HOW WOULD A SINGLE-PAYER PUBLICLY FUNDED NATIONAL PHARMACARE PROGRAM AFFECT THE QUALITY OF ACCESS TO MEDICINES FOR CANADIAN PATIENTS?

AUTHOR: Viktoria Roman, Alexandru Dobrescu, and Sarah Lussier Hoskyn

INNOVATIVE MEDICINES CANADA

The data indicates that Canada's dual-payer system works for the majority of Canadians. However, there are some **identifiable gaps** that need to be filled to ensure that all Canadians have access to needed medicines regardless of their **income, age, sex, or postal code**.

There are two priority populations that face the greatest drug access challenges and who need coverage the most in a universal pharmacare plan

Low-income Canadians with chronic diseases who would benefit from an essential medicines list.

Canadians with rare diseases, who cannot easily afford their treatments.

Canadian public plans fall short in the quality of reimbursement compared to Canadian private plans. Filling coverage gaps and lowering out-of-pocket costs for publicly-covered beneficiaries would be more fiscally responsible while still meeting the priority needs of Canadians.

BACKGROUND

The Hoskins report on National Pharmacare recommended the creation of a single-payer public model, transitioning from a list of essential medicines to a "comprehensive" list by 2027. However, evidence demonstrates the lack of comprehensiveness of coverage in the existing system for public payer beneficiaries, and raises doubts about its ability to meet the priority needs of vulnerable Canadians who are falling through the cracks.

OBJECTIVE

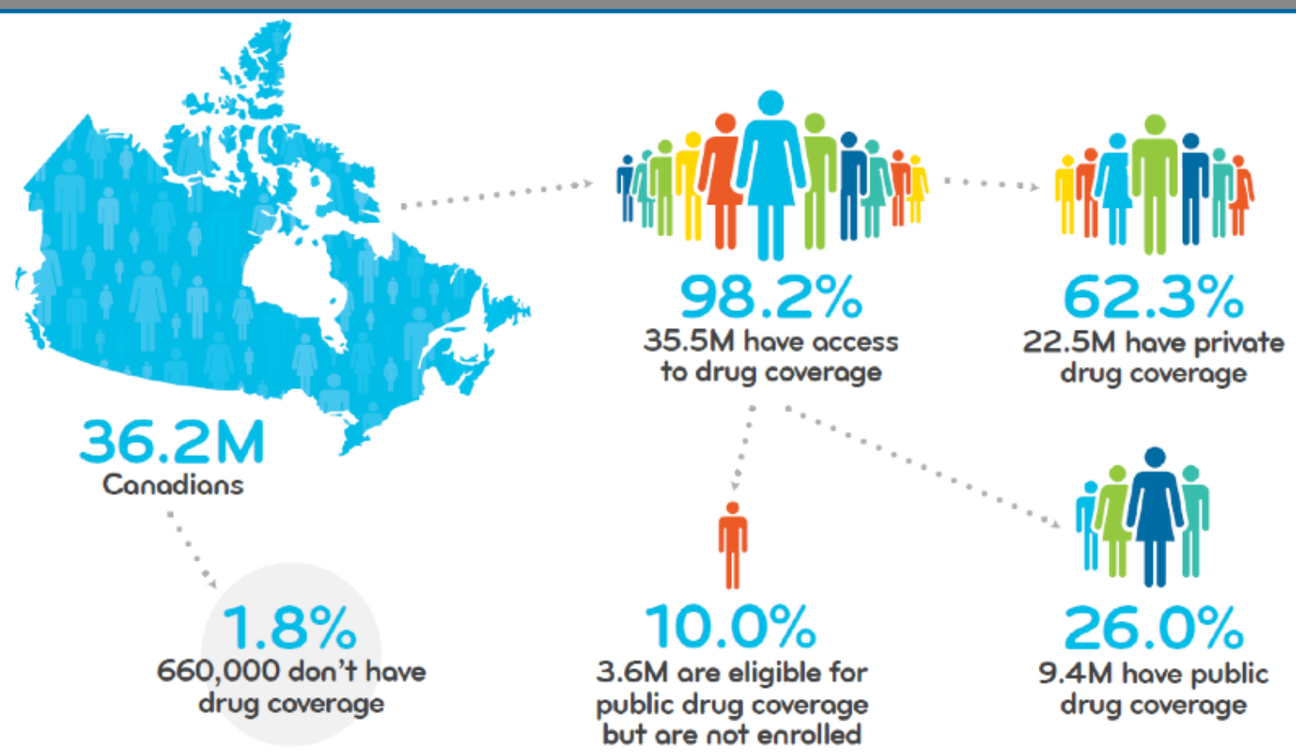
This analysis summarizes evidence found in the literature on the availability and affordability of insurance coverage and of medicines in Canada's public plans to highlight improvements needed, and to inform a universal pharmacare plan that leverages the strengths of the current mixed public-private model in a fiscally responsible manner.

METHODS

Using data from various IQVIA databases and literature, this research focuses on differences within therapeutic categories related to quality and quantity of access to medicines, and drug utilization patters of various target populations in public and private plans in Canada.

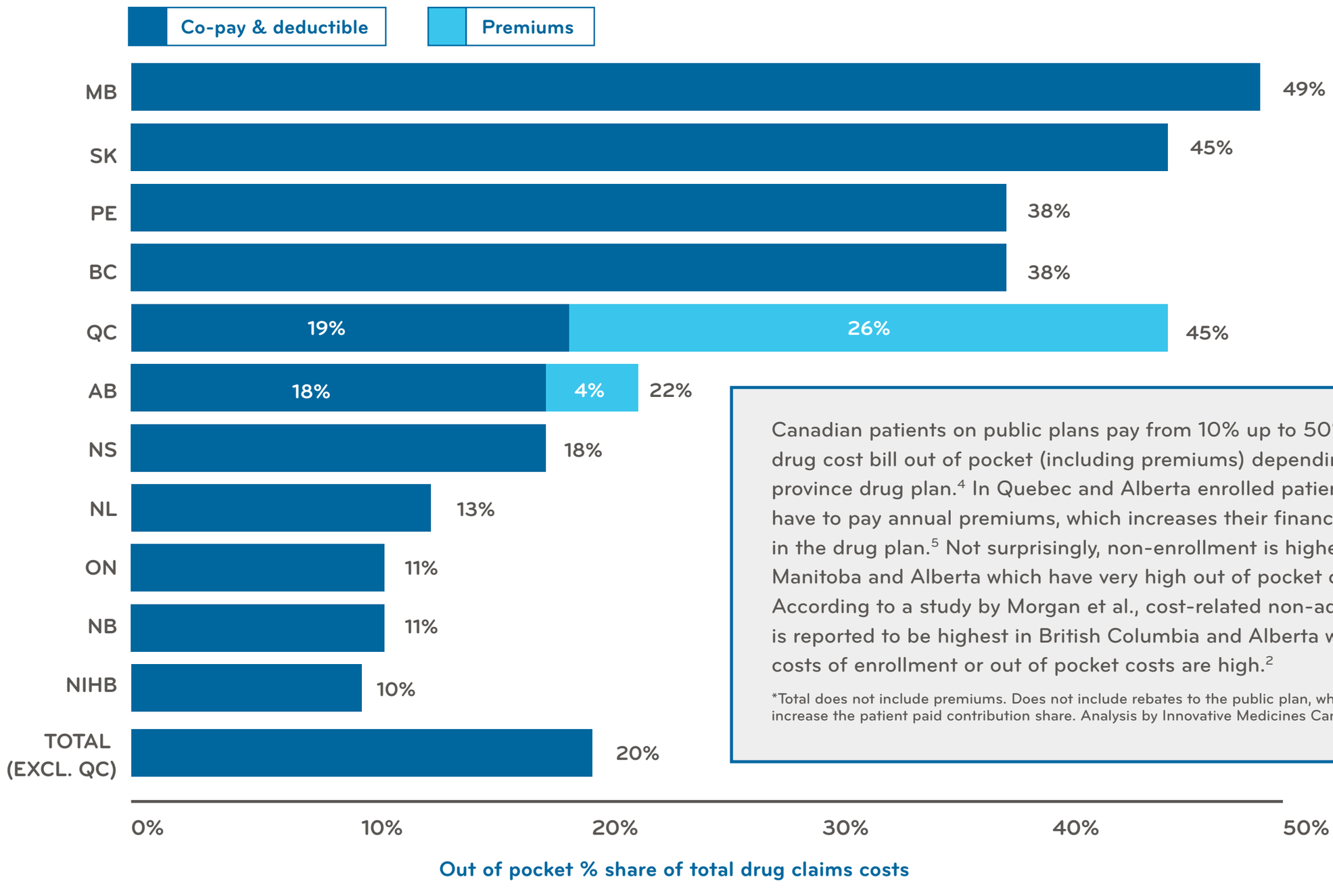
① MOST CANADIANS ARE GENERALLY WELL-SERVED BY THE CURRENT MIXED PUBLIC-PRIVATE PHARMACARE SYSTEM – HOWEVER, THERE ARE SOME WHO ARE POTENTIALLY VULNERABLE[3]

While the evidence shows that the current dual payer system is robust, there are some Canadians that are falling through the cracks and unable to pay for their medicines – those who need high cost drugs and whose employers are cutting access by adding caps on their benefit plans, as well as those who are low-income and struggle to pay for their chronic disease medications.[1,2] Insurance status also matters: those who have no coverage (1.8%), who are not enrolled (10%), and who are covered by a public plan only (26%) are the most vulnerable to affordability issues.[3]



② ONE IMPORTANT GAP IN PUBLIC PLANS IS THE HIGH COST SHARING BURDEN OF JOINING OR PARTICIPATING IN MANY PUBLIC PLANS, LEADING TO LOWER RATES OF ENROLLMENT[4,5]

Patient paid share of prescription drug expenditures, by province*



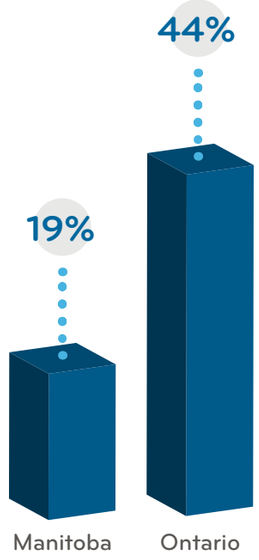
Canadian patients on public plans pay from 10% up to 50% of their drug cost bill out of pocket (including premiums) depending on the province drug plan.[4] In Quebec and Alberta enrolled patients also have to pay annual premiums, which increases their financial burden in the drug plan.[5] Not surprisingly, non-enrollment is highest in Manitoba and Alberta which have very high out of pocket costs.[3] According to a study by Morgan et al., cost-related non-adherence is reported to be highest in British Columbia and Alberta where costs of enrollment or out of pocket costs are high.[2]

*Total does not include premiums. Does not include rebates to the public plan, which would increase the patient paid contribution share. Analysis by Innovative Medicines Canada.

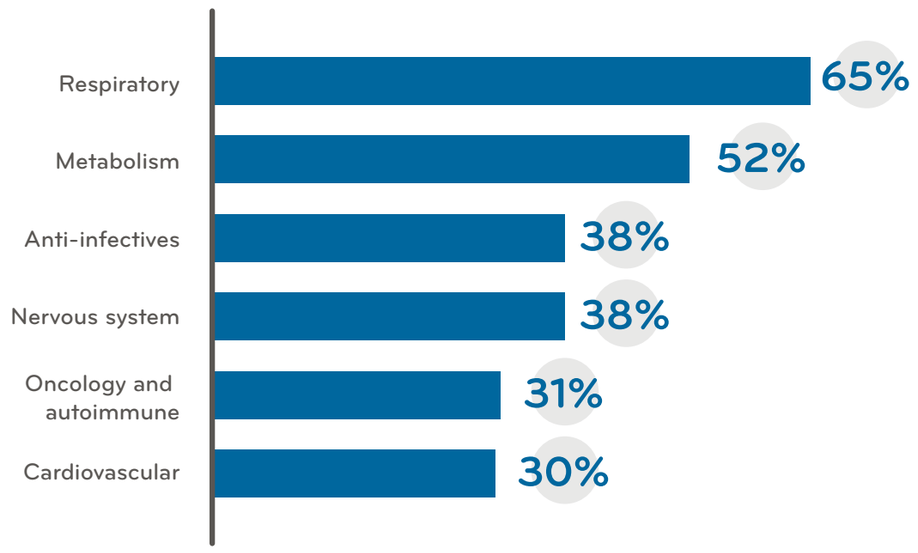
3 MANY CANADIANS CURRENTLY COVERED UNDER A PRIVATE PLAN WOULD LOSE COVERAGE TO IMPORTANT MEDICINES UNDER A PUBLICLY-FUNDED SINGLE PAYER NATIONAL PHARMACARE PROGRAM*

% Share of Private-Reimbursed DINs Not Reimbursed by Public Plan*

Highest and Lowest Provinces



Top 6 Therapeutic Classes, Ontario, by Total Claims Costs 2016-2019 (75% of total costs)

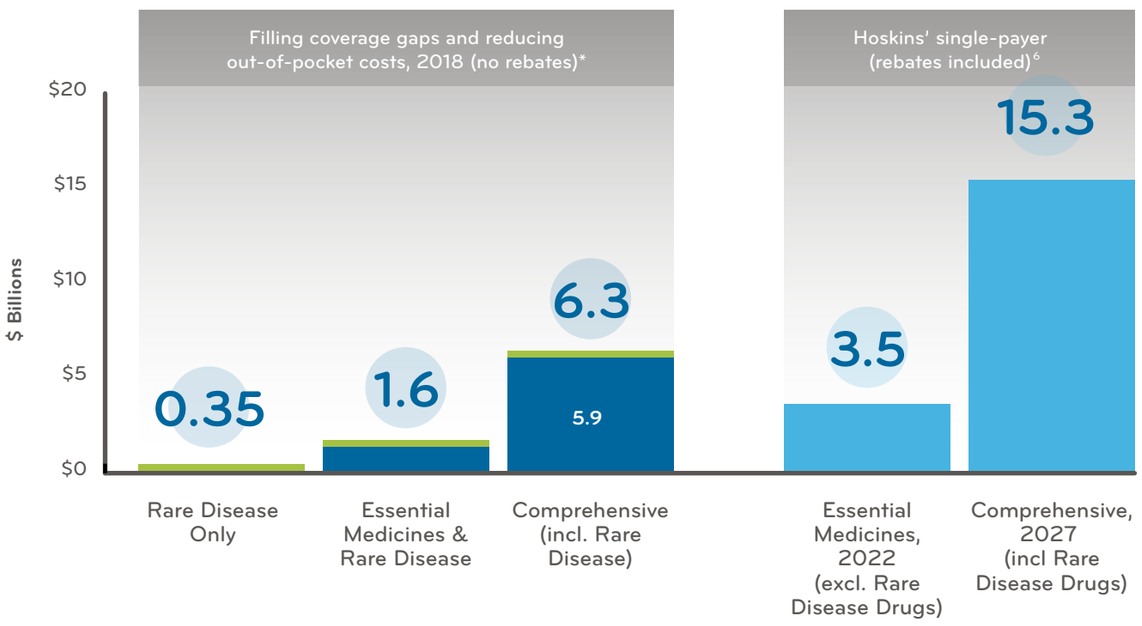


Between 19% - 44% of DINs that are reimbursed by a private plan in a given province are not reimbursed in the province's public plan counterpart, with Ontario being the highest, at 44%. In the top 6 therapeutic classes in Ontario in terms of spending, between 30-65% of DINs reimbursed by a private plan are not reimbursed by Ontario's public plan, with respiratory drugs being the highest, at 65%. These are mostly chronic conditions and, as a result, these patients are routinely facing more limited options to treat their long-term conditions.

*DINs with at least one private plan claim, without a claim in the same province's public drug plan. Data from IQVIA Pharmastat. Analysis by Innovative Medicines Canada.

4 FILLING PRIORITY GAPS WOULD COST SIGNIFICANTLY LESS, PROVIDE BETTER QUALITY OF ACCESS, AND ADDRESS AFFORDABILITY ISSUES BETTER THAN A UNIVERSAL SINGLE-PAYER PHARMACARE MODEL*[6]

Pharmacare Cost Scenarios, Fill in the Gaps vs. Single-Payer



It would cost less than half of Hoskins' single-payer estimate to cover Canadians that are uninsured or underinsured, reduce coverage gaps in public plans, and lower the out of pocket costs across Canada's public plans. Note that this does not include rebates, which would lower the cost further, and includes a more comprehensive list than the Hoskins model (any drug reimbursed in at least one provincial public plan in Canada). While Hoskins' model takes over the costs of those who currently benefit from better private insurance coverage, this model assumes that the private market continues to operate independently (except for rare disease drugs which would be taken over by the public program) while the key gaps are filled through the public reimbursement system.

*Data from IQVIA, Pharmastat, analysis by Innovative Medicines Canada. Ingredient costs & mark-ups only, dispensing fees excluded (except in Quebec). Federal plans excluded. No changes to drug ingredient costs or to mark-ups assumed. List of drugs based on availability in at least one public plan across Canada (more comprehensive than Quebec formulary and the Hoskins' model).

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