wiki/Medicare_\(Australia\)](https://en.wikipedia.org/wiki/Medicare_(Australia)); Dhara, A. 2017. ‘Australia proves national drug plan is possible for Canada,’ *The Star*, September 11.

⁴⁸ https://www.pbs.gov.au/info/about-the-pbs#What_are_the_current_patient_fees_and_charges

⁴⁹ Dhara, A. 2017. ‘Australia proves national drug plan is possible for Canada,’ *ibid*.

prescribe the medicine which is subsidized.⁵⁰ The amount of copayment for people with a High Use Health Card is NZ \$3.00. However, for people without the Card it is NZ \$5.⁵¹ But it so happens that most of the prescription drug users pay NZ\$3 (£1.40; €1.70; US\$2.20).⁵² There are no copayments for children aged 13 and under. Another important provision of patient cost-sharing is that once patients and their families have collected 20 new prescription items in a year they won't have to pay any more prescription charges until 1 February the following year.⁵³ The successful operation of PHARMAC is considered to be the key reason for New Zealand's low copayments and pharmaceutical prices.

In **the United Kingdom**, the National Health Service (NHS) provides a true comprehensive coverage for all prescription drugs outside hospitals and other medically necessary products which require no co-payments by a great majority of the population.⁵⁴ The population categories enjoying free prescription drugs, regardless of income, include people (i) aged 60 or over, (ii) under 16, (iii) between 16-18 and are engaged in full-time education, (iv) are pregnant or have had a baby in the previous 12 months, (v) have a specified medical condition, (vi) have a

⁵⁰ <https://www.newzealandnow.govt.nz/resources/buying-medicines-in-new-zealand>

<https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/pharmaceutical-co-payments>

<https://pharmac.govt.nz/medicine-funding-and-supply/the-funding-process/>

<https://en.m.wikipedia.org/wiki/Pharmac>

⁵¹ <https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/pharmaceutical-co-payments>

⁵² Cumming J. et al., 'How New Zealand has contained expenditure on drugs,'

https://researchonline.lshtm.ac.uk/id/eprint/3688/1/How%20New%20Zealand%20has%20contained%20expenditure%20on%20drugs%20_%20The%20BMJ.pdf

⁵³ <https://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/pharmaceutical-co-payments>

⁵⁴ <https://www.nhs.uk/>

https://en.wikipedia.org/wiki/National_Health_Service#Medicines

continuing physical disability, or (vii) hold a pension exemption. It also includes people under 20 and a dependent of someone, people who are, or their partners are receiving: (i) income support, (ii) jobseeker allowance, (iii) employment and support allowance, (iv) pension credit guarantee credit, (v) universal credit, (vi) NHS tax credit exemption, (vii) have income for tax credit purposes of £15, 276 or less, and (viii) NHS certificate for full help.⁵⁵ For people who do not fall into the above categories the current prescription charge is £ 9.35 (\$16 CAD).⁵⁶

In sum, **Australia, New Zealand and the UK** all fund universal public insurance to cover the cost of prescription drugs for their citizens, without deductibles and with limited or no copayments for eligible prescription drugs. These systems are financed through general tax revenues. Through their progressive taxation systems, the cost of care is shared among all members of society according to their means. This model was recommended for Canada in the past by the Hall Commission (1964), the National Forum on Health (1997) and the House of Commons Standing Committee on Health (2018).⁵⁷

In contrast, however, in **France, Germany and the Netherlands**, residents buy health insurance, including drug coverage, from insurers that are primarily not-for-profit; it must meet standards set by the government. Though the funding method is different, the experience for patients is similar to single-payer systems with a single formulary, uniform drug coverage and similar out-of-pocket costs. In France and Germany, individuals are required to make **modest copayments** for their prescriptions. In the Netherlands, individuals must pay an **annual deductible** of approximately \$600 CAD for all their healthcare costs (including prescription drug costs), but **do not pay any copayments** for prescriptions at the pharmacy. Residents of these

⁵⁵ <https://www.nhs.uk/nhs-services/prescriptions-and-pharmacies/who-can-get-free-prescriptions/>

⁵⁶ <https://www.nhs.uk/nhs-services/prescriptions-and-pharmacies/nhs-prescription-charges/>

⁵⁷ Health Canada, *A Prescription for Canada*, *ibid.*, 2019, p.54; cited: Morgan, S., ‘Evaluating National Pharmacare Options: Evidence from Comparable Countries’ (a report prepared for the Advisory Council on the Implementation of National Pharmacare. 2018; available from Health Canada.

countries can also purchase complementary private insurance for things not covered by their statutory health insurance.⁵⁸

How are other high-income countries attempting to limit over-prescribing?

One of the most remarkable (and successful) approaches to curbing over-prescribing behavior is apparent in the United Kingdom where a system for rewarding physicians for efficient prescribing is in place.⁵⁹ This strategy of financial incentives for efficient prescribing appears to meet with success compared to comparator countries, say the United States. In the US, where the strategy was followed to some extent, it has met with only limited success, in part because the payments offered were modest relative to a doctor's normal salary.⁶⁰ In contrast, GPs in the UK generally take a stronger stand in dissuading patients from abusing their NHS facilities and firmly believe that 'costs to the system are as important as costs to the individual patient.'⁶¹

In Canada too, educating doctors about the adverse effects of over-prescribing is only likely to impact modestly as most over-prescribing practices occur due to the inappropriate influence of the pharmaceutical representatives. The individual physician's integrity to resist temptations to succumb to lucrative offers by pharmaceutical companies is of crucial importance here. It thus appears that strategies on re-education should reiterate, as in the case of UK, certain core values like general welfare and ethical considerations to restrain them from over-prescribing. In addition,

⁵⁸ Ibid.

⁵⁹ Morgan, Steven G., Jamie R. Daw and Michael R. Law, 'Rethinking Pharmacare in Canada,' *Commentary*, No. 384 (June 2013), pp. 1-24; Mossialos, E., and A. Oliver. 2005. "An overview of pharmaceutical policy in four countries: France, Germany, the Netherlands and the United Kingdom." *International Journal of Health Planning & Management* 20(4): 291-306.

⁶⁰ <https://www.nytimes.com/2016/03/27/opinion/sunday/how-to-stop-overprescribing-antibiotics.html>

⁶¹ 'Cost to the patient or cost to the healthcare system? Which one matters the most for GP prescribing decisions? A UK-Italy comparison,' *European Journal of Public Health* (2003); 13:18-23.

putting a comprehensive oversight mechanism in place to monitor suspect prescribing practices is likely to be effective in curbing inappropriate prescribing.

Lessons from contemporary experience in reducing over-prescribing in comparator countries are at best ambivalent. Several attempts have been made in the US in recent years. The Prescription Drug Monitoring Programs (PDMPs), using state-run electronic databases to track the prescribing and dispensing of controlled prescription drugs to patients, have proved better than other campaigns as tools for preventing and identifying prescription drug misuse. PDMPs in some states have been found to be associated with lower rates of opioid prescribing and overdose.⁶² In another approach some pharmacies developed hotlines to alert other pharmacies in the region as and when they detected a suspected or fraudulent prescription. The implications of these experiments are clear. Pharmacists can play a significant role in preventing rampant over-prescribing practices. Being on guard for prescription falsifications or alterations, pharmacists may prove useful as the first line of defense in identifying problematic patterns in prescription drug use.⁶³

Other experiments, based on peer intervention method were conducted on small scales, have also proven successful. In one experiment, prescribers were sent monthly emails with information on their prescribing performance relative to their peers. Those with the lowest record of inappropriate antibiotic prescribing rates were congratulated as ‘top performer,’ and those not meeting this standard were simply told ‘You are not a top performer.’ The information thus passed on also included a personalized count of unnecessary antibiotic prescriptions by the individual prescriber beside the count for a typical top performer. This tactic of ‘peer comparison approach’ helped reduce inappropriate prescribing significantly, from 19.9%t in the pre-intervention period to 3.7% during the post-intervention period — overall an 81% reduction.⁶⁴

In another experiment, whenever a doctor prescribed an antibiotic not clearly called for by the relevant diagnosis, the electronic health record system asked the individual to provide a short

⁶² <https://www.drugabuse.gov/download/37630/misuse-prescription-drugs-research-report.pdf?v=add4ee202a1d1f88f8e1fdd2bb83a5ef>

⁶³ Ibid.

⁶⁴ <https://jamanetwork.com/journals/jama/fullarticle/2488307>

‘antibiotic justification note.’ The experiment also provided for entering the note into the patient’s medical record and making it visible to others. Introducing this ‘speed bump’ into the work flow, along with the barrier of social accountability, reduced inappropriate prescriptions from 23.2% to 5.2%. The controlling practices in this experiment also experienced reductions, possibly because doctors knew they were being monitored, but both the approaches were effective.⁶⁵

⁶⁵

Ibid.

CHAPTER 6

Qualitative Findings

A total of ten semi-structured qualitative interviews with select stakeholders and subject-matter experts were conducted between July 2020 and November 2020. Respondents included public policy analysts and healthcare professionals. Many important themes emerged from the interviews. Some key themes are discussed below.

6.1 Importance of a universal single-payer public system of prescription drug coverage

Respondents attributed varying degrees of importance to the implementation of a universal single-payer public system of prescription drug coverage in Canada. A common theme is that, on the one hand, the precariousness in drug affordability and health outcomes and, on the other, uncertain employment may soon be pushing Canada's lack of a comprehensive national pharmacare strategy into an acute crisis.

They also emphasised that many of the current health issues, such as mental health, would be significantly impacted by the implementation of a single-payer system. Here is an excerpt recognizing the critical importance of this issue to Canadians: *"I am strongly in favor of a single-payer insurance system. In my opinion, it is clear that the health system in Canada is due for a major rework, no matter how complicated or difficult it will be."* --(R003)

One respondent, however, expressed concern that such a program would 'stifle innovation'.

6.2 The question of 'moral hazard' and mandatory co-payments

A majority of respondents (seven out of ten) attributed low importance to the phenomenon of moral hazard; three out of ten, nevertheless, thought that the problem of overuse or misuse of drugs has a high importance.

Respondents distinguished between two categories of prescription drugs, essential and non-essential, and argued against any moral hazard impact in the absence of cost sharing. These

respondents favoured no copayments for essential prescription drugs, drawing an analogy with the existing situation of no cost sharing for physician and hospital care.

Moral hazard is of minor importance. Cost sharing make sense if the government is looking to spend less on pharmacare, but to say that cost sharing would also encourage the appropriate use of drugs/improve efficiency seems like a stretch. People already usually receive full primary health coverage when they visit their doctor's office, get an operation, etc., and to my knowledge there aren't many people who are abusing that system just because they don't have to cost share for it. If moral hazard is a concern, then that should be addressed when selecting which drugs would be covered under a national pharmacare plan. Prescriptions that are primarily used for non-essential purposes could require cost sharing while prescriptions that are deemed essential would not. —(R004)

On the other hand, the argument in favour of co-payment in regulating patient behaviour in a 'responsible' way is articulated in the following quotation: *"Cost sharing is good, as it puts "skin in the game," which encourages responsible behaviour.* —(R002)

6.3 On abiding by the Canada Health Act, 1984

The Advisory Council proposes, with good intentions, that a Canadian universal pharmaceutical program respect the five principles of the Canada Health Act, 1984 which of course include the principle that prescription drugs should be accessible to all Canadians without any cost barriers, i.e., without infringing 'the accessibility clause'. However, at the same time it has recommended modest cost sharing under a universal plan (i.e., \$2 and \$5 per prescription for essential and other drugs, respectively, with a maximum limit of \$100 per year per household).

Responses from our participants on this rather involved question are mixed. The question, involves two decision points. Does the Advisory Council's recommendation of introducing small copayments constitute a violation of the fundamental principle of universal access enshrined in the Canada Health Act, 1984. The second asks if copayments would require a legislative exemption from the "accessibility" clause to reconcile them with the letter of the Canada Health Act, 1984.

A corollary to these questions implies another: would it subsequently cause damage by creating a precedent of an exemption to the "accessible" principle. One respondent has written:

I'm not convinced that an exemption would be required with the co-pay levels set very low, annual limits of \$100 per household and co-pays waived for low-income situations. It could be argued that accessibility issues are mitigated with these proposed strategies in place. - (R001)

This respondent elaborated the point further:

If an actual exemption were required it would not be a good thing, nonetheless we have experienced other potentially destabilizing precedents without much impact. For example, the Chaoulli v Quebec decision in 2005 makes it possible to receive private hip or knee replacements in the province if a public waiting time is too long. Despite Chaoulli, the Canada Health Act is still considered legitimate across the country (despite the great omission of pharmacare). --(R001)

At the other end of the spectrum the alternative view is that cost sharing, however insignificant, constitutes a violation of the spirit of the Canada Health act, 1984 as well as the goal of 'universal' healthcare: *I believe copayments violate the intention of the [Canada] Health Act, [1984] and the intention of universal healthcare. --(R003)* A third respondent proposes a golden mean of keeping copayments apart from the spirit of the Canada Health Act and put it a safe distance away from its effects by some kind of enabling legislation:

Amending the Canada Health Act [1984]'s principle on accessibility could be a problem, but I'm not a legal expert so I can't really comment on the precedent it would set. Another option could be to develop a separate piece of stand-alone legislation tailored for a national pharmacare plan. This could avoid the problems associated with opening up the Canada Health Act, [1984]. --(R004)

6.4 On the assumed modes of cost sharing

On the assumption that cost sharing is to be introduced, each participant was asked to choose one or a combination (the Advisory Council recommended a fixed co-payment and ceiling) from the following options:

A. With a **cap** policy, patients are reimbursed for their prescription medicines up to a maximum amount, then are expected to pay costs higher than this amount.

B. With a **fixed co-payment** policy, patients pay a fixed amount per medicine or prescription.

C. With a **co-insurance** policy, patients pay a set percentage of the price of the prescription or medicine, rather than a fixed fee.

D. With a **ceiling** policy, patients pay full cost or part of the cost up to a certain amount, then are given medicines for free or at reduced cost.⁶⁶

The participants made a wide range of choices. No majority consensus emerged on any particular option offered above:

I think this combination is largely pointless. If copay must be instated, I would prefer either the ceiling or fixed cost options, as the combination does not really offer a significant change over free, universal access. – (R003)

However, this respondent preferred either option D or option B over the other two options.

Another respondent (R002), opined that option C is the best option, for it guards against any perceived moral hazard and at the same time will guarantee full public payment of medicines in case of rare diseases, which are truly unaffordable to the average patient. Here is the statement of this respondent:

I think C is critical to ensuring the system is not abused and is used responsibly (unlike Europe), but if someone has a rare disease – where drugs in the “free market” would cost thousands of dollars – it would be in the spirit of the Canada Health Act to publicly pay in-full any price beyond a certain threshold, so that payment is truly affordable – accessible, universal, comprehensive, etc. for all. -- (R002)

6.5 Substitution of generic bio-similar drugs and reduction of drug spending

Extensive substitution of generics in place of brand name drugs is an effective way to reduce the current high drug cost and a single-payer insurance program stands in a position to lower rapidly

⁶⁶ Luiza, V.L. et al., ‘Pharmaceutical policies: effects of cap and co-payment on rational use of medicines (Review),’ *Cochrane Database of Systematic Reviews* 2015, 5: CD007017. [DOI: 10.1002/14651858.CD007017.pub2](https://doi.org/10.1002/14651858.CD007017.pub2); pp. 1-142.

rising drug prices by bulk purchasing. The argument against generic substitution is loss of pharmaceutical research in Canada. Accordingly, participants were asked what importance they attached to reduction in drug prices relative to the maintenance of research efforts by brand companies in Canada.

The responses generated several themes. All (ten out of ten) participants agreed unanimously that price reduction should be the first priority. Most (nine out of ten) equally emphasised the substitution of generics over brand name drugs as a way to price reduction. Sharing similar views on generic substitution, they also offered various insights on the impact of such a policy on the pharmaceutical companies in Canada. The outstanding theme that emerged concluded there would not be a substantial damaging impact of generic substitution for brand name drugs on the healthcare sector and pharmaceutical R&D.

What follows are similar statements made by the respondents:

I believe that the contributions of pharmaceutical companies are overstated and the contributions currently made by them can easily be replicated in other areas/institutions. - (R003).

Another statement closely echoes this view:

I think keeping drug prices down is more important than ensuring the profits of the Canadian pharmaceutical industry, but the latter is still important. – (R005).

Two more statements are worth quoting at length for the force of their argument:

The concern about pharmaceutical research being hindered is not borne out by data as far as I understand. For example, the United Kingdom's 'Generics share of the pharmaceutical market' was second in 2013; and their 'business expenditure on R& D in the pharmaceutical industry' was the 5th among OECD countries; the rankings are similar for the US (1st and 6th, respectively). [From 'Health at a Glance 2015, OECD Indicators']. -- (R001)

It's likely true that pharmacare would de-incentivize pharmaceutical development in Canada to some degree, although I'm not sure by how much. However, other countries such as the United States produce most of the patented drugs that we use here anyways, so

it's not clear to me how much a pharmacare system would tangibly change home-grown pharmaceuticals in Canada. – (R004)

Having agreed on the necessity of price reduction, one participant begged to differ on the ways and means of such reduction, emphasizing strongly the need to allow free competition (i.e., among the companies), not government intervention, to effect long term drug price reduction. It's worth quoting:

It is a myth that monopolies reduce prices. They don't. Competition reduces prices. Moreover, producers will not invest in improving productivity – which dramatically cuts costs – if they do not anticipate being rewarded for doing so. Anyone today, even the poorest Canadian, can afford a cheap drug like aspirin, which only the rich could afford when first produced. Government policies did not reduce the price of aspirin. Although some exceptions exist, this general principle holds true for the bulk of the pharma industry. -- (R002)

Most respondents wanted that the pharmacare program reimburse patients at the cost of the lowest-price generic available; if the patient wished a more expensive brand equivalent, then the concerned patient must shoulder the difference.

However, one respondent preferred that the physician be allowed to decide his or her preferred brand; the pharmacist must dispense the specified brand and reimburse the patient at the relevant brand cost (subject to a copayment if imposed). This respondent also emphasized that the pharmacists' role should be expanded in deciding the appropriate drug:

I think pharmacists should be given more authority than doctors. They know more about drugs/costs than any other party, and doctors frequently rely on the information provided to them by pharmaceutical [industry] lobbyists/ salespeople. –(R005)

The conclusive point among most respondents was that, whether doctors or pharmacists decide, choosing the cheaper generic drug remains the rational option:

If there are bio-similar generics available for a given pharmaceutical, then it wouldn't make much sense clinically to have the physician decide his/her preferred brand; they should all have virtually the same clinical effect, so it would almost always make more sense to go with the cheaper generic option. --(R004)

6.6 On the drugs to be covered in the universal insurance plan

Developing and administering the national formulary is a key responsibility of a national pharmacare program.⁶⁷ Respondents raised three important themes:

- establish an independent national agency that relies on ‘evidence-based’ research;
- determine whether the provinces could add to or subtract from the national formulary;
- determine policy on specialized drugs whose cost exceeds some specified ceiling.

Most of the respondents (eight out of ten) preferred a mandatory formulary relying on ‘evidence-based’ research. While agreeing on the basic point of instituting a national formulary, respondents drew attention to different challenges and offered insights into how the agency should do its job to gain credibility. One of the emergent themes stressed the limits of an ‘evidence based’ approach and suggested a broader approach to ensure wider drug inclusion. On this question, one respondent has underscored:

Yes, obviously, but sometimes ‘evidence-based’ definitions hinge on ideas which may preclude other ways of ‘seeing’. For instance, if indigenous ways of medicine were to be included, then the definition of ‘evidence-based’ might need to allow for other than the double-blind-control-trial gold-standard in terms of ‘evidence’. – (R001)

There was also a suggestion for the national drug formulary to include “off-label” [using a drug for an illness or disease other than the authorized reason for use, sometimes called ‘expanded use’] drugs:

The formularies often exclude ‘off-label’ uses. This is a major limitation, in my view, saddling patients with the cost of these drugs or preventing physicians from using them. – (R003)

This position leads to the conclusion that the formulary should be open, and physicians should be free to prescribe whatever drug they see fit without having to consult a formulary.

⁶⁷ Health Canada, *A Prescription for Canada*, *ibid.*, p. 73.

Another significant theme concerned the independence, integrity, and sustainability of the drug agency. Several respondents raised concerns about measures the government ought to take to ensure the integrity of the independent agency:

I also question the independence of the national agency, knowing that patient groups have often been courted by pharmaceutical companies even through direct funding. How can the government ensure that this agency is not captured? – (R001)

Another respondent strongly disagreed with the idea of a formulary as such because it would be under the nominally independent agency, which itself would be susceptible to bureaucratic inefficiency: “*Such an agency would be prone to economic failure far worse than any ‘market failure’, not to mention the risks of corruption.*” – (R002)

It was largely agreed by most that, in the interest of maintaining a universal formulary, the provinces (and territories) should fully adhere to the national formulary, which would guarantee portability of the pharmacare program across the provinces (and territories). However, if certain specific population groups needed additional drugs, provinces (and territories) should be allowed to add to, but not to subtract from, the list of drugs in the universal formulary. One respondent argued that literal adherence to flexibility may be counter-productive: “*Flexibility is important, but not if it comes at the cost of uneven services which vary from province-to-province. That would defeat the purpose of universal pharmacare.* –(R005)

A recurrent theme from each recipient was the need to make sure that drugs for rare diseases are not excluded from the national formulary.

To exclude certain drugs based on their cost would be exclusionary to those who need these drugs to survive. With a well-managed system that incorporates review of costs, we can ensure that all Canadians have access to the medication they need. –(R003)

CHAPTER 7

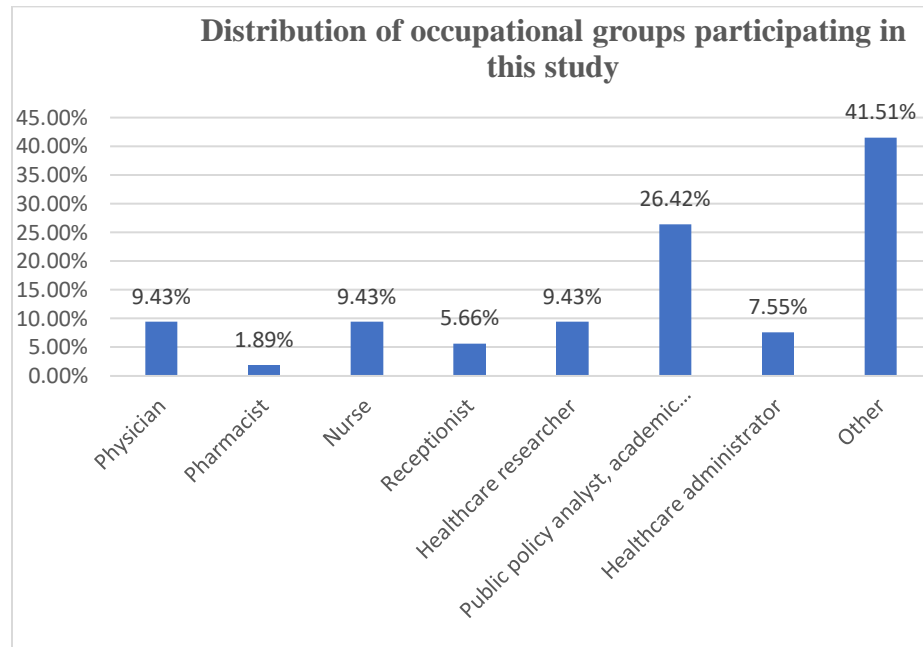
Survey Analysis

This chapter summarizes findings from a short survey conducted between October and December, 2020, using SurveyMonkey and analysed with Excel. The number of participants responding to the survey totalled 53. Participants reflect a broad spectrum, including healthcare professionals, policy analysts and members of the general public working in various sectors related to public health, health research, and academic experts. Since the sample size is small, the results are not representative of national opinion. However, they give an insight into opinions on cost sharing among a knowledgeable sample of the population familiar with the issue.

7.1 Description of respondents distributed as occupational groups

Respondents participating in this study belong to diverse categories, professionally. As presented in Figure 7.1, seven occupational groups are included; the remainder are “others”.

Figure 7.1



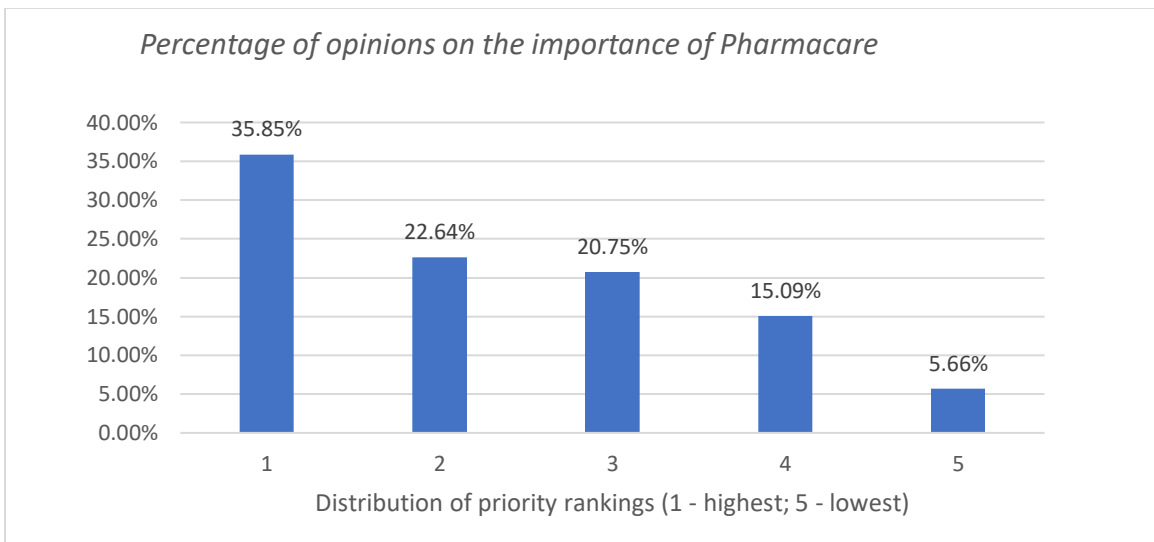
7.2 How important is a national pharmacare program?

The question asked was as follows:

Relative to other health policy issues in Canada – such as improving health standards in long-term seniors’ accommodation, addressing mental health and opioid crisis – how important do you think is implementation of a “universal, single-payer public system of prescription drug coverage”? – Choose a number, on a scale of 1-5, in "descending" order of preference, e.g., please tick 1 if you think "a universal single-payer public system of prescription drug coverage or 'pharmacare' " is the "most important concern" of all mentioned above and tick 5 if you consider it is only a minor concern; or tick any other number in between according to the importance it deserves.

The balance of opinion is overwhelmingly in favor of adopting a national Pharmacare program, with little or no strings attached. Over a third (36%) consider pharmacare to be the most important health policy concern. Only a fifth (21%) give a low ranking (4th or 5th) to a national pharmacare program.

Figure 7.2



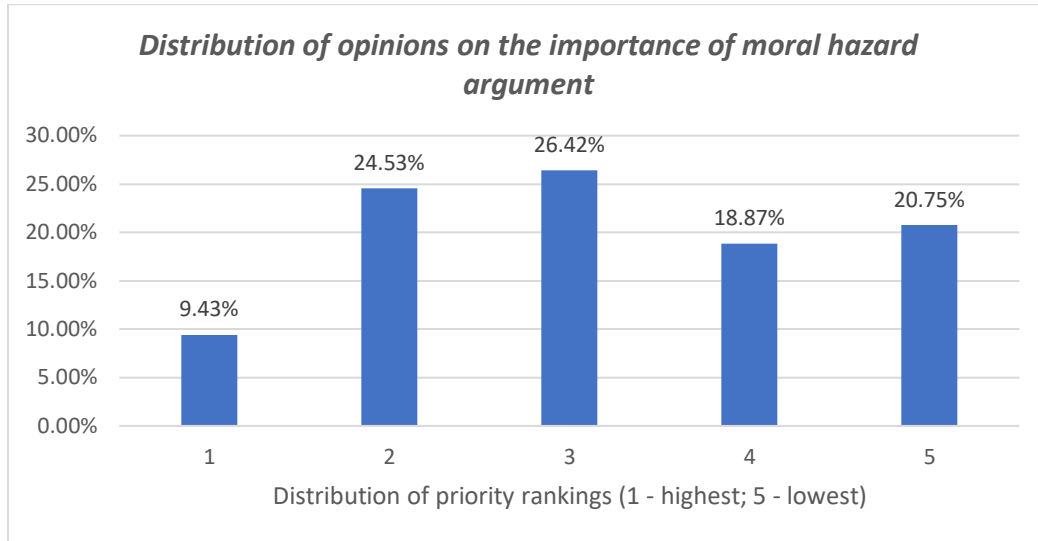
7.3 Opinion on the importance of the ‘Moral Hazard’ argument

One question was related to the problem of moral hazard. It asked if (and to what extent) introducing uniform cost sharing for prescription medicines encourages the proper use of drugs or, in other words, discourages improper use (i.e., moral hazard). A large majority thinks introducing cost sharing does not have much relevance to the moral hazard argument. The question asked was as follows:

The Advisory Council has recommended a small copayment (\$5 or less) for each prescription with an annual maximum of \$100. It concluded: "Sharing cost would help to finance pharmacare and drug plan officials told the Council they believe it does encourage the proper use of drugs." With no direct payment, patients may request unjustifiable prescriptions, and physicians may accommodate. In your opinion, how important is this argument? Choose a number, on a scale of 1-5, in "descending" order of preference, e.g. please tick 1 if you think "patient requests for unjustifiable prescription" is the "most important concern" of all and tick 5 if you consider it is only a minor concern, or tick any other number in between according to the degree of importance it deserves.

The results of the responses received (see Figure 7.3) show that only a small share (9%) of respondents think that moral hazard is the “most important” concern; only a third (34% = 9% + 24%) think it is a major (most or second-most important) concern. A larger share (40% = 19% + 21%) think that it is a minor concern (4th or 5th rank). More than a quarter (26%), the modal choice, think moral hazard is of intermediary significance. In other words, it is at best a secondary concern.

Figure: 7.3



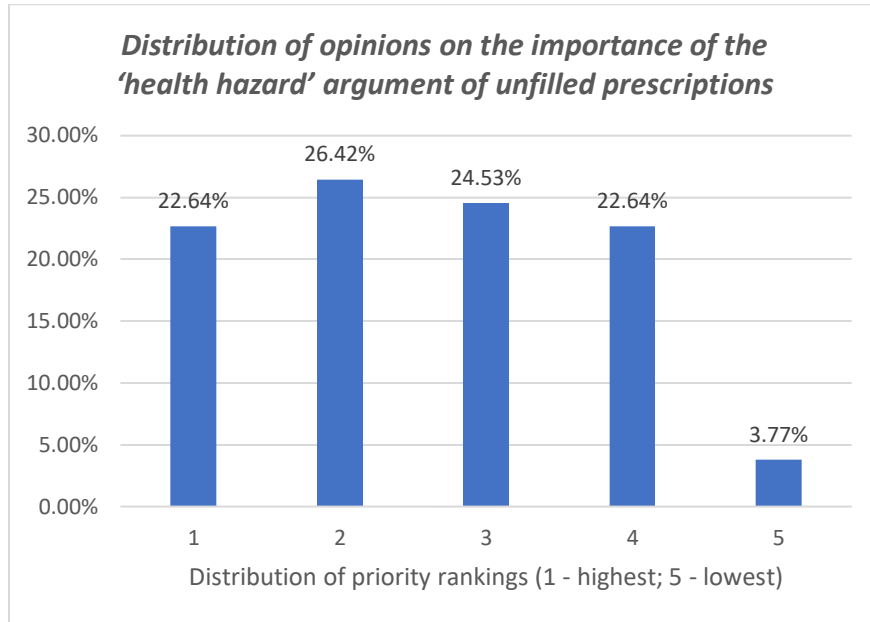
7.4 Opinion on the importance of ‘health hazard’ as a probable consequence of introducing any copayment

A third question relates to the problem of non-adherence to filling prescriptions. The well-attested risk of "health hazard" is the converse of the problem of moral hazard. The actual question asked is as follows:

Some analysts conclude that any [cost sharing] will result in an unacceptable increase in low-income patients not following their physicians' recommended drug treatment. In your opinion, how important is this argument? Choose a number, on a scale of 1-5, in "descending" order of preference, e.g. please tick 1 if you think "failure to fill prescriptions" is the "most important concern" of all and tick 5 if you consider it is only a minor concern, or tick any other number in between according to the importance it deserves.

The near-majority (49% = 23% + 26%) of respondents ranked "health hazard" to be first or second concern. Only a quarter (26% = 23% + 4%) thought "health hazard" is of minor concern.

Figure: 7.4



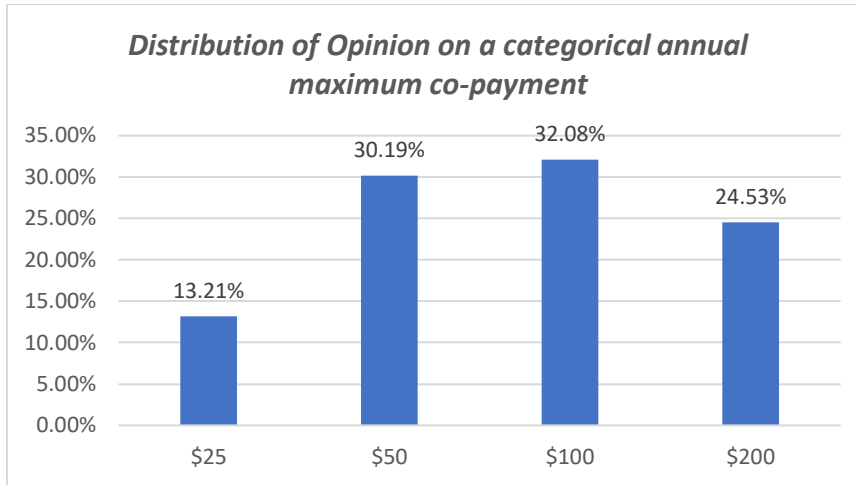
7.5 On an annual ceiling of co-payment to accompany universal Pharmacare

The next question asked the annual maximum amount to be considered in striking a balance between the perceived presence of ‘moral hazard’ when no copayment is made and apprehended risk of ‘health hazard’ when a co-payment exists. Respondents were limited to four categories from the lowest (\$25) to the highest (\$200). The actual question asked is as follows:

*If the insurance plan has a copayment, what annual maximum do you think reasonable?
Tick one response.*

Opinion tilted towards a low maximum, if any, in fixing the annual maximum copayment to be required: 13% want it to be only \$25; 30% want no more than \$50. These two groups, preferring an annual maximum amount of \$50 or less, comprise 43% of the sample. If we add the share wanting one of the three lower ceilings, three quarters (75%) want it to be \$100 or below. A quarter (25%) of respondents want the maximum \$200. By a small margin, the modal ceiling option is \$100, which also happens to be the amount proposed by the Advisory Council on National Pharmacare recommendation.

Figure 7.5



The reasons for the Advisory Council recommending an annual cap at \$100 per year are worth quoting:

The council believes that deductibles (where a patient pays 100 per cent of the cost of drugs until asset dollar threshold is reached) are likely to deter people from filling their prescriptions, and can be particularly hard on patients with chronic conditions. For those reasons, we do not support their use. Instead, we support minimal copayments, provided they include measures to limit financial hardship, such as an annual cap on how much any given household must pay out of pocket. Setting this cap at \$100 per year would protect households with above-average prescription drug needs and is significantly less than the current average household out of pocket expenditure of \$450.⁶⁸

⁶⁸ Health Canada, *A Prescription for Canada*, *ibid.*, p. 62.

CHAPTER 8

Policy Objectives and Evaluation Criteria

This chapter discusses the main objectives of the policy options considered in this paper and outlines criteria and measures that will help achieve the stated objectives, the intention always being a commitment to combine what is necessary in the collective interest (social values) with what is possible under the prevailing conditions (fiscal constraints).

8.1 Accessibility for all regardless of income (Effectiveness)

Since prescription drugs are not included in Canadian medicare for patients not hospitalized, they either rely on private insurance arrangements or pay out-of-pocket. Research studies and major official reports amply demonstrate that millions of Canadians cannot afford any of the myriad provincial or private insurance plans.⁶⁹

The principal purpose of a universal single-payer prescription drug program is to bring about a change in this situation; it must make sure that Canadians no longer face financial barriers that prevent their access to medically necessary prescription drugs. It follows that cost sharing by the patients is not the ideal means to finance the public plan. If used, then it should be only a minor supplement. Cost sharing could, for example, be limited to ensuring cost-effective use of generic drugs in place of brand names. As Dr. Danielle Martin explained before the House Standing Committee on Health, zero (or extremely low) cost sharing is necessary because of the persistent strong evidence that even small such payments can prevent individuals with low incomes from filling their prescriptions.⁷⁰ As a result millions of Canadians do not adhere to their prescription

⁶⁹ Health Canada, *A Prescription for Canada. Ibid.*, p.9.

⁷⁰ House of Commons Standing Committee on Health, *Evidence*, 1st Session, 42nd Parliament, 18 April 2016, 1545; cited in *Pharmacare Now*, p.65.

drugs. Our key objective being to enable all Canadians to fill their prescriptions, the desired increase in drug utilization will serve well to indicate the effectiveness of the policy option.

8.2 Cost reduction or securing ‘value for money’ and Equity

Canada now spends more on pharmaceutical drugs than on doctors, though somewhat less than on hospitals.⁷¹ It is the world’s second most expensive country for retail prices of prescription drugs. Moreover, Canada has the fastest rising drug costs among OECD countries: more than 10% per year. Countries with universal Pharmacare, like France, United Kingdom, Sweden, Australia and New Zealand, pay less for their drugs, and their costs increase at a much lower rate.⁷² For instance, the British system achieves prices for patented drugs that are 18% lower than in Canada and prices for generic drugs are approximately 30% lower.⁷³

The main reason prescription drugs are so expensive in Canada is because of the importance of private insurers. Insurance companies are normally paid on the basis of a percentage of spending, so they have no incentive to reduce costs. Therefore, they make no discrimination among drugs, and gladly agree to reimburse new drugs that are more expensive than existing cheaper and better drugs.⁷⁴

In view of this vital problem, one of the main objectives of the proposed universal pharmacare program is to reduce cost-- both by way of reducing unnecessary prescription drug use and through an efficient price negotiation with drug manufacturers in order to ensure the right value for money in delivering prescription drugs. Accordingly, reducing the regressive redistributive impact of drug costs on peoples’ out of pocket spending or bringing equity is an indispensable objective of the national pharmacare.

⁷¹ House Standing Committee, *Pharmacare Now*, p. 122; and *A Prescription for Canada*, p. 150.

⁷² Gagnon, M-A., 2010. “Why Canadians need universal pharmacare.” Canadian Centre for Policy Alternatives.

⁷³ Morgan, S. G. et al., “Rethinking Pharmacare in Canada,” *Commentary*, no. 384, June 2013, (Health Policy, C.D. Howe Institute).

⁷⁴ Gagnon, M-A. 2010, *ibid.*

8.3 Achieving better administrative efficiency

Administrative efficiency depends on how smooth is administering the service. The more time or human resources and technological support required, the more complex the administrative process gets. Hence, each of the policy options will be measured against the degree of complexity it entails.

As is widely acknowledged, administrative cost of a single payer plan is significantly less than the aggregate cost to administer multiple public and private insurance plans. Likewise, elimination of cost sharing can result in saving significant extra-costs due to processing patient payments. It is well-recognized that the current patchwork system is totally inefficient, and the administrative fees are much higher for private than public plans (8% as compared to 2%).⁷⁵ Achieving higher efficiency is one of the core objectives of the proposed new plan.

8.4 Stakeholder and public acceptance

Patients and their family members, healthcare providers and academics, representatives of healthcare organizations, business, labour groups, the pharmaceutical industry, private insurers and employee benefit providers all count as stakeholders in implementing a universal national plan. Perhaps the most active and influential of all are the healthcare providers as stakeholders, because implementation of a pharmacare policy involves their active participation throughout.

On the other hand, in a federal structure like Canada's the challenge of bringing most provincial opinions in alignment with a national vision is a true barrier. The National Pharmaceutical Strategy failed in the past at least in part because of differing views of federal and provincial governments.⁷⁶ Specialists hold misalignment of ideas within governing parties at the federal level responsible for the failure of pharmacare proposals get a nod. Institutions of private drug coverage also created a concentrated interest group that opposes universal pharmacare in Canada.

⁷⁵ Gagnon, M-A. 2010, *ibid*.

⁷⁶ Morgan, S.G., and K. Boothe. 2016. "Universal prescription drug coverage in Canada: Long-promised yet undelivered." *Healthcare Management Forum*, 29(6), 2016, pp. 247-254.

Public opinion does matter. Following the U.S., fierce opposition to a single-payer insurance model is likely from commercial interests. As with governments everywhere, Canadian governments too are unlikely to take on such opponents forcefully, unless there is strong public support for doing so.⁷⁷ The long-standing debate in Canada, spread out well over five-decades, is enough evidence that despite a strongly held and shared belief among a majority of Canadians, a universal drug coverage plan as component of universal healthcare could not be implemented in Canada on account of opposition from small but powerful groups. The proposed policy options should be assessed, all things considered, on the degree of both stakeholder and public acceptance.

⁷⁷ Morgan, S.G., and K. Boothe. 2016. *ibid.*

CHAPTER 9

Policy Options

In light of our research, encompassing the literature review, results of the survey analysis and of the findings from qualitative interviews, I propose the following three broad policy options with respect to cost sharing.

9.1 Policy Option I: No direct patient charges at the point of care

The policy strategy under this option is a universal single payer public prescription drug coverage program inspired by and derived from the original intention of the *Canada Health Act, 1984*, which states as follows: “that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians.”⁷⁸ This option provides a straight alternative to the present provincial systems and private drug insurance policies. It entails expansion of the *Canada Health Act* to include prescription drugs dispensed outside of hospitals as an insured service under the Act.

Under this option, whenever Canadians approach their pharmacy counters with a prescription (and proof of eligibility in hand), they would not be required to undertake any cost sharing for the medication dispensed to them. Pharmacists will follow a mandatory generic substitution policy for essential drugs to make sure patients and prescribers choose the most cost-effective treatment. The national pharmacare program will need to develop a national strategy for expensive drugs for rare diseases. Access to these drugs may be subject to discretionary decisions on benefit relative to cost. The entire insurance program will be financed through general tax revenue.

⁷⁸ The Canada Health Act, 1984, c. 6, s. 1.

9.2 Policy Option II: Modest cost sharing

Under this option I consider a special measure of modest cost sharing, close to the minimal amounts proposed by the Advisory Council on the Implementation of National Pharmacare, subsumed under a universal single-payer public prescription drug coverage program.⁷⁹

According to the Advisory Council recommendations, patients would pay no more than \$2 or \$5 per prescription depending on the drug group concerned. For instance, a prescription containing a straightforward antibiotic will cost \$2. And for prescriptions with other expensive drugs the amount will be \$5. It will include a maximum limit of payment per household not to exceed \$100 per year. To quote from the report: “The council recommends out of pocket costs for all products listed on the national formulary not exceed \$5 per prescription, with a copayment of \$2 for essential medicines and an annual maximum of \$100 per household per year to ensure that patients face few barriers to access.”⁸⁰

It may be noted that the Advisory Council strongly recommended that “all Canadian residents be eligible for national pharmacare to ensure everyone has access to the drugs they need to maintain their physical and mental health.”⁸¹

9.3 Policy Option III: Emulation of the BC ‘Fair Pharmacare Plan’

Under this option, all Canadians, including permanent residents are eligible to participate in the national pharmacare program. However, there will be cost-sharing based on BC's present formula. Families (including single-member households) are subject to an income tested deductible. As is known, deductibles are the amounts patients need to spend in a year before the program starts to share the burden of their prescription drug costs. They will pay full prescription costs until they meet their annual deductible threshold levels.

After meeting the deductible, the insurance authority pays 70% of the prescription drug costs for ‘Regular Assistance’ families, and 75% for ‘Enhanced Assistance’ families (i.e., those

⁷⁹ Health Canada, *A Prescription for Canada*, June 2019; Recommendation 8, p. 18 (also, p. 63).

⁸⁰ Health Canada, *ibid.*, p.18.; Recommendation 8.

⁸¹ Health Canada, *ibid.*, p.18; Recommendation 6.

with a member born before 1940) until they meet their family maximum. The family maximum is the annual maximum amount that a family needs to pay toward their eligible drug cost. Once they meet the family maximum the program pays 100% of eligible drug costs for the rest of the year. The BC program uses the net income from the family members' income tax returns to calculate a family's level of coverage, i.e., the range of deductibles, limit of the family maximum, and when and what percentage of assistance the program provides for the family. (See Appendix 1 for more detail.)

CHAPTER 10

Policy Criteria and Measures Weighted

10.1 Key Objective: Effectiveness

Increasing patient use of necessary prescription drugs remains the overarching objective of a national pharmacare program. The effectiveness of a policy measure will be determined based on what impact it will have on the completion of physician-recommended medical drugs. Based on research data, the effectiveness of alternative policy options is measured on the following 5-point scale put in an ascending order:

Very small increase in completion of prescription drug treatment plans relative to completion rates prior to introduction of national pharmacare (score 1);

Small increase (score 2);

Moderate increase (score 3);

Large increase (score 4); and

Very large increase (score 5).

10.2 Gross Cost of National Insurance (Cost to the Government)

Reducing the cost of unnecessary prescriptions is an integral consideration of any policy options for a national prescription drug policy. This criterion is measured on a 3-point scale put in an ascending order with larger decline estimates obtaining higher scores:

Small decline (score 1) (in unnecessary prescriptions);

Moderate decline (score 2); and

Large decline (score 3).

10.3 Redistributive Impact (Cost to Households)

What redistributive impact a particular policy option might have is estimated by the redistributive income effect of cost-sharing per household relative to a policy of no cost at the point of purchase. Measuring the regressive impact of a cost-sharing policy involves the share of low-income families on prescription drugs relative to medium and high-income families. The larger the cost-sharing option the more regressive a policy becomes, e.g., option I, with no copayments, would have no regressive impact, whereas Option III, with cost-sharing resembling the *status quo ante* in BC, would have a significant regressive impact. The scores for this criterion will be measured on a 3-point scale in a descending order:

- Significant regressive impact (score 1);
- Modest regressive impact (score 2); and
- No regressive impact (score 3).

10.4 Administrative Efficiency

The gist of administrative efficiency is to keep the process of administering the service simple and well managed. In other words, the more time or human resources (and technological support) required, the more complex the administrative process. Complexity matters in a substantial way and is **inversely related** to efficiency. Hence, each of the policy options considered is measured against the degree of complexity it entails. The specific measure being used for administrative efficiency here is the estimate of time and other kinds of logistic support required for dispensing drugs per prescription:

- ‘High complexity/Low efficiency’ (score 1);
- ‘Moderate complexity/Moderate efficiency’(score 2); and
- ‘Low complexity/High efficiency’ (score 3).

10.5 Stakeholder and Public Acceptance

The specific measures for stakeholder acceptance considered here are as follows:

- (i) Acceptability to federal, provincial and territorial governments;
- (ii) Acceptability to healthcare professionals; and

(iii) Acceptability to health policy specialists, different interest-groups with a stake in public policy and other opinion makers.

A three-point scale of low acceptance (score 1), moderate acceptance (score 2), and high acceptance (score 3). is used to rate acceptability among stakeholders and the general public.

TABLE 10.1: Policy Criteria and Measures

Criteria	Measures	Scoring
1. Effectiveness of national pharmacare plan	Impact of policy on patient completion of prescription drug treatment plan (relative to patient completion prior to the introduction of national pharmacare)	1. Very small increase (in completion of prescription drug completion plan) 2. Small increase 3. Moderate increases 4. Large increases 5. Very large increase
2. Gross cost of national insurance to the government due to "unnecessary" prescriptions	Fewer " unnecessary " prescriptions – reducing gross cost of national pharmacare (relative to "unnecessary prescriptions" prior to the introduction of national pharmacare)	1. Small decrease (in volume of unnecessary prescriptions) 2. Medium decrease 3. Large decrease
3. Redistributive impact [In terms of cost to the households]	Estimated regressive impact of the proposed insurance policy on patient income	1. Significant regressive impact 2. Modest regressive impact

	[Change in the amount of annual household spending on prescription drugs]	3. No regressive impact
4. Administrative efficiency	Amount of time and other logistic support required for dispensing drugs per prescription	1. High complexity 2. Moderate complexity 3. Low complexity
5. Stakeholder acceptance	Acceptability to Federal, Provincial (and Territorial) governments, Health care professionals, public policy analysts, interest groups, political parties and other opinion makers.	1. Low acceptance 2. Moderate acceptance 3. High acceptance
6. Public Acceptance	Acceptability to the public at large	1. Low acceptance 2. Moderate acceptance 3. High acceptance

CHAPTER 11

Analysis of Policy Options

In this chapter, the policy options are analyzed, on the basis of the criteria and measures discussed in the preceding chapters. The policy matrix at the end of this chapter (see Table 11.1) provides an overview of the analysis.

11.1 Analysis of Option I: No direct patient charges at the point of care

This policy option imposes no financial barrier to get access to prescribed drugs. Studies in various jurisdictions show that direct patient charges can result in patients not taking their necessary medication prescribed. Evidence-based studies, both Canadian and international, have amply demonstrated that removal of cost-barriers leads to increases in prescription drug utilization.

For instance, one study shows that elimination of co-payments in the Ontario Drug Benefit Plan for seniors at age 65 increased drug use.⁸² Increases in drug use were concentrated primarily among individuals with lower levels of health status. Most of the increased occurred among individuals under physician supervision, which indicates that removing cost-barriers enabled those patients to fill their unfilled prescriptions.

The Advisory Council on the Implementation of the National Pharmacare estimated that removing out-of-pocket costs for medications used to treat just three health problems (diabetes, cardiovascular diseases, and chronic respiratory conditions) would result in up to 220,000 fewer emergency room visits and 90,000 fewer hospital stays annually, leading to a saving of \$1.2 billion.⁸³ In light of these research findings, it is highly likely that no cost sharing at the point of

⁸² Grootendorst, Paul V., Bernie J. O'Brien and Geoffrey M. Anderson, 'On Becoming 65 in Ontario: Effects of Drug Plan Eligibility on Use of Prescription Medicines,' *Medical Care*, vol. 35, no. 4 (Apr., 1997), pp. 386-398.

⁸³ Tamblyn, R., Bartlett, S., Thavorn, K., Weir, D. & Habib, B. (2019). *Burden and Health Care System Costs Associated with Cost-Related Non-Adherence to Medications for Selected Chronic*

care will result in a very large measure of increase in patients filling their prescriptions. Therefore, **effectiveness** of this policy on raising prescription drug use is scored **5/5**.

There is good evidence that over-prescribing is taking place.⁸⁴ However, there is little evidence to suggest this can be addressed by cost-sharing. There are contradictory arguments on the extent to which no cost-sharing leads to physicians prescribing unnecessarily and patients requesting prescriptions unnecessarily. One stream of experts bases their argument on the assumption of demand-side moral hazard in health insurance. This assumes that patients are consuming health services beyond their needs. Empirical research on patient cost-sharing in Europe and elsewhere concludes that evidence for demand-side moral hazard is meagre. Clinical studies suggest that the great majority of health insurance beneficiaries do not aim to abuse the public healthcare system.⁸⁵ **Cost reduction** by decreasing the number of unnecessary prescription drugs will fundamentally rely on the overall effectiveness of educational programs addressing the overprescribing by physicians and inappropriate patient requests for prescriptions.

Two appropriate quotations from the qualitative interviews conducted for this capstone illustrate the sharp contradiction introduced above. For one respondent (R002), “ ‘Moral hazard’ carries a high degree of importance, definitely! Moral hazard is real and very, very important to consider and mitigate against.” Another respondent (R003), however, takes a very different stand: “ ‘Moral hazard’ is of very minor importance. I have heard this argument used against reform in the past, but in my view, the evidence suggests that it is not actually much of an issue.”

As noted above, the Advisory Council rightly estimated, adopting this option will save billions of dollars for the government by reducing hospitalization and other serious intervention in treatment procedure. However, assessing the chance of ‘moral hazard’ coming into play, this

Conditions in Canada (a report prepared for the Advisory Council on the Implementation of National Pharmacare). Available from Health Canada on request.

⁸⁴ See, this capstone, Chapter 4.2, *supra*.

⁸⁵ Holst, J. (2010). “Patient Cost Sharing – Reforms without Evidence: Theoretical Considerations and Empirical Findings from Industrialized Countries,” trans. Meredith Dale, *Discussion Paper SP I 2010-303* (Berlin: Wissenschaftszentrum Berlin für Sozialforschung), Abstract, p. iii.

policy option is judged to account for only **a very small decrease or no decrease at all in unnecessary prescription drug use** and the option scores **0/3**.

In terms of **redistributive impact**, as this option imposes no burden of direct cost-sharing on patients, it will have no regressive impact on the household costs of drug spending, which awards this option the score of **3/3**.

A prescription drug program that doesn't include any payment at the point of delivery of prescription drugs doesn't seem to create any complexity either. It will keep the administering process less time consuming for pharmacists, requiring less logistics, accounting procedures, and other administrative support services compared to options that require cost sharing arrangements. The process is likely to be pretty smooth. Thus, it is scored **3/3** for low complexity.

The acceptance of this policy option among a spectrum of stakeholders is likely to be somewhat mixed. Nationalizing standards for a policy like pharmacare will require considerable cooperation between federal and provincial (and territorial) governments. Negotiation and consensus on the specific terms of a universal pharmacare remain uncertain. Apart from that, certain groups of healthcare professionals (such as Doctors for Medicare) are eloquently vocal about adopting a policy option for the national pharmacare that would be based on the patients' health needs and certainly not their ability to pay. However, the Canadian Medical Association (CMA) has not yet been vocal on any particular policy option. Historically, the CMA opposed the idea of a national pharmacare in the healthcare system.⁸⁶ Overall, **stakeholder acceptance** of this policy is considered moderate and scored **2/3**.

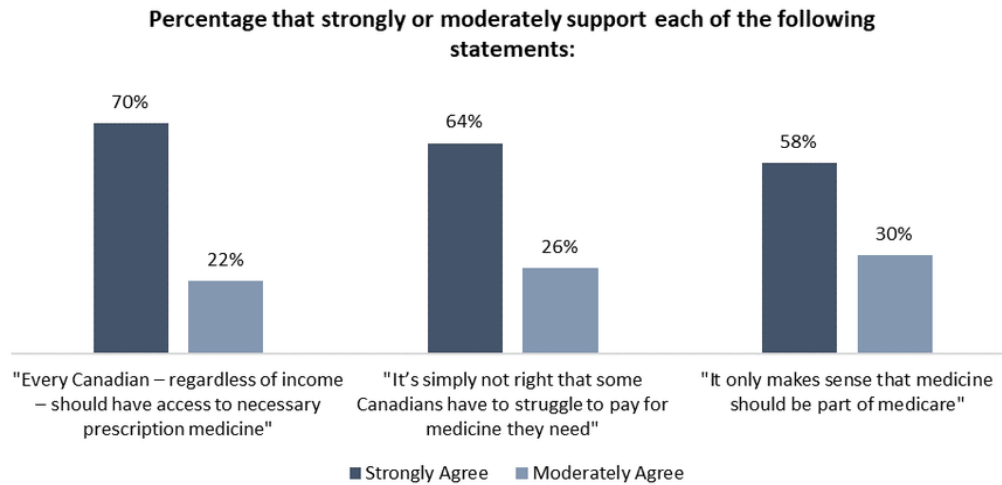
Public acceptance of this policy option, nevertheless, seems to be high as an extensive survey conducted in October 2020 by Angus Reid Institute shows.⁸⁷ According to the survey, a

⁸⁶ Marchildon, G. P., "Private Finance and Canadian Medicare: Learning from History," in Flood, C. M. and B. Thomas, eds., *Is Two-Tier Health Care the Future?* (Ottawa: University of Ottawa Press, 2020), pp. 15-35.

⁸⁷ Angus Reid, 'Access for all: Near Universal Support for a Pharmacare Plan Covering Canadian's Prescription Drug Costs'. October 29, 2020; <https://angusreid.org/pharmacare-2020/>

clear majority of those participating expressed their moral support for such a policy that provide easy, unhindered access to the prescription drugs or to include medicine to Medicare.

Figure 11.1 Public opinion on access to prescription drugs without cost-barrier



.....
Source: Angus Reid (October 29, 2020), *Access for all: Near universal support for a pharmacare plan covering Canadians' prescription drug costs.*

Considering the overall situation this policy option is judged to gain high public acceptance. Thus, it is scored **3/3** here.

11.2 Analysis of Policy Option II: Modest copayments

Under this policy option the recommended copayments are no more than \$100 per year, which will obviously bring about a steep reduction in current out-of-pocket expenditure on prescription drugs.⁸⁸ Moreover, people living on social assistance, government disability benefits, or the federal Guaranteed Income Supplement (GIS) are exempt from all copayments. Thus, this option will increase the prescription drug usage compared to the current situation. However, even a modest copayment may constitute a significant barrier for many lower-income people who are not on some **form** income assistance.

⁸⁸ Health Canada, *A Prescription for Canada: ibid.*, pp. 12-13.

As mentioned previously in Chapter 4, above, experts and practising doctors testifying before the House Standing Committee reiterated that even very small co-payments can prevent individuals with relatively low incomes from filling their prescriptions.⁸⁹ Empirical research, both Canadian and international, as discussed in Chapter 3.2, above, shows that even small direct patient charges can result in patients not taking their medically necessary medication. For instance, a study rigorously examining the evidence regarding effects of copayments on drug expenditures, appropriateness of drug utilization, and the efficiency with which prescription drug markets operate in Canada concluded that, although copayments can reduce drug program expenditures, they do so only by compromising the major program goals.⁹⁰ Thus, the effectiveness of this program is scored as **4/5**.

As discussed in the previous policy option considering the moral hazard that may arise from a universal pharmacare program with no cost-sharing this option with **modest cost sharing** may account for **modest reduction** in **unnecessary prescription drug consumption** as well. Therefore, on this criterion this option is scored as a modest reduction of **2/3**.

Likewise, the **redistributive impact** of this policy is projected to have a minor regressive impact on peoples' income as previously explained in the chapter 10.3. Hence, this policy option with modest co-payments is scored as **2.5/3**.

In assessing the **administrative complexity**, collecting different amounts of co-payments for different types of drugs will involve additional administrative work. This will no doubt add complexity to the process relative to a policy of no payment at the point of receiving the prescribed drugs. However, since it doesn't require different types of payments, e.g., percentage calculation for co-insurance or other detailed elements, this policy option will not likely to add a major complexity. Hence, it is scored a somewhat low complexity of **2.5/3**.

⁸⁹ Vide, *Pharmacare Now*, pp. 65-70.

⁹⁰ Hurley, J. and N.A. Johnson, "The Effects of Co-Payments within Drug Reimbursement Programs," *Canadian Public Policy /Analyse de Politiques*, vol. 17, no. 4 (Dec., 1991), pp.473-489.

Since this policy option strikes a balance between no direct cost sharing and high cost sharing, only this option provides a middle ground among **stakeholders** in decision making to come to a desired level of consensus. This is somewhat reflected in both my qualitative findings and quantitative survey (Chapters 6 and 7). Therefore, this policy option is scored as a **3/3** on the stakeholder acceptance.

However, in terms of public acceptance this option scores a modest figure of **2/3** as it puts a cost barrier that a greater number of Canadians do not seem to support as shown in many opinion surveys, past and present, including in the most recent one by Angus Reid referred in a previous section.

11.3 Analysis of Policy Option III: Emulation of the BC ‘Fair PharmaCare Plan’

This policy option implies that the national pharmacare plan will adopt the current structure of BC’s Fair PharmaCare Plan. It entails a deductible (paying the full cost) and a percentage of cost-sharing for expenditures above the deductible. All three elements, i.e., the deductible threshold, co-insurance, and family maximum cost-sharing, are based on the patients’ family income. The **effectiveness** of this option will essentially depend on how much national bargaining under Pharmacare would reduce drug-costs. As discussed above, as patient's cost sharing rates rise, the prescription drug completion rate goes down. This option is not likely to generate a large increase in prescription drug use. Hence, this policy option on effectiveness is scored as a **2/5**.

Some experts strongly suggest that cost-sharing effectively addresses the ‘moral hazard’ associated with unnecessary prescriptions. Since this option will require the patients to pay more out-of-pocket than under the two other options, it may decrease a relatively large amount of unnecessary prescription drugs and thus make a contribution to **cost reduction** for the government. Therefore, this policy on cost reduction scored (comparative to two other options) high as **3/3**.

In assessing the **redistributive impact**, as discussed above, the larger the cost sharing the more regressive the policy becomes. Therefore, this policy scores quite low on this criterion, as it will have a significant regressive impact relative to the two other options. It therefore scores **1/3**.

This policy, as explained above, consists of multiple elements includes all three cost-sharing elements (deductible, co-insurance, and family maximum), which also vary for every patient depending on the family income. It is understandable that this option will make the administrative process a good deal more complex as compared to the two other options. Hence, in assessing the **complexity** in administrative management, this policy is scored **1/3**.

Whether **stakeholders** will receive favourably the scaling up to the national level of a provincial formula is pretty much uncertain. Compared to other proposed options this option thus scores a **1/3** in terms of stakeholder acceptance across the country. A policy option that emulates an existing drug plan with minor reform will probably not look impressive to the general public. In the recent nationwide survey, BC and Atlantic Canada show the highest levels of access problems (29% and 26% respectively).⁹¹ Thus, in terms of **public acceptance** this policy option quite objectively obtains a low score of **1/3**.

⁹¹ Angus Reid, 'Access for All: Near Universal Support for a Pharmacare Plan Covering Canadians' Prescription Drug Costs,' *ibid*.

TABLE 11.1: Summary of Policy Evaluation

Criteria	No Direct Patient Charges at the Point of Care (Option 1)	Modest Co-Payment (Option 2)	Emulation of BC 'Fair PharmaCare Plan' (Option 3)
Effectiveness (increase in prescription drug use) (max= 5)	Very large increase (5)	Large increase (4)	Small increase (2)
Redistributive Impact (max= 3)	No regressive impact (3)	Minor regressive impact (2.5)	Significant regressive impact (1)
Cost Reduction (due to unnecessary prescriptions) (max = 3)	Very small or no decrease (0)	Moderate decrease (2)	Large decrease (3)
Administrative Efficiency (max= 3)	Low complexity (3)	Some complexity (2.5)	High complexity (1)
Stakeholder Acceptance (max= 3)	Moderate acceptance (2)	High acceptance (3)	Low acceptance (1)
Public Acceptance (max = 3)	High acceptance (3)	Moderate acceptance (2)	Low acceptance (1)
Total (max = 20)	16	16	9

CHAPTER 12

Recommendations

To move forward towards a universal single payer public prescription drug coverage program in Canada, demands doing more than merely addressing coverage gaps. The ultimate goal of a recommended policy is striking an efficient balance between better health outcomes and better cost control.

Even if the Policy Option I (with no copayments) scores higher, i.e., performs better in objective terms, especially on account of its addressing the fundamental objective of effectively securing necessary prescription drugs for all, thus ensuring improved health status and quality of life for all Canadians, it is **quite unlikely** that this option is going to be accepted by all critical stakeholders in policy-making and implementing it.

Given the vital problem of consensus-building between the federal and provincial (including territorial) governments on the one hand and, on the other hand, among policy makers, business, and all other stakeholders some pragmatism is called for in reaching a workable policy take off. Therefore, I recommend **Policy Option II**, admittedly, involving a measure of modest copayments which it strikes a just balance between the outlying options considered, namely the one (i) with no direct patient charges, and the other (ii) emulating one of the incumbent provincial plans which entails high out-of-pocket-spending similar to average existing plans. Policy Option II can be also considered some sort of **consensus by compromise** between our two extreme options. Taking all considerations into account, this seems to be **the best overall and the only feasible option** at least for the near future.

It is understandable that the Advisory Council extensively assessed the trade-offs involved and the overall benefits of a universal system to replace the existing patchwork system, which is both costly and regressive, and which leaves millions behind. The benefits of a universal public system proposed by the Advisory Council outweighs the burden of a modest cost-barrier it intends to retain, for sure, even if it violates the *Canada Health Act's* basic principle of a universal, single

payer, public system of healthcare with no cost barriers. Most worrisome is the concern that the system is now approaching the breaking point for a panoply of reasons (rapidly rising drug costs among them), which lie beyond the scope of this thesis. In the current conjuncture, a modest copayment is perhaps justifiable for making a universal public system of prescription drugs program possible in Canada, a desideratum long overdue for decades now.

As an integral part of this strategy, I would recommend Health Canada launch an **education program for physicians** on appropriate prescribing practices to understand the harm caused by excessive use of pharmaceutical treatment. (See Appendix 2.) The program is also expected to **make aware the general public**, patients in particular, on equivalence of generics to brand drugs and benefits of using generics and biosimilars in order to save money and to keep the insurance program affordable. The experts for the program will negotiate performance-based **financing agreements with the drug manufacturers** in order to ensure better value for money.

As part of this policy, all jurisdictional governments need to actively co-operate in this process of maintaining an oversight mechanism and regulating appropriate prescribing by carefully regulating **all manners of pharmaceutical industry payments to prescribers and other healthcare providers, institutions and patient groups, with a mandatory requirement for public disclosure** of any such payments duly enforced.

Chapter 13

Conclusion

In conclusion I would like to reiterate that my study analyzes a set of primary data collected by both quantitative survey and qualitative interviews. I also analyze secondary data culled from the latest information available and apply both qualitative and quantitative methods of data analysis in processing the relevant data. My recommendation is, in part, derived from the findings of my primary survey data where the modal option favored a small copayment. Their choice, as I take it, is motivated by a concern for building a nationwide consensus for a universal pharmacare in Canada.

The similarity between the Council's position and the outcome of my study is coincidental. The methods I applied are substantially different. In comparing the **two contending policy options**, (between 'no cost-sharing' Option 1 and 'modest cost-sharing' Option 2 at the point of filling prescriptions), I found that the overarching objective of the universal prescription drug plan, i.e., **increasing prescription drug use**, is better served with no direct cost-sharing at the point of dispensing prescription drugs.

However, given the Canadian historical perspective, reaching a consensus among myriad stakeholders is an indispensable condition to end the *status quo* and let the prospective universal prescription drug plan take off. In the end, that became my determining factor for recommending a modest cost-sharing, with **the sole objective of securing a consensus among stakeholders**. My substantial reasons for endorsing the provision for modest direct copayment are, however, fundamentally different from those of the Advisory Council's on an important respect. The Council agrees, on the one hand, that "there is little evidence that 'free' prescription medicines lead to overuse, abuse or wastage" and that direct out-of-pocket costs at the point of dispensing drugs contribute to "creating a financial barrier" for patients. It also admits "collecting user fees will add to the cost of running pharmacare." On the other hand, notwithstanding these arguments, the Council opts for copayments.⁹² I respectfully disagree with the reason the Council adduces. To

⁹² Health Canada, *A Prescription for Canada: Achieving Pharmacare for All: Final Report of the Advisory Council on the implementation of National Pharmacare*, 2019, pp.18, 63.

stress perceived 'moral hazard' is not an overarching concern; but by all accounts, **inaccessibility to medically necessary prescription drugs** is the major concern.

Appendix 1

DETAILED DESCRIPTION OF PROVINCIAL PRESCRIPTION DRUG PLANS

British Columbia, Alberta, Ontario, and Quebec

1.1 British Columbia: Family-income-based Voluntary Plan

British Columbia's prescription drug insurance plan, Fair PharmaCare, has been in operation since 2003. Under this plan families (including single member families) are subject to an income-based deductible, a percentage of shared payment (once the deductible has been met), and an annual out-of-pocket maximum. There are no deductibles and family maximum when income is \$13,750 or less. As a proportion of income, deductibles range up to \$10,000 per family.⁹³

It is a voluntary program under which any resident may receive public subsidy for costs exceeding deductibles determined by income. The plan incorporates other criteria to include people with special eligibilities and needs. Once a family has spent approximately 2% of its net income on prescription drugs or related costs, Fair PharmaCare pays for 100% of any subsequent costs for the rest of the year. The plan also offers coverage to families with higher incomes but requires them to first pay out-of-pocket for drug costs (up to 2–3% of their income) before any plan coverage begins.⁹⁴

British Columbia currently offers altogether eight public drug insurance plans for its residents who are active Medical Services Plan (MSP) holders.⁹⁵ Eligibility criteria vary for each plan. The eight existing plans are as follows:

- (a) Fair PharmaCare (for most of the BC residents)

⁹³ Government of British Columbia, *Fair PharmaCare*, <https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/who-we-cover/fair-pharmacare-plan/fair-pharmacare-changes-in-2019>

⁹⁴ Barua, B., et al., *Provincial Drug Coverage for Vulnerable Canadians* (Fraser Institute, 2018), p. iii.

⁹⁵ Government of British Columbia, *Fair PharmaCare*, *ibid.*

- (b) Plan B (for residents of licensed residential care facilities)
- (c) Plan C (for individuals receiving income assistance)
- (d) Plan D (for individuals registered with a provincial cystic fibrosis clinic)
- (e) Plan F (for children receiving medical or full financial assistance through the ‘At Home Program of the Ministry of Children and Family Development’)
- (f) Plan G (for mental health patients who can’t afford the cost of medication for treatment)
- (g) Plan P (for those who choose to receive palliative care at home)
- (h) Plan W (for First Nations Health Benefits).

Fair Pharmacare is the largest of BC plans. Reimbursement under this plan is based on net family income guided by the principle—“the lower a family’s income, the more help they receive.”⁹⁶ The three main components of the plan are (1) deductibles (2) co-insurance and (3) a maximum out-of-pocket spending limits (based on the net family income). A family’s deductible is the amount required to be spent each year by the family before Fair PharmaCare starts to work with the co-insurance and rest of the cost.

Under the plan a registered family pays full prescription drug costs until it meets the deductible during a calendar year (January-December). Once a family meets the deductible, PharmaCare pays 70% of the eligible cost of a drug for *regular assistance* families and 75% for *enhanced assistance* families (those with at least one member born before 1940) until they reach their family maximum. The family maximum is the annual amount that a family pays toward eligible drug costs. After the family maximum is reached, PharmaCare will pay 100% of eligible drug costs for the rest of the calendar year.

Since January 1, 2019, ‘regular assistance’ families earning up to \$45,000 per year have lower deductibles and/or family maximums. ‘Enhanced assistance’ families earning up to \$13,750 per year have *no deductible or family maximum*. For a family with net income up to \$30,000 there is no deductible and a lower family maximum—Fair PharmaCare pays 70% of eligible prescription costs right away. A lower deductible amount and a lower family maximum apply to all families

⁹⁶ Government of British Columbia, *Fair PharmaCare*, *ibid.*

with net income above \$30,000 but below \$41,667. In case of families with income below \$45,000 but above \$41,667 a lower family maximum applies.⁹⁷

All British Columbia residents are eligible for plan coverage, provided they have (a) Medical Services Plan (MSP) and (b) give the plan authorities permission to check their income (for the last two years) with the Canada Revenue Agency (CRA). A family, for the purposes of the plan, is either a single person, or a couple (‘couple’ defined as ‘married or common-law’ couple), or a single person with children, or a couple with children (‘dependent children’).

1.2 Alberta: Premium-based Comprehensive Voluntary Plan Model

Alberta offers ten different drug coverage programs⁹⁸ including (1) a premium-based **non-group coverage** plan available to all Albertans under age 65 years and their dependents; (2) a premium-free **coverage for seniors** plan available to Albertans 65 years and older and their dependents; (3) a **palliative coverage** plan for people diagnosed as being palliative and receiving treatments at home; and (4) an **optical assistance for seniors** plan for low-to-moderate income seniors to receive financial assistance for optical services.⁹⁹ Alberta plans, in general, are voluntary premium-based plans with comprehensive drug coverage involving no patient charges (except for the non-group one) at the point of prescription care.¹⁰⁰

Albertans under 65 (and their dependents) have access to the **Non-Group coverage** plan sponsored by the provincial government (run by *Alberta Blue Cross*). Individuals and families are charged monthly premiums based on income and family arrangements. Under the Non-Group

⁹⁷ Government of British Columbia, *Fair PharmaCare*, *ibid.*

⁹⁸ Health Canada, *A Prescription for Canada: Achieving Pharmacare for All* *ibid.*, Appendix 4, pp.134-5.

⁹⁹ These supplementary health benefit plans also cover pre-existing health conditions; see, Alberta Health, *Drug Coverage and Supplementary Health Benefits*; <https://mssociety.ca/support-services/programs-and-services/588/drug-coverage-and-supplementary-health-benefits-alberta-health>

¹⁰⁰ Health Canada, *A Prescription for Canada: Achieving Pharmacare for All*, *ibid.*, Appendix 4, p.134.

coverage plan families (with children), a family with income less than \$39,250 pays a monthly premium of \$82.60 to access the plan. Prescription drugs covered under the Non-Group program are subject to a 30 percent copayment to a maximum of \$25 per prescription. There is no deductible for coverage, nor is there an out-of-pocket maximum. Higher-income families can also access this program paying higher premiums. Lower-income families (also those with additional covered circumstances such as pregnancy, high ongoing prescription needs, and disability) are exempted from premiums and co-payments for many prescription drugs as well as some over-the-counter products.

Subject to meeting certain eligibility criteria, *Alberta Seniors Benefit* offers some added benefits. To be eligible one must, (i) be a Canadian citizen or permanent resident, (ii) be 65 years (or older), (iii) have lived in Alberta for at least three months immediately before applying and (iv) be receiving OAS (Old Age Security) pension. In general, a single senior with an annual income of \$28,785 or less (and senior couples with a combined annual income of \$46,745 or less) may be eligible for a benefit. These income levels are, however, guidelines only and are limited to seniors whose income includes full OAS (Old Age Security) pension. The amount of eligible is determined by factors including (i) the person's income, combined with spouse/partner's income, regardless of age, (ii) on receiving federal OAS pension (i.e., on living in Canada for 10 years), (iii) the person's accommodation category and (iv) her/his marital/cohabitation status.¹⁰¹

Comprehensive drug-benefits are provided to seniors. Age-tested and income-tested drug benefits for children in low-income families are also available. Alberta seniors (and their spouses/interdependent partners and dependents) are eligible for the Coverage for Seniors Benefit. *Alberta Blue Cross* administers the program coverage and claims, while *Alberta Health* manages eligibility and registration. It offers the same drug coverage as the Non-Group Coverage plan. However, seniors do not have to pay a monthly premium.¹⁰²

¹⁰¹ Government of Alberta, *Family and social supports: Seniors: Financial assistance for seniors: Alberta Seniors Benefit*; <https://www.alberta.ca/alberta-seniors-benefit.aspx>

¹⁰² Government of Alberta, Department of Health, *Coverage for Seniors Benefit*. Government of Alberta. <http://www.health.alberta.ca/services/drugs-seniors.html>

Table 1: Premiums for Non-Group Coverage, Alberta ¹⁰³

Family Type	Income	Monthly Premium
Single	< \$20,970	\$44.45
	> \$20,970	\$63.50
Family without Children	< \$33,240	\$82.60
	> \$33,240	\$118.00
Family with Children	< \$39,250	\$82.60
	> \$39,250	\$118.00

Among the provinces, Alberta provides the most generous level of public drug coverage. A family with four children, for example, would qualify for the lower premium provided its family income is below \$39,250. In comparison British Columbia offers a higher range of benefits (i.e., no deductible or family maximum) to a family with net income of \$13,750).¹⁰⁴ However, strictly speaking, the two provincial plans are not comparable (as they offer different kinds of benefits). Alberta also offers a number of programs specially designed for low-income individuals and families, as well as other vulnerable populations. The *Alberta Adult Health Benefit Program* is available to low-income Albertan's who fulfil certain criteria (such as those who are pregnant, have high ongoing prescription needs, are refugees or refugee claimants, or are leaving the Income Support program or the Assured Income for the Severely Handicapped Program).¹⁰⁵ Children living in low income families are eligible for the *Child Health Benefit*.¹⁰⁶

These two programs cover, among other things, the full cost of many prescription drugs and some over-the-counter products with no premiums or cost sharing requirements. Where a

¹⁰³ Government of Alberta, Department of Health, *Health Services and Benefits: Drug Coverage and Health Benefits: Non-Group Coverage*; <https://www.alberta.ca/non-group-coverage.aspx>

¹⁰⁴ Barua, B. et al., *ibid.*, pp. 21-22.

¹⁰⁵ Government of Alberta, Department of Health (n.d., c). *Alberta Child Health Benefit*. Government of Alberta. <https://www.alberta.ca/alberta-child-health-benefit.aspx>

¹⁰⁶ Government of Alberta, Department of Health (n.d., d). *Alberta Adult Health Benefit*. Government of Alberta. <https://www.alberta.ca/alberta-adult-health-benefit.aspx>

child, adult, or member of the household already has coverage through another plan, these programs may help cover the remaining costs. Eligibility to avail of these plans is determined by family arrangement and income (Table 2).

Table 2: Coverage for Low Income Albertans (including children) ¹⁰⁷

<i>Family Type</i>	<i>Maximum Qualifying Income</i>
Single adult	\$16,580
1 adult + 1 child	\$26,023
1 adult + 2 children	\$31,010
1 adult + 3 children	\$36,325
1 adult + 4 children*	\$41,957
Couple, no children	\$23,212
Couple + 1 child	\$31,237
Couple + 2 children	\$36,634
Couple + 3 children	\$41,594
Couple + 4 children*	\$46,932

* To be added \$4,973 to qualifying income for each additional child.

Albertans severely handicapped and on social assistance receive full coverage for drugs with no premiums or cost sharing.¹⁰⁸ There is also a program offered for those receiving **palliative**

¹⁰⁷ Government of Alberta, Department of Health, *Alberta Adult Health Benefit*. Government of Alberta. <https://www.alberta.ca/alberta-adult-health-benefit.aspx>

¹⁰⁸ Government of Alberta, *Your Guide to AISH: The Assured Income for the Severely Handicapped Program*. Government of Alberta, 2017; <https://open.alberta.ca/dataset/928e010e-6b26-46af-a8e2-8c938e5f1b10/resource/27769011-64a5-4396-8c67-f741505b7264/download/your-guide-to-aish-11dec17final.pdf>

care at home, which has a 30 percent co-payment to a maximum of \$25, with a \$1,000 lifetime maximum.¹⁰⁹ Finally, there are programs that provide high-cost drugs to treat a subset of conditions including HIV, cancer, cystic fibrosis, organ transplants, intraocular disease, and others.¹¹⁰ The province's special drug coverage programs include an *Outpatient Cancer Drug Benefit Program* that covers some medications used to treat cancer at no cost to patients and a *Specialized High Cost Drug Program* with coverage for drugs used in highly specialized procedures like organ transplants and major heart surgery. In addition, the *Retina Anti-Vascular Endothelial Growth Factor Program for Intraocular Disease (RAPID)* provides coverage for Avastin, Lucentis and Eylea, drugs that are used to slow down loss of vision and the *Insulin Pump Therapy Program* is designed for Albertans who have Type I or Type III diabetes and covers the cost of an insulin pump and associated supplies.¹¹¹ Many disease modifying drugs for multiple sclerosis are eligible for *special authorization* to be covered by the ministry's supplementary health benefit programs.¹¹²

1.3 Ontario: Age-based and Income-tested Voluntary Plan Model

¹⁰⁹ Government of Alberta, Department of Health, *Palliative Coverage Program*. Government of Alberta, no date; <http://www.health.alberta.ca/services/drugs-palliativecare.html>

¹¹⁰ Government of Alberta, Department of Health, *Specialized High Cost Drug Program*. Government of Alberta, no date. <http://www.health.alberta.ca/services/drugs-high-cost.html>; Government of Alberta, Department of Health, *Retina Anti-Vascular Endothelial Growth Factor Program*. Government of Alberta, no date; <http://www.health.alberta.ca/services/drugs-retina-program.html>; Alberta Health Services, *Outpatient Cancer Drug Benefit Program*. Alberta Health Services, no date. <https://www.albertahealthservices.ca/info/service.aspx?id=1025651>

¹¹¹ Alberta Health, *Drug Coverage and Supplementary Health Benefits*; <https://mssociety.ca/support-services/programs-and-services/588/drug-coverage-and-supplementary-health-benefits-alberta-health>

¹¹² Alberta Health, *ibid.* https://www.ab.bluecross.ca/dbl/pdfs/dbl_sec1_sa.pdf

The Ontario system of prescription drug insurance plan is “a hybrid of comprehensive coverage for seniors and income-based coverage for all others”.¹¹³ The current system of Ontario’s drug insurance emphasizes both age and civil-status of the person in determining both the amounts of deductibles and co-payments.¹¹⁴ Taking into account their ages and income levels, seniors are distributed into four groups:

- (a) Single senior with income above \$19,300
- (b) Senior couple with combined income above \$32,300
- (c) Single senior with income of \$19,300 or less
- (d) Senior couple with combined income of \$32,300 or less.

A person qualifies for the Ontario Drug Benefit (ODB) program on turning 65. With the ODB a person age 65 or older pays a portion of prescription-drug costs based on her/his after-tax annual income and civil status. One can get coverage as a single senior (including widowed spouses) or as a couple (includes spouses who are married, same-sex or common-law partners). A single person age 65 or older with a yearly **after-tax** income above **\$19,300** pays the **first \$100** of total prescription costs each program year (August 1-July 31, the following year). Once prescription expenses exceed the deductible, he or she pays a co-payment, **up to \$6.11** for each prescription, whether filled or refilled.

In the case of a couple (where at least one person is 65 or older) the \$100 deductible is payable if the combined income exceeds **\$32,300**. **Otherwise, the plan is identical with the program describe in the previous paragraph.** A single senior, with an annual after-tax income of \$19,300 or less, **has to make a copayment of up to \$2** for each prescription drug–filled or refilled–but need not pay a deductible. A senior couple (where at least one person is 65 or older), with a combined annual income of \$32,300 or less (after taxes), each senior is eligible for benefits

¹¹³ Morgan, S. G., Daw, J.R. and Law, M.R., ‘Rethinking Pharmacare in Canada,’ *Commentary*, 384. (Vancouver: CD Howe Institute, 2013), p.6.

¹¹⁴ Government of Ontario, *Get coverage for the prescription Drugs*, <https://www.ontario.ca/page/get-coverage-prescription-drugs#section-2>

and has to make a copayment of up to \$2 for each prescription drug—filled or refilled—but **need not** pay a deductible.

There are exemptions for vulnerable groups. Some become eligible before reaching 65 if they are living in long-term care-home or home for special care or in a Community Home for Opportunity. Others also become eligible if they are 24 or younger and not covered by a private insurance plan or are receiving professional home and community care services or receiving benefits from special social assistance plans (such as ‘Ontario Works’ or ‘Ontario Disability Support Program’ or enrolled in the ‘Trillium Drug Program’). People living in one of the home types are automatically covered by the ODB program. They have a copayment (**up to \$2** for each drug filled or refilled)—but **need not** pay a deductible. Those who are 24 or under and are living in these homes **have no** copayment either.

Those who receive professional home and community care services arranged through their ‘Local Health Integration Network’ are automatically covered by ODB. They **make a \$2** copayment for each prescription filled or refilled, but **do not** have to pay a deductible. People 24 years and under (with no private insurance or beneficiaries of professional home and community care services) **do not** have to pay the \$2 for each prescription filled or refilled. People who are receiving benefits from ‘Ontario Works’ or ‘Ontario Disability Support Program’ are automatically covered by the ODB. They **pay up to \$2** for each prescription filled or refilled – and do **not** pay a deductible. To register for the income-based program, non-seniors in Ontario are obliged to declare that they do not have private health insurance or that their private insurance does not cover 100 per cent of their prescription drug costs.¹¹⁵

Provinces with public prescription drug coverage for seniors (65 and above)—like Ontario and the Atlantic provinces—have lately been under pressure as the changing age-structure of their population began to swell up the senior population and to their insurance liability. Concerned

¹¹⁵ Morgan, S. G., Daw, J.R. and Law, M.R., ‘Rethinking Pharmacare in Canada,’ *ibid.*

specialists think that recognition of this pending liability has motivated Ontario, among others, to replace age-based programs with universal income-based drug coverage.¹¹⁶

1.4 Québec: Statutory Multi-Payer Drug Plan Model

Québec has achieved universal drug coverage by making drug insurance mandatory for all residents, “by giving priority to private plans.”¹¹⁷ The province requires residents not covered by private group insurance to enroll in the government drug insurance plan run by RAMQ (Régie de l'assurance maladie du Québec).¹¹⁸ Persons receiving public assistance (including the unemployed), newborn children whose parents already have coverage and seniors 65 and above are covered by the government scheme. Insured individuals must pay premiums subject to a scaled subsidy. Monthly deductibles and copayments apply for adults to a monthly maximum, while prescriptions for those under the age of eighteen are not subject to copayment.

Two types of plans provide coverage: private plans (group insurance or employee benefit) and the public plan, managed by RAMQ. All permanent residents eligible for a private plan must join that plan and provide coverage under it for their spouse and children. Only those persons who are not eligible for a private plan (if they are unemployed or employed in a position without benefits) may register for the PPDI (Public Prescription Drug Insurance) plan. In general, every resident pays an annual premium to ‘Revenue Québec’ for coverage under the PPDI plan. The premium is variable, ranging from \$0 to \$636 per person, based on the annual rates in effect, is established according to the person’s situation and net family income. It is payable even if a person does not purchase any prescription drugs. Rates are adjusted annually on July 1 and collected by the ‘Revenue Québec’. The PPDI plan requires that beneficiaries, in addition to annual premiums

¹¹⁶ Morgan, S.G. and Coombes, M. ‘Income-based Drug Coverage in British Columbia: Toward an Understanding of the Policy,’ *Healthcare Policy* (2006), 2(2): 92-108; cited Morgan, S.G. et al. (2013), at p. 4.

¹¹⁷ Health Canada, *ibid.*, p.34.

¹¹⁸ Government of Quebec, *Régie de l'assurance maladie*,
<https://www.ramq.gouv.qc.ca/en/citizens/prescription-drug-insurance/register-deregister>

at a variable rate from \$0 to \$636, pay at the pharmacy monthly deductibles of \$21.75 (previously \$16.25) and 37 per cent coinsurance (previously 32%).

The Québec plan limits patient charges with monthly out-of-pocket maximum contribution per adult in a household. Amount payable for covered drugs is either \$93.08 per month or \$1,117 per year. Exceptions include persons 65 or over receiving 1%-93% of the GIS (Guaranteed Income Supplement) for whom the annual amount payable now is \$649 or \$54.08 monthly. Children under 18, full-time students aged 18 to 25 (not married and living with parents, or without access to a private plan through a student job or otherwise) and persons with a functional impairment or on social assistance get medications free. Revenue Québec collects the annual premium through income tax returns. Everyone has to pay the public plan premium for every full month during which one had no coverage under a private plan.

Table 3: Quebec's Public Plan for Persons Without Private Insurance¹¹⁹

Member	Annual premium (with subsidy)	Monthly deductible	Co-insurance after deductible	Out-of-pocket maximum (monthly)	Out-of-pocket maximum (annual)
Persons 18-64	\$0 - \$616	\$19.90	34.9%	\$90.58	\$1,087
Seniors (no GIS)	\$0 - \$616	\$19.90	34.9%	\$90.58	\$1,087
Seniors (GIS 1%-93%)	\$0 - \$616	\$19.90	34.9%	\$53.16	\$638
Seniors (GIS 94%-100%) and people with a claim slip from Ministère du Travail, de l'Emploi et la Solidarité Social	\$0	\$0	\$0	\$0	\$0

However, there are exemptions for some. They are generally covered, free of charge, by the PPDI Plan. Three kinds of people are considered eligible for the PPDI plan, namely (1) persons

¹¹⁹ See, Barua, B., et al., *ibid.*, Table 5, p.13.

without access to a private plan; (2) persons aged 65 and over but have not joined a private plan; (3) recipients of last-resort financial assistance.

‘Last-resort financial assistance’ is a *Québec government program providing financial support to persons with limited resources. A person receiving ‘last-resort financial assistance’ benefits is automatically registered for the PPDI plan when his or her file is created* and the opportunity is also available to certain other holders of claim slips. The Guaranteed Income Supplement (GIS) is a monthly benefit added to the Old Age Security (OAS) pension among low-income seniors. Prescription drug insurance plans set out a rate based on the amount of the supplement received. This rate establishes whether or not one qualifies for medications free of charge under the PPDI plan. The working of the plan is illustrated below by a scheme and a numerical example.

Table 4: Québec Resident’s Contribution Explained

Prescription cost	Prescription drug cost + Pharmacist’s professional fee
– Contribution by insured person	Monthly deductible + patient’s portion of the co-insurance (until resident reaches her/his maximum monthly contribution)
= Amount to be paid by the insurer	Cost paid by RAMQ for prescription drugs covered by the public plan

The payment of a prescription of \$60, for example, is apportioned at the pharmacy on the first day of the month in the following way: for a total prescription cost of \$60, the resident first pays the deductible of \$21.75. Then on the remaining \$38.25, she/he pays her/his portion of the co-insurance, amounting to \$14.15. In the end, she/he pays \$35.90 (\$21.75 + \$14.15) of the \$60 invoice.

Table 5: Apportioning Prescription Drug Costs in Quebec

Prescription cost	\$60
--------------------------	------

– Deductible (set amount payable)	– \$21.75
– Remainder to be paid	= \$38.25
Co-insurance	Patient: $\$38.25 \times 37\% = \14.15 RAMQ: $\$38.25 - \$14.15 = \$24.10$

It may be noted that even if the deductible is \$21.75, a resident need not pay this amount for her/his first purchase if the **cost of the prescription is less than the deductible**. This means that, if the first prescription costs \$8, the remainder of the deductible will be payable when the resident makes his/her next purchases, if applicable.¹²⁰

1.5 Conclusion: A snapshot of myriad cost-sharing schemes under provincial plans

In the four provincial models discussed above several different types of cost-sharing schemes are encountered: **deductibles, co-payments and coinsurance, premiums and plan maximum limits or out-of-pocket spending limits**. Based on the most crucial element, i.e., patient charges, a comparative picture of the three select models is shown below in the **Table 6**.

Table 6: Varieties of Patient Charges in Select Models

BC	AB	ON	QC
Deductibles +Co-insurance	Premiums (+Co-insurance only for Non-group coverage)	Deductibles + Co-payments	Premiums + Deductibles + Co-insurance

Deductibles are what an individual (or household) has to pay out-of-pocket (annually or monthly) on prescription drugs before the plan is activated. A **premium** is a fixed amount (monthly or annual) that an individual or household must pay to enroll in a drug insurance plan. This amount

¹²⁰ For more details on Québec, GOQC/RAMQ 2019;
<http://www.ramq.gouv.qc.ca/en/citizens/prescription-drug-insurance/Pages/prescription-drugs-covered.aspx>

is payable whether or not any claims are made. **Co-payments and coinsurance (which have to be paid only after the deductible limit has been reached)** are amounts paid out-of-pocket by an individual or a household each time a prescription is filled, while the remainder is paid by the plan. Coinsurance refers to a percentage amount (e.g., coinsurance of 20% of the prescription cost) whereas co-payment is a fixed payment per prescription (e.g., co-payment of \$5 per prescription). **Plan maximum is the** maximum amount a plan contributes to an individual's (or a household's) prescription drug costs—this can be either an annual or a lifetime maximum— and decides the out-of-pocket spending limit. What eventually matters is the actual amount of out-of-pocket expenditure one must make.

Appendix 2

APPROPRIATE PHYSICIAN PRESCRIBING

Cross-border drug advertisements on US television have considerable spill-over effects in Canada due to proximity, often leading to the impression that drug advertising is legal in Canada.¹²¹ Owing to this cross-border effect, according to a somewhat dated opinion survey, approximately 53% of Canadians believe that prescription drug advertising is legal, even though it is restricted by the FDA.¹²² In Canada, many believe Direct-to-Consumer-Advertising (DTCA) to be permitted and some criticize **the restrictions on DTCA as remaining ineffective**. The spill-over of US drug advertisements compromises the federal government's objective to protect Canadians. US FDA does not require pre-clearance of drug advertisements, leaving them unregulated.¹²³

Even if advertising prescription drugs directly to the public is prohibited in Canada, as in most countries a shift in interpretation of the policy, known as **direct-to-consumer advertising** (DTCA), has nevertheless occurred in Canada, resulting in its partial introduction without public and parliamentary debate. Consultations on the potential introduction of DTCA have been held by *Health Canada* since 1996, but there has been little interest in allowing DTCA from health professional and consumer organizations or provincial governments. Despite this, some forms of advertising of prescription drugs to consumers have become widespread.¹²⁴

¹²¹ Mintzes, B., 'What are the Public Health Implications? Direct-to-Consumer Advertising of Prescription Drugs in Canada' (Toronto: Health Council of Canada, 2006) p.8; cited: Chow, E.C., 'Direct-to-Consumer Advertising of Pharmaceuticals on Television: A Charter Challenge,' *Canadian Journal of Law and Technology*, vol. 9 (2011), p.76.

¹²² "Ipsos-Reid Survey Shows Strong Public Support for Direct-to-Consumer Advertising of Prescription Medications", *Canada News Wire*, News Release (31 January 2002); cited: Chow, *ibid.*

¹²³ *Ibid.*

¹²⁴ Gardner, D.M., et al., 'Direct-to-consumer prescription drug advertising in Canada: Permission by default?' *CMAJ* (September 2, 2003) vol. 169, no. 5, pp.425-427.

Surmising about the role the proposed national drug agency, several respondents in my study expressed concerns over the agency's independence and integrity. Would the officials running such a national agency be immune from the courting by pharmaceutical companies? What measures should the government take to ensure the integrity of the independent agency? One of my respondents wrote: "I also question the independence of the national agency, **knowing that patient groups have often been courted by pharmaceutical companies even through direct funding**. How can the government ensure that this agency is not captured?" –(R001)¹²⁵

Pharmaceutical firms attempt to bias physicians in many ways. That they often invite prescribing doctors to the expensive vacation trips and other inducements are well-known, thanks to investigative journalism.¹²⁶ No less conspicuous are small but carefully crafted day-to-day interactions. The pharmaceutical industry holds on to Canada's healthcare system — swaying doctors' opinions, funding medical schools and, ultimately, affecting the type of drugs we are prescribed by all of these means.¹²⁷

Physicians face financial pressure to prescribe pharmaceutical manufacturers' expensive new drugs even when cheaper drugs may be at least as effective are available. Besides emotional or social pressure distorting a doctor's judgment, free gifts and subtle economic incentives also are at work to bias them, according to many studies on the interactions between doctors and drug company representatives. In 2004, pharmaceutical companies in the US spent an average of \$10,000 per practicing physician on free meals, free continuing medical education (CME) training, free trips to conferences, and payments for various services, according to data compiled by the monitoring company 'IMS Health'. Those drug representatives also gave the average doctor an

¹²⁵ See this thesis, *infra*. Ch 5, Sect. 5.6. Another respondent (R002), also thinks that an independent agency may be susceptible to be corrupted by drug companies: "Such an agency would be prone to economic failure far worse than any 'market failure', not to mention **the risks of corruption.**"

¹²⁶ Hensley, L. and J. Geerster, "'Manipulating physicians': How drug reps pitch your docs," *Global News*, August 5, 2019; <https://globalnews.ca/news/5702980/how-drug-reps-pitch-doctors/>

¹²⁷ *Ibid.*

extra \$21,000 in free drug samples. The total 2004 tab for drug representative strategies: \$23.7 billion. This is two times as much as drug manufacturers spent influencing physicians in 1998.¹²⁸

A survey of nearly 3,200 US physicians in 6 specialties (*New England Journal of Medicine*) found this fact of financial pressure verified. The study showed that drug companies' influence is more ubiquitous than previous studies had found. 94% of the family practitioners, internists, pediatricians, cardiologists, general surgeons, and anesthesiologists surveyed said they accepted drug company money or gifts. Of those, 83% accepted free food, and 78% accepted free drugs. 35% accepted reimbursements for the cost of conferences or CME, and 28% took money for consulting, giving speeches to persuade other doctors to use companies' drugs, or steering their patients into companies' clinical trials.¹²⁹ A study in 2000 (*Journal of the American Medical Association*) reported that from 1982 through 1997, 16 surveys of doctors from a variety of specialties showed that **drug company representatives visited them an average of 4.4 times per month**. By early 2004, as the *New England Journal of Medicine* survey found it, **company representatives were visiting** family practitioners 16 times a month, internists 10 times a month, cardiologists 9 times a month, and pediatricians 8 times (the study did not look at meetings with oncologists). They can visit that often because an army of approximately 100,000 drug industry representatives work to influence around 700,000 active physicians, according to data from industry and the Health Resources and Services Administration.¹³⁰

¹²⁸ [Miller](#), J.D., 'Study Affirms Pharma's Influence on Physicians,' *Journal of the National Cancer Institute*, vol. 99, no. 15, 1 August 2007, pp. 1148-1150; <https://doi.org/10.1093/jnci/djm097>

¹²⁹ *Ibid.*

¹³⁰ *Ibid.*