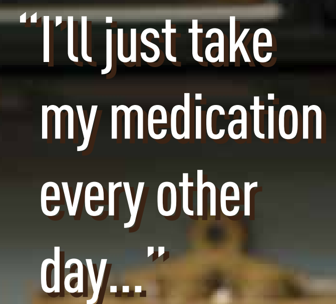
Access to Pharmaceuticals

Why Canadians need to re-think their approach to access to pharmaceuticals, especially in tough economic times.



January 2010

A position paper from the Canadian Council on Integrated Healthcare (CCIH) on why now, more than ever, Canada needs to work towards a new national framework for access to pharmaceuticals, and what incremental building blocks can help us get there.

CCIH
Canadian Council On Integrated Healthcare
Conseil canadien sur les soins de santé intégrés

WHO WE ARE

The Canadian Council on Integrated Healthcare (CCIH) is an independent, non-aligned think tank whose mandate is "to influence and catalyze change…[and to] build bridges between sectors in the healthcare system." Founded in 1997, we are dedicated to helping Canadians understand emerging health issues.

Our vision is for an integrated healthcare system that balances quality, access and cost, and creates better health for all Canadians. Our membership includes key opinion leaders from the private health sector, consumers, and health professions.

The activities of the CCIH are funded through an arm's-length, unrestricted educational grant from sanofi-aventis.

The CCIH also acknowledges the support it receives in time and assistance from its members and their employers.

For more information on the CCIH, please see: www.ccih.ca

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Why this paper by the CCIH

The CCIH is a national, multi-stakeholder professional forum in Canada working to encourage constructive and inclusive dialogue on challenging health-related issues. As our name suggests, integration is a major focus for all the work we do.

We have considered the topic of access to pharmaceuticals[i] over the course of our last three bi-annual sessions.[ii] We gathered information from experts (including our own membership), from people who are living with the hardship of having to pay for expensive medication, and from current literature on this topic. Based on what we learned, we are profoundly concerned about the growing limitations that Canadians are facing across the country in their ability to access prescription drugs that are considered to be an essential component of evidence-based treatment, especially in a time of economic uncertainty. This brief paper is our call to action that seeks to join in a widening and increasingly important dialogue about this topic.[iii]

The primary recommendation we make in this paper

The CCIH believes that Canada must move toward a new framework where there is equitable and reasonable access without undue financial hardship for all Canadians to prescription drugs that are considered to be an essential component of evidence-based treatment. Federal, provincial, and territorial governments must act now to foster this change by:

(a) Providing incentives and funding to ensure Canadians in every province and territory have access to basic coverage for essential drugs where the cost to an individual does not exceed 5% of his or her net income.

(b) Encouraging an integrated approach by governments, individual Canadians, and employers to achieve the goal set out in point (a), recognizing that individual provinces and territories will have unique design solutions based on their own priorities.

(c) Using tax, expenditure, and regulatory levers to achieve an integrated national pharmaceutical coverage solution.

This paper will look at:

ACCESS TO PHARMACEUTICALS – THE PRESENT

- Why change is imperative: We look at variations in access and affordability across the country, stories from real Canadians who are suffering, and challenges currently facing employers.

WHAT'S HAPPENED (OR NOT) SO FAR TO ADDRESS THE ISSUE OF PHARMACEUTICAL ACCESS IN CANADA?

- A brief review of the lack of progress to date.

WHAT IF WE CHOOSE TO DO NOTHING?

- The implications of a failure to act.

ACCESS TO PHARMACEUTICALS: BUILDING BLOCKS TO THE FUTURE

- Our recommendations for how Canada can and should build a new framework for access to pharmaceuticals, including what principles should underlie this new structure and what iterative and concrete steps could be taken to help us get there.

This paper is written for:

Among other audiences, this paper is targeted to policy makers and business leaders. Our intent is to help give explicit, clear suggestions to those who have the ability to influence change. As the paper sets out, however, this topic is one that affects and involves all Canadians: Our hope is that our primary audiences will help channel the messages in this paper outward at different levels and to different audiences to stimulate dialogue.

ACCESS TO PHARMACEUTICALS – THE PRESENT

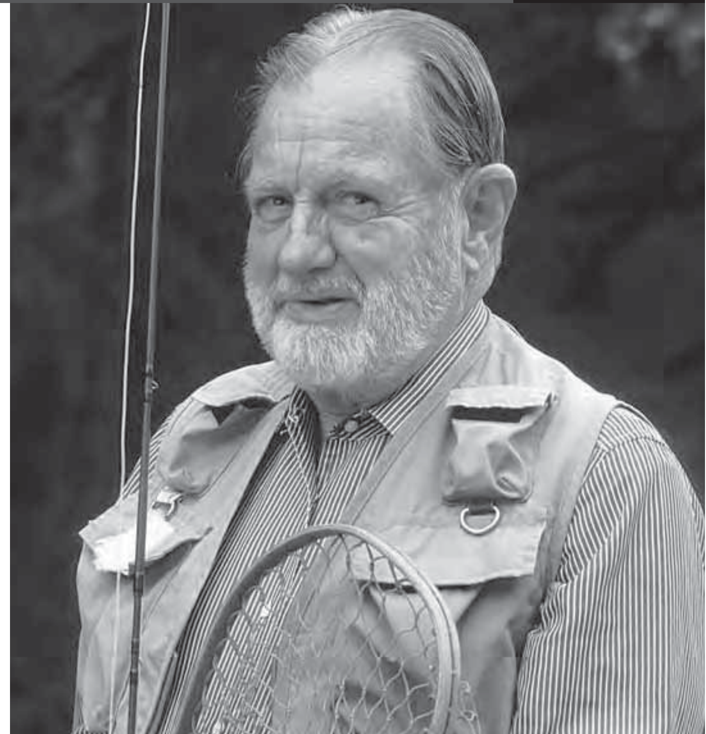
Canadians know that pharmaceuticals help to improve their health and lives, from taking pills for a headache to life-saving cancer drugs.[iv] But few Canadians are aware of the multi-billion dollar cost of pharmaceuticals, who pays for them, and who has (or doesn't have) access to them.[v] Particularly when times are tough, we need to remind ourselves what fundamental beliefs we share as Canadians around healthcare in general, and access to pharmaceuticals in particular. This includes a consideration of ethical issues, such as whether it is fair that someone is covered for essential medication in one province but not in another, or whether employment should assure some Canadians of a higher level of coverage. Our answers truly define who we are as a nation.

The need to act now

Why is it so urgent that we develop a new framework for pharmaceutical coverage in Canada? Some quick facts to consider:

- A recent survey showed that about one in 12 Canadians (8%) said they had not filled a prescription or had missed a dose of medicine in the previous year because of cost, and this survey was before the recent onset of recession.[vi]
- In 2008, the Canadian Institute of Health Information (CIHI) estimated that Canadians spent $25.14 billion on prescription pharmaceuticals.[vii]
- Prescription drugs have been the second-ranked health expenditure type since 1997.[viii] Hospitals are ranked first.
- As recently as 1985, the average annual amount per capita spent on prescribed drugs was $99. It was forecast to be $683 in 2007, a nearly seven-fold increase over the last 22 years. The average annual growth rate was 9.2% over that period, almost four times the general inflation rate of about 2.4%. [ix]
- Less than 40 per cent of drug costs are covered by government; the rest is in the hands of employers, unions and individual consumers.

According to the Health Council of Canada's latest annual report and its January 2009 report on the status of Canada's national pharmaceutical strategy, a major concern in our present system is that government drug plans leave millions of Canadians with little or no protection against financial hardship due to the cost of needed medicines.[x] Furthermore, the harsh reality is that the current economic recession has already, and will continue, to exacerbate an already difficult situation.



The CCIH believes that, as a nation, we have cause to be alarmed. The people of Canada are becoming aware of growing insufficient protection and will hold their governments accountable for funding and structural solutions to help ensure and gain access to reasonable pharmacare coverage.

Real people, real stories

At its essence, the issue of access to pharmaceuticals is really all about people.

It's about Darryl Lynch and Ambrose MacDonald from New Brunswick, who recently lost their jobs at the local mill when it shut down. In their mid-50s, both men say their drug coverage was something they took for granted during their thirty-plus years at the mill. They now have to pay for private insurance for themselves, but neither can get coverage for their wives, because both women were already on medication, and pre-existing medication requirements are not covered by private plans.

According to Darryl, his monthly drug costs "would cover fuel for a month." He feels that losing drug coverage has been "devastating." For his part, Ambrose now pays about $1,700 every three months for his wife's diabetes medication. He works part time, and says it's very hard to pay the bills. He feels that people like him and Darryl are caught in the middle – they don't have coverage from their employer, but they are not yet old enough to be covered by the New Brunswick provincial plan (government coverage for individuals under age 65, healthy or otherwise, does not exist in New Brunswick, except for welfare recipients and those who qualify under a handful of 'Specialty Programs'). When questioned about the idea of moving to get better coverage, Darryl merely responded, "Where am I going to move at this age?"

Then there are those folks who have been facing ongoing challenges for years in terms of their ability to access expensive medication, like Dave Gamblin who has ankylosing spondylitis (a debilitating form of arthritis) and is on Remicade (an intravenous medication that is indicated when there is an inadequate response or intolerance to more conventional therapies). He receives a disability pension and has a rental property that helps pay his bills. His annual income is under $30,000 but, because he and his wife have managed to save some money over the years for retirement, his provincial government plan won't help him until all his savings are gone. Dave says: "I feel like I'm being discriminated against, just because I was responsible over the years and put some money away. I don't understand why the politicians can't see this. Something needs to be done."

Right now drug manufacturer Schering pays for half of Dave's medication and he pays the other half (Remicade costs about $3,000 per month), but he is always fearful that Schering – who reviews his case annually – may stop at some point. He says the cost of the medication is a huge worry and he doesn't know what he'll do in the future if he has to pay the full price. He even said he would consider moving to get better coverage in another province, but added that it would be heart wrenching to leave his grandchildren.

And these are only some examples among many. In the fall of 2007, the Canadian Centre for Policy Alternatives and the Canadian Health Coalition heard from more than 250 Canadians through a series of national public hearings on the subject of access to pharmaceuticals. The final report from that project presents many moving and compelling stories from individual Canadians (both patients and health care professionals) relating the challenges they have faced or seen in terms of accessing necessary prescription medication.[xi]

Why where you live can really matter

Not only is access to pharmaceuticals a critical issue for individual Canadians, depending on their employment, economic well-being, state of health, etc., but it is also highly dependent on where they live. Because provincial drug plans are non-portable, individual Canadians can face tough decisions if they move from province to province: for example, if Remicade is covered in one province but not another, the individual on that medication may either face dire financial consequences from moving, or be unable to move altogether. Different provincial drug plans offer coverage for different groups of patients, utilize different user fee structures for those they do cover, and have different drugs on their formularies (see Appendix 1 for a broad overview of how different provincial drug plans incorporate certain principles).

Statistics show how significant out-of-pocket prescription drug expenditure can be for Canadian households, as well as the differences between provinces.

- Statistics Canada collects data on detailed household expenditures through its Survey of Household Spending (SHS),[xii] which is conducted annually in the 10 provinces and every second year in the territories.
- The expenditures that are reimbursed (e.g., work-related expenses or expenditures covered by insurance) are excluded from the tabulations.[xiii]
- In 2005 Luffman published a detailed analysis of out-of-pocket spending on prescription drugs using SHS data over the 1997-2002 period.[xiv] She reported that the proportion of households spending more than the Kirby threshold of 3% of after-tax income on prescription drugs[xv] had increased from 5.9% to 6.5% over the period.[xvi]
- The most recently released data from the SHS that update Luffman's analysis are for 2006.
- The following Table 1 from Statistics Canada's CANSIM database shows that there has been a further increase in the national proportion of households exceeding the 3% threshold from 6.5% in 2002 to 8.0% in 2006.

Table 1: Proportion of Households Spending Greater than 3% of After-Tax Income on Prescription Drugs, Canada and Provinces, 1997-2006[xvii]

Geography	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Canada	5.9	5.8	6.1	6.3	6.2	6.5	7.1	7.1	7.5	8.0
Newfoundland and Labrador	8.9	8.8	8.8	8.9	8.6	10.6	10.1	11.8	11.5	12.1
Prince Edward Island	10.4	11.8	10.7	13.2	12.9	11.7	14.6	15.2	16.2	14.7
Nova Scotia	6.0	6.8	6.6	7.8	15.0	9.3	9.5	9.7	9.9	8.6
New Brunswick	8.0	8.0	9.0	8.5	11.0	10.2	11.9	9.6	12.2	11.1
Quebec	7.6	7.2	7.3	8.9	8.9	9.5	9.3	10.0	12.1	11.1
Ontario	4.0	4.1	4.5	3.6	3.0	3.3	3.3	3.6	3.3	4.6
Manitoba	8.8	8.0	8.0	10.5	8.5	10.3	12.3	10.1	11.1	12.7
Saskatchewan	15.9	15.6	14.9	15.8	16.4	15.9	16.6	19.0	18.7	16.5
Alberta[xviii]	5.5	5.1	5.6	6.4	5.6	5.2	6.8	4.8	5.8	5.9
British Columbia	4.0	4.3	5.0	4.2	5.3	5.7	8.1	7.7	5.8	8.3

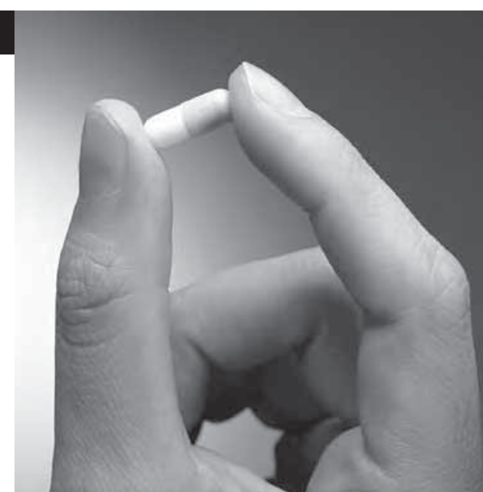
Employers facing challenges

Of course, tough economic times also mean grave challenges for employers and plan sponsors. As a January 2009 article in *Benefits Canada* pointed out (with specific reference to Atlantic Canada), "Private plans that remained viable during a time of relative prosperity now face key issues that have a direct impact on the continued affordability of these plans."[xix] The economic downturn is forcing a re-thinking of plan design; plan members may suddenly find themselves with a different level or type of drug coverage than in the past.[xx]

WHAT'S HAPPENED (OR NOT) SO FAR TO ADDRESS THE ISSUE OF ACCESS TO PHARMACEUTICALS IN CANADA?

Within the past decade, both provincial and federal governments have recognized the ever growing problem of pharmaceutical access. Two federal commissions – Romanow and Kirby – have studied and made recommendations concerning this issue.[xxi] But momentum for change has been disappointingly slow. In its June 2008 report on the 2003 Health Accord, the Health Council of Canada reported that "progress on catastrophic drug coverage has stalled. Meanwhile the current patchwork of government drug plans leaves millions of Canadians with little or no protection against financial hardship due to the cost of needed medicines."[xxii] Three months later, in September 2008, provincial and territorial Health Ministers echoed their disappointment about the lack of movement toward a catastrophic drug plan of some kind; they proposed that the federal government share responsibility for catastrophic drug coverage 50/50 with the provinces and territories.[xxiii] In January 2009, the Health Council reiterated how uneven and inequitable catastrophic coverage is across different jurisdictions in Canada.[xxiv] At the time of writing this paper, no further public pronouncements about catastrophic coverage have been made. The highly political – and constitutional – nature of who pays for what when it comes to multi-billion dollar healthcare has been the major obstacle.[xxv]

WHAT IF WE CHOOSE TO DO NOTHING?



So we have a problem. Right now, prescription drug coverage is at the discretion of each province, thousands of employers, and some unions. Our patchwork of coverage is seriously inadequate and clearly inequitable:

- There is no guarantee of protection against catastrophic drug costs;
- There are no universal standards, benchmarks or criteria for eligibility of either persons or products;
- There are no systems-based processes to guide decisions and policy;
- Too many Canadians are unable to access needed medication because of costs;
- The current reality is that Canadians have highly variable access to an essential healthcare product.

Our challenging economic climate has not changed this. In fact, the combination of rising unemployment and resultant separations from employer-sponsored drug benefit plans, coupled with spending constraints on many of the social determinants of health, makes the need for action even more acute. When individuals have difficulty accessing necessary medications, other health system costs, such as the use of hospital emergency rooms and other services, are likely to grow.[xxvi] Without a national prescription drug framework, our country cannot meet the major needs of our population – particularly a population that is aging and where chronic diseases are becoming more prevalent. The health of many Canadians, especially the elderly, underemployed and unemployed, will remain in jeopardy.

ACCESS TO PHARMACEUTICALS: BUILDING BLOCKS TO THE FUTURE

For all the reasons set out above, the CCIH believes it makes social, ethical and economic sense to improve the access to the pharmaceuticals landscape. Affordable and effective access to drugs should be a basic element of Canadian healthcare and all Canadians should be relieved of a significant financial burden arising from the costs of prescription pharmaceuticals both in and out of the hospital setting. The bottom line is that we need affordable access to high-cost prescription drugs for each Canadian.

Fresh thinking: Looking toward the Québec model for ideas

Our study of the Québec model of pharmaceutical insurance suggests it could serve as one example of a framework that may be politically attainable. We think Québec's approach to pharmaceutical coverage, adopted in 1997, merits further study with regards to its applicability in other jurisdictions.

In his recent Task Force report,[xxvii] Castonguay has summarized the principal features of the Québec model as follows:

- This is a universal plan, meaning that all Québec citizens benefit from basic coverage for medications and pharmaceutical services.
- The plan is contributory, meaning that it provides for the insured's financial participation in the form of a contribution upon purchase (co-insurance and deductible) and an annual premium. However, certain clientele of the public plan do not have to pay anything: these are children, employment or social assistance recipients, and persons age 65 and over receiving at least 94% of the Guaranteed Income Supplement.
- The plan is a mixed plan, which involves the co-existence and co-dependence of private and public drug insurance plans.
- A key element of the Québec model is the use of pooling of risk.[xxviii]

After carefully considering all that we have heard, read and discussed on the issue of access to pharmaceuticals in Canada, including looking at the Québec model for ideas, the CCIH has reached the following conclusions.

The objective for Canada

To move toward a new framework where there is affordable access for all Canadians to prescription drugs that are considered to be an essential component of evidence-based treatment.

Basic principles that should underlie a new framework for access to pharmaceuticals in Canada

1. A new framework should provide affordable coverage for pharmaceuticals. This framework should be needs-based and take into consideration an individual's province/territory of residence, employment status, and ability to pay.

2. The role of the federal government is to provide guidance on principles and hopefully financial incentives for provinces to incorporate these principles. Provinces and territories must have room for flexibility based on provincial/territorial design or priorities, but there also must be strict accountability among and between governments to Canadians for action related to coverage and timelines for access to prescription medicines.

3. Components of a new Canadian framework for access to pharmaceuticals should include:

   - Consideration of a minimum standard formulary or 'category list' that meets the health needs of Canadians and is consistent across the country;
   - Transparency for decision-making related to eligible drugs and populations, cost and cost-effectiveness;
   - Integrated, organized partnerships between federal/provincial/territorial governments, employers, and patients;
   - Assistance for people with special needs (for example, those with low incomes, or those with drug costs that are high relative to their incomes);
   - A ceiling or maximum on what the patient pays (catastrophic drug coverage).

Final recommendations:

Primary recommendation

In response to highly variable access to pharmaceutical coverage in Canada, the changing nature of medical care and the rising costs of coverage, and the current pressures of the global economic recession on individual Canadians, employers and governments, the Canadian Council on Integrated Healthcare makes the following primary recommendation:

That federal, provincial, and territorial governments must act now to ensure equitable and universal access to prescription drugs in Canada by:

(a) Providing incentives and funding to ensure Canadians in every province and territory have access to basic coverage for essential drugs where the cost to an individual does not exceed 5% of his or her net income;[xxix]
(b) Encouraging an integrated approach by governments, individual Canadians, and employers to achieve the goal set out in point (a), recognizing that individual provinces and territories will have unique design solutions based on their own priorities;
(c) Using tax, expenditure, and regulatory levers to achieve an integrated national pharmaceutical coverage solution.

Recommendations for iterative steps

The CCIH also recognizes, however, that building a new framework, especially during a period of fiscal crisis, takes time. To that end, the CCIH recommends the use of iterative steps, including the following:

(a) That there should be agreement nationally on basic coverage for out-of-hospital therapeutic pharmaceuticals that cover the priorities of the provincial/territorial and federal areas of investment such as chronic disease management (for example, diabetes). Such a comprehensive approach would show alignment with overall strategic planning within health care.[xxx]

(b) That the health insurance industry should consider developing a national strategy to pool high-cost drugs (keeping in mind the next step that follows). A next step would be for governments and the health insurance industry to coordinate a national pooling mechanism for high cost prescription medicines.

(c) That governments of all levels should work with representatives of the private payer community to improve the equity, affordability, and integration of coverage for prescription medicines and attempt to ensure that system changes do not negatively affect plan sponsor willingness to continue to sponsor programs.

CONCLUSION

There is a clear problem around access to life-saving and life-altering drugs in Canada. This problem is getting worse. The economic, social, health and ethical costs associated with this lack of access are growing and stand to accelerate as the Canadian economy enters what many economists believe to be the worst recession in 30 years. News coverage about Canadians who are worried about their ability to access prescriptions in the future is becoming more frequent.[xxxi]

This issue affects all Canadians. We are truly ‘all in this together’ – and finding a solution really does necessitate collaboration to reach a different and better framework down the road. This paper is part of ongoing dialogue, where many other voices (some of which have been mentioned here) are being raised. Our goal has not been to suggest a perfect solution to the access to pharmaceuticals challenge, and much work surely must be done in this area. But this paper reflects the culmination of CCIH deliberation over the past year and a half along with some supporting research.

Our hope is to get Canadians (including individuals, governments and the private sector) more aware and active around this whole issue so that the changes we recommend can become reality. It simply is not acceptable for Canada to continue stagnating on this extremely important issue affecting all of us.

We invite you to comment on the ideas presented in this paper. The Canadian Council on Integrated Healthcare can be reached by e-mail at info@ccih.ca or via our website at www.CCIH.ca.

APPENDIX 1

Principles of Provincial Prescription Drug Plans

Principle	BC	AB	SK	MB	ON	QUE	NB	NS	PEI	NL	Territories
Coverage											
over 65	Yes	Yes	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes*	Yes	
under 65	Yes	Yes	No*	Yes	Yes*	Yes	No	No	No	No	
Premium											
over 65	No	No	No*	No	No	Yes*	No	No	No	No	
under 65	No	Yes	No	No	No	Yes*	N/A	N/A	N/A	N/A	
Deductible											
over 65	Yes	No	Yes	Yes	Yes*	Yes*	No	No	No	No	
under 65	Yes	No	No*	Yes	Yes*	Yes	N/A	N/A	N/A	N/A	
User Co-payment											
over 65	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	
under 65	Yes	Yes	Yes	No	Yes	Yes	N/A	N/A	N/A	N/A	
Yearly max.											
User contribution over 65	Yes	No	Yes*	Yes	No	Yes*	Yes*	Yes	No	No	
under 65	Yes	No	No	Yes	No	Yes	N/A	N/A	N/A	N/A	
Exceptional Circumstances Consideration	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Public/Private payers	Yes	No	No	Yes	No	Yes	No	Yes	No	No	

*Income dependent

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Members
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Observers
Nicholas Neuheimer and Michèle Parent

END NOTES

i By access to pharmaceuticals, we mean people's ability to obtain medications that have been proven to treat, prevent, or mitigate a disease or medical condition. See also three opportunities for access to pharmaceuticals as set out in the National Pharmaceutical Strategy: Develop, assess and cost options for catastrophic pharmaceutical coverage; Common National Drug Formulary; Accelerated access to breakthrough drugs through regulatory improvements http://www.hc-sc.gc.ca/hcs-sss/pubs/pharma/2006-nps-snpp/2006-nps-snpp-2-eng.php

ii See our September 2008 communiqué as well as previous meeting synopses for further background on the Council's deliberations on the subject of access to pharmaceuticals. Of note, the CCIH also held a Payers' Forum in late 2006 where the issue was identified by diverse participants from both public and private sectors as a pressing challenge within Canada's health care system. Information on all the foregoing is available at www.ccih.ca.

iii Some of the other voices in this dialogue are referenced in this paper. Among the most recent commentaries on the issue of access to pharmaceuticals is the Health Council of Canada's January 30, 2009 report titled, 'The National Pharmaceuticals Strategy: A Prescription Unfilled'. Toronto. 2009. http://www.healthcouncilcanada.ca/docs/rpts/2009/HCC_NPS_StatusReport_web.pdf

iv According to Health Canada, "Pharmaceuticals are playing an increasingly important role in Canadians' health and Canada's health care system. They save lives, prevent the spread of disease, improve the quality of life for many, and control pain and suffering. Their role is likely to grow in the future as technological advances result in new drug therapies that replace earlier treatment methods or provide new options where no treatment existed before." http://www.hc-sc.gc.ca/hcs-sss/pharma/indexeng. php

v The Health Council of Canada remarks on this, suggesting that the issue of pharmaceuticals in Canada "has not received the same level of public interest as changes to other areas of the health care system, perhaps because the concerns about prescription medications are not well known or understood." The National Pharmaceuticals Strategy: A Prescription Unfilled. Toronto. 2009.

vi Schoen C, Osborn R, Doty MM et al. (2007). Toward higher-performance health systems: adults' health care experiences in seven countries, 2007. Health Affairs; 26(6): w717–w734.

vii CIHI, November 13, 2008 release. Spending on health care to reach $5,170 per Canadian in 2008. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_13nov2008_e

viii CIHI, 2008. National Health Expenditure Trends, 1975-2008. ix CIHI, 2008. Drug Expenditure Report. See Table A – CA Per Capita. p. 62.

x Health Council of Canada. Rekindling reform: Health care renewal in Canada, 2003-2008. Toronto. 2008. Health Council of Canada. The National Pharmaceuticals Strategy: A Prescription Unfilled. Toronto. 2009.

xi The hearings were held to learn "about Canadians' experiences and insights regarding the cost, effectiveness, appropriateness, and availability of prescription drugs. " The final report from those hearings, titled 'Life Before Pharmacare', can be found at: http://www.policyalternatives.ca/~ASSETS/DOCUMENT/National_Office_Pubs/2008/Life_Before_Pharmacare.pdf

xii Canadian Intergovernmental Conference Secretariat. Backgrounder - National Pharmaceutical Strategy: decision points. http://www.scics.gc.ca/cinfo08/860556005_e.html.

xiii Statistics Canada. User guide for the Survey of Household Spending, 2008. Catalogue no. 62F0026M. Ottawa: Minister of Industry, 2008.

xiv Luffman J. Out-of-pocket spending on prescription drugs. Perspectives on Labour and Income 2005; 6(9):5-13.

xv In 2002, Senator Michael Kirby, Chair of the Standing Senate Committee on Social Affairs, Science and Technology, tabled a final report that was the culmination of two and half years of study and input regarding the Canadian health care system. The threshold figure mentioned here is from that report: The health of Canadians – the federal role. Volume six: Recommendations for reform. Ottawa. 2002.

xvi Luffman does acknowledge that "Data on prescription drug expenditures rely heavily on the respondent's interpretation of the question. Variation in coverage, method of payment, and deductibles in many private and public insurance plans also adds to the complexity. For example, respondents are asked to exclude amounts for which they were reimbursed, but this may be difficult to calculate for some types of insurance." However, Luffman also notes that "An estimated 62% of Ontarians are covered by private drug plans, the highest level in Canada (AMFGTR 2000). Smaller, less industrialized provinces are less likely to have private plans that cover expenses not picked up by the public plan (CFHCC 2002)." Statistics Canada further points out that "In 2001, public insurance plans covered approximately 46% ($6.1 billion) of total prescription costs, and private insurance plans covered approximately 34% ($4.5 billion). Individuals paid the remaining 20% ($2.6 billion) out of their own pockets (CIHI 2004)." http://www.statcan.gc.ca/pub/75-001-x/10905/8621-eng.pdf

xvii Source: Statistics Canada. Table 109-5012 – Household spending on prescription drugs as a percentage of after-tax income, Canada and provinces, annual, CANSIM (database). http://cansim2.statcan.gc.ca/cgiwin/cnsmcgi.pgm?&Lang=F&ArrayId=109-5012&Array_Pick=1&Detail=1&ResultTemplate=CII/CII___&RootDir=CII/&C2SUB=HEALTH

xviii Alberta has announced a major change to its drug support program effective for 2010. Please see http://www.health.alberta.ca/

xix Falcone, Leslie, MacGillivary, Uriel, et al. (2009). East Coast Swing. Benefits Canada online, January 1, 2009 at: http://www.benefitscanada.com/benefit/health_wellness/article.jsp?content=20090106_174659_29808

xx According to the Health Council of Canada: "When insurance companies are faced with the increasing costs of prescriptions, eventually they look to their beneficiaries to contribute more to the total cost through higher premiums, larger deductibles, and co-payments. Insurance companies might also opt to drop coverage of some medications. In some cases, private plans will pay for prescription costs only to a yearly or lifetime maximum, or will not cover certain medications at all. And the loss of a job that includes private insurance coverage can catapult someone with high prescription costs into a financial crisis, placing undue stress on patients and their families." The National Pharmaceuticals Strategy: A Prescription Unfilled. Toronto. 2009.

xxi The national studies reported in 2002 by Senator Kirby and by the Commission on the Future of Health Care in Canada (Romanow) have forged a consensus on the need for "catastrophic" pharmaceutical coverage, which may be defined as out-of-pocket prescription drug expenditures that exceed a certain threshold of household income. Standing Senate Committee on Social Affairs, Science and Technology. The health of Canadians – the federal role Volume six: recommendations for reform. Ottawa, 2002. Canadian Intergovernmental Conference Secretariat. 2003 First Ministers' Accord on Health Care Renewal. February 5, 2003. http://www.scics.gc.ca/pdf/800039004_e.pdf.

xxii Health Council of Canada. Rekindling reform: Health care renewal in Canada, 2003-2008. Toronto. 2008.

xxiii Canadian Intergovernmental Conference Secretariat. Annual conference of provincial-territorial Ministers of health, Québec City, Québec, September 4, 2008. http://www.scics.gc.ca/cinfo08/860556004_e.html

xxiv Health Council of Canada. The National Pharmaceuticals Strategy: A Prescription Unfilled. Toronto. 2009.

xxv Legally, health care is a provincial responsibility, but the Canada Health Act (1984) ensured a limited federal role for health care financing.

xxvi Tamblyn R, Laprise RL, Hanley JA, Abrahamowicz M, Scott S, Mayo N, et al, 2001. Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons. Journal of the American Medical Association (JAMA) 285: 421-429. Goldman DP, Joyce GF, Zheng Y, 2007. Prescription Drug Cost Sharing: Associations With Medication and Medical Utilization and Spending and Health. JAMA, 298: 61-69.

xxvii GETTING OUR MONEY'S WORTH. Task Force on the Funding of the Health System http://www.financementsante.gouv.qc.ca/en/rapport/pdf/RapportENG_FinancementSante.pdf

xxviii By way of further background: • All Québec residents who are eligible for a private plan must join that plan. The public plan covers persons aged 65 or over, employment assistance recipients and 1.7 million people who do not have access to a private plan. In 2006, the public plan covered 3.2 million people or 41% of the Québec population. • The public plan has an annual premium that varies from $0 to $570 per adult, depending on net income and it is collected retrospectively through the income tax system. Both public and private plans have a maximum annual contribution per person of $927 (2008-09) including premium and copayments.

xxix "Establishing a national standard of pharmacare coverage for all Canadians. The proposed funding agreement would protect the flexibility and autonomy of provinces and territories to define programs for their populations, ensure that prescription drug costs will not exceed 5% of the net income base for their respective populations, and recognize shared responsibility by allocating the cost of catastrophic drug coverage 50/ 50 between the federal government and the provinces or territories…." From the Health Council of Canada. The National Pharmaceuticals Strategy: A Prescription Unfilled. Toronto. 2009. Here the Health Council is referring to National Pharmaceuticals Strategy decision points of the Canadian Intergovernmental Conference Secretariat (September 4, 2008), Annual Conference of Provincial-Territorial Ministers of Health [backgrounder at http://www.scics.gc.ca/cinfo08/860556005_e.html].

xxx Studies show that prescription drug costs rise along with an individual's incidence of chronic disease. See, for example: The Commonwealth Fund. The 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults. New York. 2008.

xxxi For example, see Tavia Grant's February 9, 2009 article in the Globe and Mail titled "Use it before you lose it", an account of how employees are "maxing out" on health benefits, including prescriptions, before being laid off or facing a reduced benefit plan. Story accessed at: http://www.theglobeandmail.com:80/servlet/story/RTGAM.20090209.wxlbenefits09/BNStory/Business/

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